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On behalf of themselves and all others similarly situated

SUPERIOR COURT OF THE STATE OF CALIFORNIA

FOR THE COUNTY OF LOS ANGELES

ARTHUR BODNER and MICHAEL FELKER, on behalf of themselves and all others similarly situated,

Plaintiffs,

v.

BLUE SHIELD OF CALIFORNIA LIFE AND HEALTH INSURANCE COMPANY, Does 1 through 25, Inclusive,

Defendants.

CASE NO. BC516868
Assigned to Honorable Elihu M. Berle, D 323

FIRST AMENDED CLASS ACTION COMPLAINT

1. **BREACH OF CONTRACT**
2. **BREACH OF THE IMPLIED COVENANT OF GOOD FAITH AND FAIR DEALING**
3. **VIOLATIONS OF BUSINESS AND PROFESSIONS CODE § 17200**
4. **DECLARATORY RELIEF**

Plaintiffs, by their attorneys, bring this action on behalf of themselves and all others similarly situated against Defendant Blue Shield of California Life & Health Insurance Company ("Blue Shield") and Does 1 through 25 (Blue Shield and Does 1 through 25 are collectively referred to as the "Defendants"). Plaintiffs allege the following on information and belief, except as to those allegations that pertain to the named Plaintiffs, which are stated on personal knowledge:

NATURE OF THE ACTION

1. The commonly accepted meaning of "deductible" in health insurance is the specific dollar amount of covered expenses that an insured must pay in a year before the insurer starts paying for these expenses. The commonly accepted meaning of "out-of-pocket maximum" in health insurance is the highest dollar amount for covered expenses an insured could pay in a year for deductibles, co-payments and coinsurance.

2. This action concerns Blue Shield's attempt to twist and bend the meaning of these commonly used terms until they are rendered unrecognizable and meaningless, so as to defeat the reasonable expectations of policyholders and effectively steal thousands of dollars in benefits from them.

3. Contrary to the commonly accepted meaning of "deductible" and "out of pocket maximum," as well as statements in Blue Shield's marketing materials and the policy language itself, Blue Shield relies upon a variety of obscure, contradictory and confusing provisions contained in footnotes and elsewhere in the policies' Summary of Benefits ("Summary") to increase the policies' annual deductible and out-of-pocket maximum to indefinite and ever-expanding amounts. These provisions do this by purporting to eliminate from the deductible and out-of-pocket maximum commonly used medical services such as doctor visits, x-rays, MRIs and laboratory services. Blue Shield even transforms certain admittedly covered services to non-covered services until the out of pocket maximum is met.

4. Blue Shield's separate treatment of various covered services for purposes of determining the deductible and out-of-pocket maximum is not presented in a simple, unambiguous, let alone clear and understandable provision, or even on a single page, such that an objectively reasonable insured would have any idea of Blue Shield's intent. Rather, Blue Shield scatters this information throughout the lengthy policy in different provisions, footnotes and asterisked language. The policyholder must conduct lengthy back and forth mental gymnastics to try and determine if and when services are subject to a deductible, if and when services count and don't count toward the deductible, if and when services count and don't count toward out-of-pocket maximum, and if and when no-copayment really means no copayment, or no coverage at all.

5. The result is that policyholders purchase Vital Shield policies believing they have a particular finite deductible and out-of-pocket maximum, only to learn after injury or illness that Blue Shield is taking an entirely different position, and that they have fallen into a financial bottomless pit.

THE PARTIES

6. Plaintiff Arthur Bodner is a resident of San Francisco, California. Mr. Bodner is currently enrolled in a Blue Shield Vital Shield 2900[1] individual health insurance policy, which he purchased in July 2008. Mr. Bodner's Vital Shield 2900 policy describes a Calendar Year Deductible of $2,900 and a Calendar Year Copayment/Coinsurance Maximum responsibility of $5,900. Attached as Exhibit A is a true and correct copy of Mr. Bodner's Vital Shield 2900 policy.

7. At all times herein mentioned, plaintiff Michael Felker was a resident of Malibu, California. Mr. Felker purchased a Blue Shield Vital Shield Plus 400 Generic Rx individual health insurance policy in March, 2010. Mr. Felker's Vital Shield Plus 400 Generic Rx policy

[1] In December 2011, Mr. Bodner received a notice from Blue Shield that, effective March 1, 2012, or upon the first billing date after March 1, 2012, his policy would become the "Vital Shield 2900 – G" policy ("G" indicates a "grandfathered health plan" under the federal Affordable Care Act).

describes a Calendar Year Deductible of $400 and a Calendar Year Copayment/Coinsurance Maximum responsibility of $2,900. Attached as Exhibit B is a true and correct copy of Mr. Felker's Vital Shield Plus 400 Generic Rx policy.

8. Blue Shield is a corporation duly organized and existing under the laws of the State of California, with its principal place of business located in San Francisco, California. It is authorized to transact and is transacting the business of providing health insurance throughout California.

9. The true names, roles and capacities of defendants named as Does 1 through 25, inclusive, are currently unknown to Plaintiffs and, therefore, are named fictitiously pursuant to California Code of Civil Procedure section 474. Plaintiffs will identify their true identities and their involvement in the wrongdoing at issue if and when they become known. The conduct of all defendants described herein, including that of Does 1 through 25, and each of them, was undertaken or authorized by Blue Shield's officers or managing agents who were responsible for supervision and operations decisions. The described conduct of said managing agents and individuals was therefore undertaken on behalf of Blue Shield. Blue Shield further had advance knowledge of the actions and conduct of said individuals whose actions and conduct were ratified, authorized, and approved by said managing agents.

JURISDICTION AND VENUE

10. This Court has jurisdiction over this action under Article VI, section 10 of the California Constitution, and section 410.10 of the Code of Civil Procedure. Jurisdiction is also proper under Business and Professions Code section 17200, *et seq.*

11. This Court has jurisdiction over Blue Shield, which is a resident of the State of California. Jurisdiction over Blue Shield is also proper because Blue Shield has purposely availed itself of the privilege of conducting business activities in California and because Blue Shield currently maintains systematic and continuous business contacts with this State, and has many

thousands of policyholders who are residents of this State and who do business with Blue Shield.

12. Venue is proper in this Court because Plaintiff Michael Felker and many class members transacted business with Blue Shield in the County of Los Angeles, because Blue Shield maintains a principal place of business in Los Angeles County, and because Blue Shield received substantial revenue from policyholders/Class members who reside in Los Angeles County.

FACTUAL ALLEGATIONS

A. Blue Shield's Marketing and Sale of the Vital Shield Policies

13. Consumers shopping for health insurance generally look at three critical pieces of information to evaluate a health insurance product: 1) the premium; 2) the deductible and 3) the annual out-of-pocket maximum – the most they will have to personally pay each year for the deductible and expense sharing (copayments and coinsurance). Health insurance companies compete for business by advertising their premiums, deductibles and out-of-pocket maximums to the public.

14. In 2007, Blue Shield introduced its Vital Shield products to target the large numbers of consumers searching the Internet for health insurance price information. Blue Shield's business plan for these products was to mass-market them online, and through brokers, on the basis of low premium rates and low or moderate out-of-pocket maximums. "With more individual health insurance purchasers using online comparison sites, Blue Shield of California Life & Health Insurance Company has introduced a lower-cost PPO plan designed to grab the attention of web-savvy consumers." (Blue Shield Press Release, *Blue Shield of California Introduces New Lower Cost PPO Plan for Individuals* (July 11, 2007).[2]

15. Blue Shield believed that the optics of low cost – low premiums on the front end and low or moderate deductibles and out-of-pocket maximums once claims were incurred on the back – would readily attract thousands of purchasers. As Karen Vigil, senior vice president of

[2] The Blue Shield press release is attached as Exhibit C.

Blue Shield's Individual, Small Group and Government Business, stated: "More and more consumers are looking for lower-cost options that will help them receive routine medical coverage . . . That's what this plan delivers – and with a price structure that will make sure that those consumers will find it, whether they're buying coverage online or working with a trusted broker." (*Id.*)

16. To execute this plan, Blue Shield developed and used online and print materials that advertised, promoted, and emphasized the Vital Shield policies' low premiums and low or moderate deductibles and out-of-pocket maximums. For instance, Blue Shield developed and used sales brochures proclaiming that the "Vital Shield plans offer you valuable heath coverage at an affordable rate." The brochures stated that the advantages of the plan include "low monthly rates," certain expenses to which the deductible ***did not apply***, such as two physician office visits, and "100% coverage for most services after meeting the out-of-pocket maximum." The brochures also set forth a graphic illustrating the "Annual deductible" and the "Annual out-of-pocket maximum." For example, for the Vital Shield 2900 policy, the brochures list a deductible of $2,900 and an "out-of-pocket maximum" of $5,900.[3]

17. In its "choosing your health plan" booklet, Blue Shield advised purchasers that "the maximum amount you have to pay each **calendar year** is called the **copayment/coinsurance maximum** or the **out-of-pocket maximum**." (Emphasis in original.)[4] The booklet advises that the Vital Shield plans' advantages include "[m]onthly rates as low as $45," a "[c]hoice of low or moderate annual deductible ($900 or $2900)," and that "[y]ou're covered at 100% after you meet the copayment maximum." The booklet goes on to state that the calendar-year copayment/coinsurance maximum includes the deductible amount and then lists the amounts of $5,900 and $4,900, respectively, as the copayment/coinsurance maximum amounts for the Vital

[3] Blue Shield's Vital Shield and Vital Shield Plus brochure, attached as Exhibit D.

[4] Blue Shield's "choosing your health plan" booklet, attached as Exhibit E.

Shield 2900 and Vital Shield 900 policies.

18. Statements regarding "low" premiums and low or moderate out-of-pocket maximum amounts were repeated in other advertising materials disseminated by Blue Shield. For instance, on its website, Blue Shield advertised the Vital Shield Plus policies as having "[a]nnual out-of-pocket maximums as low as $2,900" and "[a]nnual medical Deductibles as low as $400." On the same website page, Blue Shield promised that Vital Shield Plus policyholders "can have the confidence they're protected in case of unexpected medical problems or emergencies, without copayments after the out-of-pocket maximum is met, for most covered services."[5]

19. As intended by Blue Shield, various online comparison sites repeated these numbers and provided premium quotes.

20. Blue Shield's plan to lure purchasers through the advertising of the Vital Shield products' low premiums and low or moderate deductibles and out-of-pocket maximums was successful. Tens of thousands of Californians purchased[6] the following Vital Shield policies:

Vital Shield 900

Vital Shield 2900

Vital Shield Plus 400

Vital Shield Plus 900

Vital Shield Plus 2900

Vital Shield Plus 400 Generic Rx

Vital Shield Plus 900 Generic Rx

Vital Shield Plus 2900 Generic Rx

21. Blue Shield, however, did not intend to provide products with low premiums and low or moderate deductibles and out-of-pocket maximums. Blue Shield actuarially designed the

[5] Blue Shield website page, Vital Shield Plus Individual and Family Plans, downloaded May 23, 2012, attached as Exhibit F.

[6] Blue Shield stopped selling the Vital Shield products in approximately July of 2012.

Vital Shield policies to carry artificially low premiums and shift the balance of cost to those who would incur claims through the use of ever-expanding deductibles and virtually non-existent out-of-pocket maximums. Despite the ordinary and plain meaning of "deductible" and "out-of-pocket maximum," and Blue Shield's use of those terms in the same sense when marketing and selling the policies, Blue Shield used contradictory and confusing policy language to disguise the fact that it would substantially expand the amounts recited for the deductible and out-of-pocket maximum to the detriment of policyholders.

C. The Deductible

22. The policies' "Deductible" provision states that the deductible amount is shown in the Summary and that benefits are paid after this amount is satisfied "for those Services to which the appropriate deductible ***applies***." (Ex. A at p. 33; Ex. B at p. 37, emphasis added.) The provision further provides that the deductible ***applies*** to all covered expenses except those shown in the Summary. As stated above, Blue Shield advertised the fact that the deductible did not apply to certain expenses because Blue Shield paid for them, such as the first two physician office visits. The Deductible provision then draws a distinction between when an expense does not apply to a limit (because Blue Shield pays for it) and when it does count toward a limit by stating that the deductible "***does not count toward***" the copayment/coinsurance maximum. (Ex. A at p. 33; Ex. B at p. 36.)

23. This distinction is maintained in the Summary. The Summary begins by saying it is "only a brief description of the benefits," and that the policyholder should "read this Policy carefully for a complete description of provisions, benefits," *etc.* (Ex. A at p. 1, Ex. B at p. 1.) It then sets forth a highlighted area with the bolded heading "Calendar Year Deductible" and the corresponding "Deductible Responsibility" amount, for instance, "$2,900" for the Vital Shield 2900. (*Id.*) Below this section, the Summary states that the deductible ***applies*** to all covered

expenses except certain expenses Blue Shield pays for (*e.g.*, the first two physician office visits).[7] The Summary goes on to state, however, that a variety of other expenses "***do not count toward***" the deductible such as physician office visits, x-rays, MRIs, *etc.*

24. Through use of this contradictory language, Blue Shield improperly expands the deductible amount. It disregards the plain and ordinary meaning of "deductible," the same meaning it used when advertising the policies' low cost and low deductible amounts. Blue Shield uses language in the Summary to change the meaning of the words "applies" and "does not count toward" in the Deductible provision so as to render the deductible amount a meaningless and ever-expanding number.

25. Rather than follow the ordinary and plain meaning of "deductible," the meaning it used when marketing and selling the policies, Blue Shield applies a contrary meaning that changes the finite deductible amount to an indefinite and ever-expanding amount by removing a variety of commonly used services, such as physician office visits, radiological procedures, pathology and laboratory services, from its calculations as to when a deductible has been met. Because many of the eliminated services are medical procedures that occur early in the diagnosis and treatment of an illness, *e.g.*, policyholders have been forced to pay hundreds or thousands of dollars beyond the stated deductible amount.

C. The Copayment/Coinsurance Maximum

26. As set forth above, Blue Shield's marketing materials included the representation that the policies had an "out-of-pocket maximum" and provided a specific dollar figure for that amount. The materials also equated the phrase "out-of-pocket maximum" to "copayment/coinsurance maximum" and explained that this is "the maximum amount you have to pay each calendar year." (Ex. D.)

[7] In truth, not even the first two doctor visits are in fact paid for by Blue Shield. Blue Shield has designed the policy so that it can claw back these expenses from patients who frequently visit the doctor by not counting doctor office visit expenses towards the deductible or out-of-pocket maximum, and eliminating doctor visits from coverage until the maximum has been met.

27. In the policies' "Maximum . . . Copayment/Coinsurance Responsibility" provision, Blue Shield continues to refer to a "maximum" amount for copayment and coinsurance but inserts an asterisk to reference a "note" that says "[c]ertain Services" are not included in the calculation of the maximum and that these items are shown in the Summary. (Ex. A at p. 35; Ex B. at p. 39.) The note does not distinguish between covered and non-covered services and uses the defined term "Services" which simply includes "medically necessary" services. (*Id.*)

28. The portion of the Summary relating to the copayment/coinsurance maximum, like the Summary's deductible section, contains a bolded section listing the purported maximum annual amount a policyholder will have to pay, for instance, "$5,900" for the Vital Shield 2900. (Ex. A at p. 2.) In footnotes to the bolded heading "Maximum . . . Copayment/Coinsurance Responsibility," however, the Summary then lists a variety of expenses that are not covered at all until the maximum is met and/or "are not included in the calculation of the Maximum . . . ."

29. Footnote 1 purports to transform admittedly covered services into non-covered services (*e.g.*, physician office visits, x-rays, MRIs, laboratory expenses, psychological testing, Home Health Care Services) until the copayment/coinsurance maximum is met, and further states that those expenses "do not count toward" the maximum. (Ex. A at p. 2; Ex. B at p. 5.) This footnote contradicts the accepted notion of a maximum, the highest amount a policyholder could pay for covered expenses. Further, the language purportedly transforming covered services into non-covered services until the maximum is met: 1) contradicts the language of the Maximum provision where the asterisked note only references expenses "not included in the calculation of the Maximum" with no mention of nonpayment of covered expenses; 2) creates an irreconcilable conflict with the meanings of Copayment and Coinsurance, defined policy terms that refer to the ***cost-sharing*** (by dollar amount or percentage) between Blue Shield and the policyholder; and 3) is further confused by Blue Shield's use of the phrase "No Copayment" with respect to these services in the Summary's chart.

30. To confuse matters further, a second footnote does not preclude payment for what is a greater number of services (including out-patient prescription drugs[8]) but says these expenses "are not included in the calculation of the Maximum . . ." Here again, the notion that a maximum can be transformed into something other than a maximum by eliminating expenses for a variety of purportedly covered services from its calculation, contravenes the meaning of an out-of-pocket maximum.

31. Blue Shield has also improperly expanded the copayment/coinsurance maximum by not counting the deductible toward it. To begin with, the policies place a statement regarding the deductible not counting toward the maximum in the Deductible provision. But it is the copayment/coinsurance maximum that is affected by this exclusion, not the deductible, so this placement is not appropriate. This double-counting of expenses contradicts the meaning of a maximum and the promise in Blue Shield's marketing materials, consistent with that meaning, that the deductible ***does*** count toward the maximum, as referenced above.

32. Rather than adopt the ordinary and plain meaning of out-of-pocket maximum (or copayment/coinsurance maximum), and in the same sense it used that term when marketing and selling the policies, Blue Shield applies a contrary meaning that changes the finite maximum amount to an indefinite and ever-expanding amount by excluding and/or not counting expenses for a variety of services, and by not counting the deductible toward the maximum. Because many of the eliminated expenses are for medical procedures that occur early in the diagnosis and treatment of an illness, *e.g.*, physician office visits, radiological procedures, pathology and laboratory services, policyholders are regularly forced to pay hundreds or thousands of dollars beyond the stated out-pocket-maximum amounts.

33. Further, the eliminated medical procedures include some very expensive

[8] As with the first two physician office visits, Blue Shield does not apply the deductible to prescription drug charges, it pays for them. However, Blue Shield then claws back these expenses by not counting them toward the out of copayment/coinsurance maximum. (See Ex. A at p. 2; Ex. B at p. 5)

treatments, which the policies purport to cover. Accordingly, an insured could potentially incur thousands of dollars for such treatments, supposedly covered expenses, without ever reaching his or her coinsurance maximum.

D. Explanation of Benefits

34. Blue Shield provides its insureds with Explanation of Benefits ("EOB") statements after it processes claims. Blue Shield's EOBs do not clearly and understandably set forth how much of a claim counts towards the deductible. The EOBs do not mention co-insurance/co-payment maximum or out-of-pocket maximum at all. Accordingly, the EOBs further serve to confuse insureds and hide Blue Shield's deceptive, fraudulent and unlawful business practices, and breaches of policy terms.

E. Plaintiff Arthur Bodner

35. In July 2008, based on representations made by a Blue Shield customer service representative that he would save "about one-hundred dollars a month" in premium payments if he switched from his Blue Shield "Shield Savings 4000/8000 Plan" to the Blue Shield Vital Shield 2900 Plan, Mr. Bodner undertook independent research to understand the difference in the policies and whether he should move from one to the other. He reviewed the web site of defendants Blue Shield, and Does 1 through 25 and each of them. There he was shown a comparison chart that enabled him to directly compare the provisions of a number of individual Blue Shield health plans including the Vital Shield plans. Based upon these comparisons, Mr. Bodner elected to terminate his "Shield Savings 4000/8000 Policy" and enroll in the Vital Shield 2900 plan. Critical to his decision were the representations on the web page that the Vital Shield 2900 policy had a $2,900 annual deductible, and a $4,900 annual maximum out-of-pocket provision.

36. In February 2011, Mr. Bodner sustained injuries in a fall. As a result, Mr. Bodner required appropriate medical services, including surgery.

37. Following his accident, Mr. Bodner had accrued $2,355.88 in out-of-pocket costs

for doctor's office visits, x-rays, and laboratory and diagnostic tests rendered through April 26, 2011. Of that $2,355.88, Blue Shield only credited $1,290.76 toward Mr. Bodner's $2,900 annual deductible and $1,065.12 toward his $5,900 coinsurance maximum.

38. By the time Blue Shield determined that Mr. Bodner had met his annual deductible of $2,900, he had in fact been charged a total of $5,056.09 in out-of pocket costs for doctor's visits, lab tests, x-rays, surgery and surgery-related costs through April 29, 2011. At that point, he still had not met his policy's $5,900 out-of-pocket maximum ("Maximum Calendar Year Copayment/Coinsurance Responsibility").

39. Although he had met his annual deductible, Mr. Bodner continued to incur charges for medical service without any contribution from Blue Shield. Moreover, Mr. Bodner's out-of-pocket costs for certain covered services were not applied toward the stated annual deductible or toward the out-of-pocket maximum.

40. In the six or more months following his 2011 injury, Mr. Bodner continued to pay for necessary medical treatment. On August 31, 2011, Mr. Bodner underwent another surgery. After that surgery, Mr. Bodner's out-of-pocket costs for doctor's visits, lab tests, x-rays, surgery and surgery-related costs through August 31, 2011 totaled $13,765.27.

F. Plaintiff Michael Felker

41. In 2010, Plaintiff Michael Felker purchased the Blue Shield Vital Shield 400 Generic Rx plan. His decision to purchase this plan was based upon the representations of his insurance agent that the plan carried an annual deductible of $400 for providers within the Blue Shield provider network, and an annual out-of-pocket maximum of $2,900 for services within the Blue Shield network. The agent's representations were based on the agent's review of Blue Shield's marketing materials regarding the Vital Shield plans.

42. In May, 2010, Mr. Felker was involved in an automobile accident. As a result of injuries sustained in the accident, Mr. Felker was advised by his physician to undergo an

outpatient MRI. He was told by the radiology provider that the MRI required "pre-approval" from Blue Shield, which Mr. Felker thereafter obtained. Blue Shield's requirement of pre-approval for an MRI validated Mr. Felker's expectation that his Vital Shield Plus 400 Generic Rx individual health insurance policy would cover the cost of the MRI once he met his $400 annual deductible.

43. In August of 2011, Mr. Felker received a bill for the MRI totaling $2,900. Subsequent billing by the medical provider and Mr. Felker's inquiries to Blue Shield revealed that the insurer was refusing to cover the cost of the MRI altogether. By August of 2012, Mr. Felker's insurance agent had determined by inquiry to Blue Shield that not only would the $2,900 MRI bill not be covered, but also that it couldn't be covered until the policy's $5,900 coinsurance maximum had been satisfied. The agent also advised that she had never understood, until her inquiry to Blue Shield concerning Mr. Felker's circumstance, that under the Vital Shield plans, for certain services such as an MRI, there was no coverage until both the annual deductible and the coinsurance maximum were satisfied.

44. Even after Mr. Felker paid $2,900 for his MRI, not a single cent of that out-of-pocket expenditure went toward meeting his $400 annual deductible, or the $2,900 coinsurance maximum.

CLASS ALLEGATIONS

45. This action is brought on behalf of Plaintiffs both individually and on behalf of all other similarly situated current California residents pursuant to Code of Civil Procedure section 382. Plaintiffs seek to represent the following Class:

> All current California residents who are currently enrolled in, or who were enrolled in, an individual Blue Shield Vital Shield policy, including Vital Shield 2900, Vital Shield 2900-G, Vital Shield Plus 2900, Vital Shield Plus 2900-G, Vital Shield Plus 2900 Generic Rx, Vital Shield Plus 2900 Generic Rx-G, Vital Shield 900, Vital Shield 900-G, Vital Shield Plus

900, Vital Shield Plus 900-G, Vital Shield Plus 900 Generic Rx, Vital Shield Plus 900 Generic Rx-G, Vital Shield Plus 400, Vital Shield Plus 400-G, Vital Shield Plus 400 Generic Rx, and/or Vital Shield Plus 400 Generic Rx-G policies.

46. Excluded from the Class are persons who are no longer enrolled in an individual Vital Shield policy and did not incur any expanded deductible or out-of-pocket maximums.

47. The proposed Class is composed of thousands of persons dispersed throughout the State of California. The precise number and identity of Class members are unknown to Plaintiffs at this time, but can be obtained from Blue Shield's records.

48. There are questions of law and fact common to the members of the Class, which predominate over questions affecting only individual Class members.

49. Plaintiffs' claims are typical of the claims of the Class as they both have suffered similar harm and/or are threatened with irreparable harm as set forth in detail below.

50. Plaintiffs are willing and prepared to serve the Court and the proposed Class in a representative capacity. Plaintiffs will fairly and adequately protect the interests of the Class and have no interests adverse to or which materially or irreconcilably conflict with the interests of the other members of the Class.

51. The self-interests of Plaintiffs are co-extensive with and not materially antagonistic to those of absent Class members. Plaintiffs will undertake to represent and protect the interests of absent Class members.

52. Plaintiffs have engaged the services of counsel listed below who are experienced in complex class litigation and the issues raised in this action, will adequately prosecute this action, and will assert and protect the rights of and otherwise represent Plaintiffs and absent Class members.

53. A class action is superior to other available means for the fair and efficient

adjudication of this controversy. The injuries suffered by individual Class members are small compared to the burden and expense of individual prosecution of the complex and extensive litigation needed to address the Defendants' conduct. Individualized litigation presents a potential for inconsistent or contradictory judgments or the establishment of incompatible standards of conduct. By contrast, a class action presents far fewer management difficulties, allows the hearing of claims that might otherwise go unaddressed, and provides the benefits of single adjudication, economies of scale, and comprehensive supervision by a single court.

54. Blue Shield, Does 1 through 25, and each of them have acted or refused to act on grounds generally applicable to the Class, thereby making appropriate final and injunctive relief with respect to Plaintiffs and members of the Class as a whole.

FIRST CAUSE OF ACTION
(Breach of Contract)

55. Plaintiffs hereby repeat and reallege paragraphs 1 through 55, and incorporate the same as though fully set forth herein.

56. Blue Shield issued to Plaintiffs and class members the Vital Shield policies.

57. The essential material terms of the Vital Shield policies are: (A) Blue Shield's promise that it would provide Benefits for all Medically Necessary Services once Plaintiffs had met their specifically stated deductible amount, except for copayments and co-insurance and (B) Blue Shield's promise that Plaintiffs and class members would not pay more than the specifically set forth out-of-pocket maximum in any calendar year for deductibles, co-payments or co-insurance. These material terms are inferred from the written provisions of the Vital Shield policies, namely the "Principle Benefits and Coverages," Deductible and Out-of-Pocket Maximum Provisions, interpreted in their ordinary and popular sense and read in the context and circumstances under which the Policies were marketed and entered into.

58. At the very least, the Deductible and Co-Insurance Provisions are ambiguous, and should be interpreted against the insurer to protect the Plaintiffs' objectively reasonable

expectations of coverage, which were Blue Shield's promises: (A) To provide Benefits for all Medically Necessary Services once Plaintiffs had met their specifically stated deductible amounts, except for copayments and co-insurance, (B) That Plaintiffs and class members would not pay more than the specifically set forth out-of-pocket maximum in any calendar year for deductibles, co-payments or co-insurance; and (C) That the Deductible would count towards the out-of-pocket maximum.

59. Additionally, Blue Shield's attempt to exclude or limit coverage for many commonly-used services, contrary to the Plaintiffs' objectively reasonable expectations of coverage, through the use of footnotes and other obscure provisions, is not "conspicuous, plain or clear" and thus unenforceable under California law. The limits on coverage are not conspicuous because, among other things, they are not placed and printed so that they would attract the reader's attention, such as with headings in capitals or language in the body in larger type than the surrounding test, or in contrasting type, font or color. Additionally, the limiting language is not precise and understandable.

60. Blue Shield breached the terms and provisions of the Vital Shield policies by, among other things:

(a) Expanding the specifically stated deductible amounts set forth in the policies;

(b) Expanding the specifically stated out-of-pocket maximum (or co-insurance/co-payment maximum) set forth in the policies;

(d) Failing to pay for all Medically Necessary Services, except for Co-Payment and Co-Insurance, once the specifically stated annual deductible amounts in the policies had been met; and

(e) Failing to pay for all Medically Necessary Services once the Plaintiffs' specifically stated out-of-pocket maximum amounts set forth in the policies had been met.

61. As a proximate result of the aforementioned unreasonable and bad faith conduct of defendants, plaintiffs have suffered, and will continue to suffer in the future, damages under the Vital Shield policies, plus interest, and other economic and consequential damages, for a total amount to be shown at the time of trial.

SECOND CAUSE OF ACTION
(Breach of Implied Covenant of Good Faith and Fair Dealing)

62. Plaintiffs hereby repeat and reallege paragraphs 1 through 62, and incorporate the same as though fully set forth herein.

63. Under California law, the duty of good faith and fair dealing exists in every contract. Essentially, the doctrine provides that each party to a contract should act reasonably and in good faith. In the insurance context, that doctrine imposes additional requirements on insurers to, among other things, not refuse coverage on the basis of an arbitrary or unreasonable interpretation of its policy and to provide benefits promptly and without any unreasonable delay.

64. As alleged above, the relationship of insurer and policy owner existed between Plaintiffs and Blue Shield. Such relationship caused there to be implied in law a duty of good faith and fair dealing.

65. Blue Shield breached its duty of good faith and fair dealing by, among other things, unreasonably misconstruing the Vital Shield Policies' Deductible and Co-Insurance Maximum/Out-of-Pocket Maximum provisions. Among other things, Blue Shield improperly and unreasonably expanded the deductible and out of pocket maximum (or copayment/coinsurance maximum) stated in the policies to an indefinite and ever-expanding amount. Blue Shield also improperly and unreasonably excluded a variety of services from coverage until the maximum was met, if ever.

66. As a proximate result of the aforementioned unreasonable and bad faith conduct of defendants, plaintiffs have suffered, and will continue to suffer in the future, damages under the Vital Shield policies, plus interest, and other economic and consequential damages, for a total

amount to be shown at the time of trial.

67. As further proximate result of the unreasonable and bad faith conduct of the Blue Shield, Plaintiffs and members of the Class were compelled to retain legal counsel and to institute litigation to obtain benefits due under the Vital Shield policies. Therefore, Blue Shield is liable for the attorneys' fees, witness fees and litigation costs reasonably incurred in order to obtain such policy benefits.

68. The conduct of the Defendants, and each of them, as hereinbefore alleged, was committed with fraud, malice, and oppression as defined in California Civil Code section 3294, in that said conduct was despicable, and was carried out with a willful and conscious disregard for the rights of insurance consumers such as the Plaintiffs, thereby subjecting the Plaintiffs to cruel and unjust hardship. The Plaintiffs are informed and believe, and thereon allege that the acts of fraud, malice, and oppression on the part of the Defendants, and each of them, were on the part of their officers, directors, and alter egos, or managers and agents, and/or were ratified by the Defendants, and each of them. Therefore, the Plaintiffs request the imposition of an exemplary damage award against the Defendants, and each of them, pursuant to California Civil Code section 3294, in an amount to be determined according to proof at the time of trial, which is sufficient to punish and deter the Defendants, and each of them, and to make an example of them.

THIRD CAUSE OF ACTION
(Violation of Business & Professions Code § 17200, *et seq.*)

69. Plaintiffs hereby repeat and reallege paragraphs 1 through 70, and incorporate the same as though fully set forth herein.

70. Business and Professions Code section 17200, *et seq.*, the Unfair Competition Act (hereinafter, "UCL") prohibits acts of "unfair competition", which includes "any unlawful, unfair or fraudulent business act or practice and unfair, deceptive, untrue or misleading advertising" as well as any act prohibited by Sections 17500, *et seq.* Defendants' acts constitute unlawful, unfair and/or fraudulent business practices and unfair, deceptive, untrue or misleading advertising within

the meaning of Sections 17200 and 17500, as alleged more specifically below.

A. Unlawful Acts

71. Defendants have violated the unlawful prong of the UCL through violations of Insurance Code sections 330, *et seq.*, 780, 790.03(a), 10603 and 10604, and 10 Cal. Code Regs 2536.2.

72. Insurance Code section 780 provides, in pertinent part: "An insurer or officer or agent thereof, or an insurance broker or solicitor shall not cause or permit to be issued, circulated or used, any statement that is known, or should have been known, to be a misrepresentation of the following: (a) The terms of a policy issued by the insurer or sought to be negotiated by the person making or permitting the misrepresentation. (b) The benefits or privileges promised thereunder."

73. Insurance Code section 790.03(a) expressly provides that advertisements and other marketing techniques, which misrepresent the terms of any policy to be issued, are unfair and fraudulent acts and thus constitute unfair competition.

"The following are hereby defined as unfair methods of competition and unfair and deceptive acts or practices in the business of insurance.

(a) "Making, issuing, circulating or causing to be made, issued or circulated, any estimate, illustration, circular, or statement misrepresenting the terms of any policy issued or to be issued or the benefit or the benefits or advantages promised thereby ...."

74. Defendants violated Insurance Code sections 780 and 790.03(a) by causing, permitting to be issued, circulated and using in its press releases, website advertisements, sales brochures, and communications to brokers and agents, statements that Defendants knew, or should have known, to be misrepresentations of the terms of the Vital Shield Policies, including but not misrepresentations regarding the amount of the deductible, the amount of out-of-pocket maximum, and that the deductible did not count towards the out-of-pocket maximum.

75. Defendants also violated specific regulations regarding the use of misleading advertising in the sale of insurance promulgated by the California Insurance Commissioner. For instance, 10 Cal.Code. Regs Section 2536.2(a)(1) expressly prohibits the use of deceptive words, phrases and illustrations in health insurance advertisements which have the "capacity, tendency or effect of misleading or deceiving purchasers or prospective purchasers as to the nature or extent of any policy benefit payable, loss covered or premium payable." Moreover, Section 2536.2 expressly provides that the fact the policy offered is made available for inspection prior to consummation of the sale, such as through a 10-day free look period, does not relieve the insurer of liability for its deception.

76. The California regulations provide a numbers of specific examples of unfair and deceptive advertisements prohibited by section 2536.2. For example, Guideline 2536.2(a)(1), Example No. 28, identifies as deceptive and unfair "Advertisements for policies whose premiums are modest because of their limited coverage or limited amount of benefits [that] describe premiums as "low," "low cost," "budget" or se qualifying words of similar import. This rule also prohibits the use of words such as "only" and "just" in conjunction with statements of premium amounts when used to imply a bargain."

77. Defendants' advertising campaign directed at potential policyholders and agents/brokers, repeatedly violated Example No. 28 by promising "low" premiums to imply a bargain.

78. Example No. 33 in Guideline 2536.2(a)(1) prohibits "An advertisement which is an invitation to contract and which fails to disclose the amount of any deductible and/or the percentage of any co-insurance factor...." Guideline 2536.2(a)(8)(b)(1) further provides that advertisements regarding specific dollar amounts of benefits, must also disclose the exceptions, reductions and limitations in the advertisement.

79. Defendants' advertising campaign directed at potential policyholders repeatedly

violated Example No. 33 to Guideline 2536.2(a)(1) and Guideline 2536.2(a)(8)(b)(1) because its advertisements presented the insureds with very specific deductible and co-insurance information, without disclosing all the exceptions and limitations.

80. Insurance Code section 330, *et seq.*, imposes on insurers a duty to disclose to purchasers all facts material to their purchase which the purchaser has not the means of ascertaining.

81. Blue Shield violated Insurance Code section 330, et seq., because it failed to disclose in good faith material information about the Vital Shield policies to the plaintiffs prior to their purchase of the policies, namely that the deductibles and out-of-pocket maximum were not finite, but were ever-expanding. Plaintiffs did not have the means to ascertain that the deductible and out-of-pocket maximums were indefinite and ever-expanding.

82. The Vital Shield insurance policies also violate Insurance Code sections 10603 and 10604 because they misrepresent important terms of coverage and fail to provide, in easily understood language that is clearly organized, information about the exceptions, reductions, and limitations of the coverage.

B. Fraudulent Acts

83. Defendants have also violated the "fraudulent" prong of the UCL. As alleged above, Defendants misrepresented to Plaintiffs that Blue Shield would provide them health insurance policies with low premiums and low or moderate deductibles and out-of-pocket maximums. But defendants' representations were misleading and deceptive because Blue Shield actuarially designed the Vital Shield policies to carry artificially low premiums and shift the balance of the actual cost of coverage to the sick and injured through the use of ever-expanding deductibles and virtually non-existent out-of-pocket maximums.

84. Plaintiff Bodner relied on the above misrepresentations and omissions in purchasing the Vital Shield 2900 plan.

85. Plaintiff Felker relied on the above misrepresentations and omissions in purchasing the Vital Shield 400 plan.

C. Unfair Acts

86. Defendants' conduct violates the "unfair" prong of the UCL because Defendants' aforementioned conduct breached the implied covenant of good faith and fair dealing contained in the Vital Shield policies as alleged above.

87. Finally, Defendants' conduct also violates the "unfair" prong because the Vital Shields policies are form contracts, which the Defendants have systematically breached as alleged above.

88. As a direct and legal result of the Defendants' violations of section 17200 as described above, Plaintiffs and Class members have suffered injury in fact in the form of damages for out-of-pocket medical expenses because Defendants failed to properly give Plaintiffs credit for certain covered medical services against their annual deductible and their annual out-of-pocket maximum.

89. Plaintiffs and Class members are entitled to equitable relief in the form of full restitution of all monies paid for unexpected annual out-of-pocket costs for medical treatments and services, and for disgorgement of the profits derived from said Defendants' unlawful business acts and practices.

90. Plaintiffs also seek an order enjoining Defendants and each of them from engaging in such unlawful, fraudulent and unfair business practices in the future.

FOURTH CAUSE OF ACTION
(Declaratory Relief)

91. Plaintiffs hereby repeat and reallege paragraphs 1 through 90, and incorporate the same as though fully set forth herein.

92. As set forth in detail above, an actual controversy over which this Court has jurisdiction now exists between Plaintiffs on the one hand, and Blue Shield, Does 1 through 25,

and each of them on the other hand, concerning their respective rights, duties and obligations under the terms of the Vital Shield policies and under law.

93. Additionally, all health insurance policies sold in California must provide certain coverages, without limitation, including for (a) severe mental illness (Ins. Code section 10144.5(d)); (b) emotional disturbances of children (Ins. Code section 10144.5(d)); diabetes outpatient self-management training (Ins. Code section 10176.61(e)) and contraceptives (Ins. Code section 10123.196).

94. Plaintiffs contend that any language in the Vital Shield policies' Summary which would exclude payment for Outpatient Diabetes self-management training, Family Planning, treatment for Severe Mental Illness and Serious Emotional Disturbances of a Child and Psychological Testing until the out-of-pocket maximum has been met, and provides that such services do not count toward the deductible and out-pocket maximum, violates the above statutes, and is therefor unenforceable. Upon information and belief, Blue Shield contends that such language does not violate California law and is enforceable.

95. Plaintiffs desire a declaration of rights under such agreements and under law, which declaration may be had before there has been any further breach of such obligations in respect to which such declaration is sought.

96. Plaintiffs may be without adequate remedy at law, rendering declaratory relief appropriate in that:

(a) relief is necessary to inform the parties of their rights and obligations under the above-described Vital Shield contracts;

(b) damages may not adequately compensate Plaintiffs for the injuries suffered, nor may other claims permit such relief;

(c) the relief sought herein in terms of ceasing such practices may not be fully accomplished by awarding damages; and

(d) if the conduct complained of is not enjoined, harm will result to Class Members and the general public because the Defendants' wrongful conduct is either imminent or continuing. A judicial declaration is therefore necessary and appropriate at this time and under these circumstances so the parties may ascertain their respective rights and duties.

97. Plaintiffs request a judicial determination and declaration of the rights of Class members, and the corresponding responsibilities of the Defendants and each of them.

PRAYER FOR RELIEF

WHEREFORE, Plaintiffs, on their own behalf and on behalf of the Class, pray for relief as follows:

FIRST CAUSE OF ACTION

1. Compensatory damages in an amount to be determined according to proof;
2. An order awarding Plaintiffs and the Class pre-judgment and post-judgment interest as permitted by law;
3. For Attorneys' fees and litigation costs;
4 For costs of suit incurred herein; and
5. For such other and further relief as the Court deems just and proper.

SECOND CAUSE OF ACTION

1. Compensatory damages in an amount to be determined according to proof;
2. An order awarding Plaintiffs and the Class pre-judgment and post-judgment interest as permitted by law;
3. For punitive damages;
4. For attorneys' fees and litigation costs for pursuing policy benefits;
5. For costs of suit incurred herein; and
6. For such other and further relief as the Court deems just and proper.

THIRD CAUSE OF ACTION

1. An order enjoining the Defendants and each of them from future breaches of their individual policy contracts and violations of Insurance Code sections 780, 790.03(a), 10603 and 10604, 10 Cal.Code Regs 2536.2 and Business and Professions Code section 17200, *et seq.* and 17500, *et seq.* as alleged herein;

2. An order awarding Plaintiffs and the Class restitution and/or disgorgement and such other equitable relief as the Court deems proper;

3. For attorneys' fees pursuant to Code of Civil Procedure section 1021.5;

4. For costs of suit, including expert witness fees; and

5. For such other and further relief as may be just and proper.

FOURTH CAUSE OF ACTION

1. A declaratory judgment stating that the Defendants and each of them may not pursue the policies, acts and practices complained of herein;

2. An order awarding Plaintiffs compensation and their counsel's attorneys' fees, and expert witness fees and other litigation costs; and

3. An order awarding such other and further relief as may be just and proper.

DATED: May 21, 2014

GIANELLI & MORRIS
STUART LAW FIRM
LAW OFFICE OF KATHRYN TREPINSKI

By: _____
ROBERT S. GIANELLI
JOSHUA S. DAVIS
Attorney for Plaintiffs ARTHUR BODNER and MICHAEL FELKER, on behalf of themselves and all others similarly situated

Exhibit A

Vital Shield℠ 2900

Blue Shield of California Life & Health Insurance Company

Policy

Effective Date: July 1, 2008

Individual Plan

Vital Shield 2900

Policy for Individuals

This Policy is issued by Blue Shield of California Life & Health Insurance Company ("Blue Shield Life"), to the Insured whose identification cards are issued with this Policy. In consideration of statements made in the application and timely payment of Premiums, Blue Shield Life agrees to provide the benefits of this Policy.

NOTICE TO NEW SUBSCRIBERS

Please read this Policy carefully. If you have questions, contact Blue Shield Life. You may surrender this Policy by delivering or mailing it with the Identification Cards, within ten (10) days from the date it is received by you, to BLUE SHIELD LIFE, 50 BEALE STREET, SAN FRANCISCO, CA 94105. Immediately upon such delivery or mailing, the Policy shall be deemed void from the beginning, and Premiums paid will be refunded.

PLEASE NOTE

Some hospitals and other providers do not provide one or more of the following services that may be covered under your policy and that you might need: family planning; contraceptive services, including emergency contraception; sterilization, including tubal ligation at the time of labor and delivery; infertility treatments; or abortion. You should obtain more information before you become a policyholder or select a network provider. Call your prospective doctor or clinic, or call the health plan at Blue Shield Life's Customer Service telephone number provided on the last pages of this booklet to ensure that you can obtain the health care services that you need.

IMPORTANT!

No Insured has the right to receive the benefits of this Plan for Services or supplies furnished following termination of coverage. Benefits of this Plan are available only for Services and supplies furnished during the term it is in effect and while the individual claiming benefits is actually covered by this Policy. Benefits may be modified during the term of this Plan as specifically provided under the terms of this Policy or upon renewal. If benefits are modified, the revised benefits (including any reduction in benefits or the elimination of benefits) apply for Services or supplies furnished on or after the effective date of the modification. There is no vested right to receive the benefits of this Plan.

The Blue Shield Life Vital Shield 2900

Subscriber Bill of Rights

As a Blue Shield Life Vital Shield 2900 Subscriber, you have the right to:

1. Receive considerate and courteous care, with respect for your right to personal privacy and dignity.

2. Receive information about all health Services available to you, including a clear explanation of how to obtain them.

3. Receive information about your rights and responsibilities.

4. Receive information about your Blue Shield Life Vital Shield 2900, the Services we offer you, the Physicians, and other practitioners available to care for you.

5. Have reasonable access to appropriate medical services.

6. Participate actively with your Physician in decisions regarding your medical care. To the extent permitted by law, you also have the right to refuse treatment.

7. A candid discussion of appropriate or Medically Necessary treatment options for your condition, regardless of cost or benefit coverage.

8. Receive from your Physician an understanding of your medical condition and any proposed appropriate or Medically Necessary treatment alternatives, including available success/outcomes information, regardless of cost or benefit coverage, so you can make an informed decision before you receive treatment.

9. Receive preventive health Services.

10. Know and understand your medical condition, treatment plan, expected outcome, and the effects these have on your daily living.

11. Have confidential health records, except when disclosure is required by law or permitted in writing by you. With adequate notice, you have the right to review your medical record with your Physician.

12. Communicate with and receive information from Customer Service in a language that you can understand.

13. Know about any transfer to another Hospital, including information as to why the transfer is necessary and any alternatives available.

14. Be fully informed about the Blue Shield Life grievance procedure and understand how to use it without fear of interruption of health care.

15. Voice complaints or grievances about the Blue Shield Life Vital Shield 2900 or the care provided to you.

16. Participate in establishing Public Policy of the Blue Shield Life Vital Shield 2900, as outlined in your Policy.

The Blue Shield Life Vital Shield 2900

Subscriber Responsibilities

As a Blue Shield Life Vital Shield 2900 Subscriber, you have the responsibility to:

1. Carefully read all Blue Shield Life Vital Shield 2900 materials immediately after you are enrolled so you understand how to use your Benefits and how to minimize your out of pocket costs. Ask questions when necessary. You have the responsibility to follow the provisions of your Blue Shield Life Vital Shield 2900 membership as explained in the Policy.

2. Maintain your good health and prevent illness by making positive health choices and seeking appropriate care when it is needed.

3. Provide, to the extent possible, information that your Physician, and/or the Plan need to provide appropriate care for you.

4. Follow the treatment plans and instructions you and your Physician have agreed to and consider the potential consequences if you refuse to comply with treatment plans or recommendations.

5. Ask questions about your medical condition and make certain that you understand the explanations and instructions you are given.

6. Make and keep medical appointments and inform your Physician ahead of time when you must cancel.

7. Communicate openly with the Physician you choose so you can develop a strong partnership based on trust and cooperation.

8. Offer suggestions to improve the Blue Shield Life Vital Shield 2900.

9. Help Blue Shield Life to maintain accurate and current medical records by providing timely information regarding changes in address, family status and other health plan coverage.

10. Notify Blue Shield Life as soon as possible if you are billed inappropriately or if you have any complaints.

11. Treat all Plan personnel respectfully and courteously as partners in good health care.

12. Pay your Premiums, Copayment, Coinsurance, and charges for non-covered Services on time.

13. For all Mental Health and substance abuse Services, follow the treatment plans and instructions agreed to by you and the Mental Health Services Administrator (MHSA) and obtain prior authorization for all Non-Emergency Inpatient Mental Health and substance abuse Services.

14. Follow the provisions of the Blue Shield Life Benefits Management Program.

TABLE OF CONTENTS

Summary of Benefits

Preferred Provider Plan

Note: The SUMMARY OF BENEFITS represents only a brief description of the Benefits. Please read this Policy carefully for a complete description of provisions, benefits, exclusions, and other important information pertaining to this Plan.

Calendar Year Deductible per Insured Deductible [1] (Medical Plan Deductible)	Deductible Responsibility
The Calendar Year deductible is as indicated.	**$2,900 per Insured**

The Calendar Year deductible applies to all Covered Services Incurred during a Calendar Year except for the following:

- The first two office visits per Calendar Year by a Preferred Physician as described in the Additional Details on Certain Services for Certain Medical Conditions section;
- The first two visits per Calendar Year by a MHSA Participating Provider as described in the Additional Details on Certain Services for Mental Illness or Serious Emotional Disturbances of a Child section;
- Gynecological, colorectal, and osteoporosis screenings as describe in the Preventive Care Services section; and
- Outpatient prescription drugs and mail service prescription drugs including covered diabetes–related medications and diabetic testing supplies;

Claims for these Services do not count toward the Calendar Year Deductible:

- Outpatient Diabetes self-management training;
- Family Planning visits including counseling, consultations, and diaphragm fitting;
- Home Health Care Services;
- Outpatient or Out-of-Hospital X-Ray, Pathology, and Laboratory Services;
- Office visit to an MHSA Participating Provider [2] for Severe Mental Illnesses or Serious Emotional Disturbances of a Child even if such visit is used to determine the condition and diagnosis of the Insured [3];
- Psychological Testing;
- Covered travel expenses for bariatric surgery Services;
- Any injectable contraceptive when administered by a Physician as specified in the Family Planning Services section; and
- Outpatient physician office visits in the Insured's home or physician's office [4].

[1] The Calendar Year deductible applies to all applicable Services and may include Services on both a Copayment and/or Coinsurance basis.

[2] A Mental Health Services Administrator (MHSA) Participating Provider is a Provider who participates in the MHSA Mental Health Provider Network. See the Definitions section for additional information.

[3] See the Additional Details on Certain Services for Mental Illness or Serious Emotional Disturbances of a Child section for additional information.

[4] See the Additional Details on Certain Services for Certain Medical Conditions section for additional information.

Maximum per Insured Calendar Year Copayment/Coinsurance Responsibility [1 & 2]	Copayment/Coinsurance Responsibility [1]
The maximum Calendar Year Copayment/Coinsurance responsibility for applicable covered Services rendered by any combinations of Preferred Providers, Participating Providers, MHSA Participating Providers, and/or Other Providers.	**$5,900 per Insured**
The maximum Calendar Year Copayment/Coinsurance responsibility for applicable covered Services rendered by any combination of eligible providers.	**$8,900 per Insured**

[1] No benefit payment is made by the Plan for the following Services until the Maximum per Insured Calendar Year Copayment/Coinsurance responsibility is met. Until that responsibility is met, the Insured pays 100% of the Allowable Amount for the following Services. Additionally, claims for these Services do not count toward the Maximum per Insured Calendar Year Copayment/Coinsurance responsibility. Once the Maximum per Insured Calendar Year Copayment/Coinsurance responsibility is met, the Plan pays 100% of the Allowable Amount for the remainder of the Calendar Year.

- Outpatient Diabetes self-management training;
- Family Planning visits including counseling, consultations, and diaphragm fitting;
- Home Health Care Services;
- Outpatient or Out-of-Hospital X-Ray, Pathology, and Laboratory Services;
- Office visits to an MHSA Participating or MHSA Non-Participating Provider for Severe Mental Illnesses or Serious Emotional Disturbances of a Child even if such visit is used to determine the condition and diagnosis of the Insured ✦;
- Psychological Testing; and
- Outpatient physician office visits in the Insured's home or physician's office ✧.

[2] Charges for the following Services are not included in the calculation of the Maximum per Insured Calendar Year Copayment/Coinsurance responsibility and may cause the Insured's payment responsibility to exceed the maximums listed in this section.

- Outpatient prescription drugs including mail service prescription drugs including covered diabetes related medications, home self-administered injectables, and diabetic testing supplies;
- Charges in excess of specified benefit maximums;
- Services received from MHSA Non-Participating hospitals;
- Charges for Services which are not covered and charges by non-Preferred and MHSA Non-Participating Providers in excess of amounts covered by the Plan;
- Services provided by a Non-Preferred Hospital-based Skilled Nursing Facility;
- Non-Emergency Services from a Non-Participating Hospital;
- Outpatient Surgery from a Non-Participating Ambulatory Surgery Center;
- Any additional payment Incurred under the Benefits Management Program section;
- Family Planning injectable contraceptives administered by a Physician;
- Services received from a non-participating Dialysis Center;
- Copayments for the first two covered MHSA Participating Provider Outpatient or office visits ✦; and
- Copayments for the first two covered Preferred Physician office visits ✧

✦ See the Additional Details on Certain Services for Mental Illness or Serious Emotional Disturbances of a Child section for additional information.

✧ See the Additional Details on Certain Services for Certain Medical Conditions section for additional information.

Note that Copayments, Coinsurance, and charges for Services not accruing to the Maximum per Insured Calendar Year Copayment/Coinsurance responsibility continue to be the Insured's payment responsibility after the Maximum per Insured Calendar Year Copayment/Coinsurance responsibility is reached.

Additional Payments

Additional payments for failure to utilize the Benefit Management Program.

Please refer to the Benefits Management Programs section for additional information.

Maximum Aggregate Payment	Maximum Blue Shield Life Payment
The maximum aggregate payment amount is determined by totaling all covered Benefits provided to you whether covered under the Plan as a Subscriber or Dependent while covered under this Plan or while covered under any prior or subsequent health Plan with Blue Shield of California or any of its affiliated companies, including Blue Shield Life. Benefits in excess of this amount are not covered under this Plan.	**$3,000,000 per Insured**

Additional Details on Certain Services for Certain Medical Conditions

The Plan provides a benefit for the first two visits per Calendar Year by a Preferred Physician, excluding a MHSA Participating Provider, for any of the following Services, prior to the satisfaction of the Calendar Year deductible and the Maximum per Insured Calendar Year Copayment/Coinsurance responsibility:

Outpatient Diabetes self-management training; or
Physician/Professional office visits, except as specifically listed elsewhere in this Summary of Benefits; or
An annual physical examination, or annual gynecological examination, or well baby care examinations as specified in the Preventive Care Services section.

Note: The benefits as described above cannot be applied to certain Services rendered by a MHSA Participating Provider. See the Additional Details on Certain Services for Mental Illness or Serious Emotional Disturbances of a Child for additional information on certain Services from a MHSA Participating Provider.

Additional Details on Certain Services for Mental Illness or Serious Emotional Disturbances of a Child

The Plan provides a benefit for the first two visits per Calendar Year by a MHSA Participating Provider for office or outpatient visits related to Severe Mental Illness or Serious Emotional Disturbances of a Child, including the initial visit to determine the condition and diagnosis of the Insured. This benefit is provided prior to the satisfaction of the Calendar Year deductible or the Maximum per Insured Calendar Year Copayment/Coinsurance responsibility.

Benefit	Copayment/Coinsurance Responsibility *	
	Services by Preferred, Participating, and Other Providers **	**Services by Non-Preferred and Non-Participating Providers *****
Ambulance Services Covered Services by ambulance companies	40% [1]	Not applicable
Ambulatory Surgical Services Covered Services by Ambulatory Surgery Centers Note: Participating Ambulatory Surgery Centers may not be available in all areas. Outpatient ambulatory surgery Services may also be obtained from a Hospital or an ambulatory surgery center that is affiliated with a Hospital. Ambulatory surgery Services obtained from a Hospital or a Hospital affiliated ambulatory surgery center will be paid at the Preferred or Non-Preferred level as specified in the Hospital section of this Summary of Benefits.	40%	50% of up to $300 per visit Allowable Amount *

* Unless otherwise specified, Copayments/Coinsurance are calculated on the Allowable Amount.

** Other Providers are not preferred Providers and so for Services from Other Providers you are responsible for all charges above the Allowable Amount. Other Providers include acupuncturists, ambulance companies, nursing homes, and certain labs (for a complete list of Other Providers see the Definitions section).

*** For Services by Non-Preferred and Non-Participating Providers you are responsible for all charges above the Allowable Amount.

[1] For Services by ambulance companies, which are Other Providers, you are responsible for all charges above the Allowable Amount.

Benefit	Copayment/Coinsurance Responsibility *	
	Services by Preferred Bariatric Surgery Service Providers [1]	Services by Non-Preferred and Non-Participating Providers [1]
Bariatric Surgery Services for Residents of Designated Counties in California [2]		
Facility Bariatric Surgery Services	40%	Not covered [1]
Physician Bariatric Surgery Services	30%	Not covered [1]
Note: Bariatric surgery Services for residents of non-designated counties [1] will be paid as any other covered Inpatient surgery as described elsewhere in this Summary of Benefits. All bariatric surgery Services must be prior authorized in writing, from the Plan's Medical Director. Prior authorization is required for all Insureds, whether residents of designated or a non-designated county.		

* Unless otherwise specified, Copayments/Coinsurance are calculated on the Allowable Amount.

[1] Bariatric Surgery Services for residents of designated counties must be provided by a Preferred Bariatric Surgery Services Provider. See the Bariatric Surgery Services Benefits and Definitions sections for additional information.

[2] See the Bariatric Surgery Services Benefits section for a list of designated counties.

Benefit	Copayment/Coinsurance Responsibility *	
	Services by Preferred, Participating, and Other Providers **	**Services by Non-Preferred and Non-Participating Providers *****
Clinical Trials for Cancer Covered Services for the Insured who has been accepted into an approved clinical trial for cancer when prior authorized by the Plan. Services for routine patient care will be paid on the same basis and at the same Benefit levels as other covered Services shown in the Summary of Benefits.	No charge	No charge

* Unless otherwise specified, Copayments/Coinsurance are calculated on the Allowable Amount.

** Other Providers are not preferred Providers and so for Services from Other Providers you are responsible for all charges above the Allowable Amount. Other Providers include acupuncturists, ambulance companies, nursing homes, and certain labs (for a complete list of Other Providers see the Definitions section).

*** For Services by Non-Preferred and Non-Participating Providers you are responsible for all charges above the Allowable Amount.

[1] No benefits are provided for Chiropractic Services by Non-Preferred or Non-participating Providers.

Benefit	Copayment/Coinsurance Responsibility *	
	Services by Preferred, Participating, and Other Providers **	**Services by Non-Preferred and Non-Participating Providers *****
Diabetes Care Services		
Covered Services and supplies	40%	50%
Outpatient self-management training		
If one of the two Calendar Year office visits is used for Outpatient self-management training	$40 per visit [1]	No Copayment ★
Otherwise	No Copayment ★	No Copayment ★
Dialysis Centers [2]	40%	50% of up to $300 per day

* Unless otherwise specified, Copayments/Coinsurance are calculated on the Allowable Amount.

** Other Providers are not preferred Providers and so for Services from Other Providers you are responsible for all charges above the Allowable Amount. Other Providers include acupuncturists, ambulance companies, nursing homes, and certain labs (for a complete list of Other Providers see the Definitions section).

*** For Services by Non-Preferred and Non-Participating Providers you are responsible for all charges above the Allowable Amount.

[1] If billed by your provider, you will also be responsible for an office visit Copayment.

[2] Prior authorization by Blue Shield Life is required for all dialysis Services.

★ No benefit payment is made by the Plan for this Service until the Maximum per Insured Calendar Year Copayment/Coinsurance responsibility is met. Once the Maximum per Insured Calendar Year Copayment/Coinsurance responsibility is met, the Plan pays 100% of the Allowable Amount for this Service. See the Maximum per Insured Calendar Year Copayment/Coinsurance Responsibility section for more information.

Benefit	Copayment/Coinsurance Responsibility *	
	Services by Preferred, Participating, and Other Providers **	Services by Non-Preferred and Non-Participating Providers ***
Family Planning Services [1]		
Counseling and Consultation Services	No Copayment ★	Not covered
Injectable Contraceptives when administered by a Physician during an Office Visit	$25 [2]	Not covered
Tubal ligation, vasectomy, and elective abortion	No Copayment ★	Not covered

* Unless otherwise specified, Copayments/Coinsurance are calculated on the Allowable Amount.

** Other Providers are not preferred Providers and so for Services from Other Providers you are responsible for all charges above the Allowable Amount. Other Providers include acupuncturists, ambulance companies, nursing homes, and certain labs (for a complete list of Other Providers see the Definitions section).

*** For Services by Non-Preferred and Non-Participating Providers you are responsible for all charges above the Allowable Amount.

[1] No benefits are provided for Family Planning Services by Non-Preferred or Non-Participating Providers.

[2] Copayment for injectable contraceptives is in addition to any Copayment for the Office Visit.

★ No benefit payment is made by the Plan for this Service until the Maximum per Insured Calendar Year Copayment/Coinsurance responsibility is met. Once the Maximum per Insured Calendar Year Copayment/Coinsurance responsibility is met, the Plan pays 100% of the Allowable Amount for this Service. See the Maximum per Insured Calendar Year Copayment/Coinsurance Responsibility section for more information.

Benefit	Copayment/Coinsurance Responsibility *	
	Services by Preferred, Participating, and Other Providers **	**Services by Non-Preferred and Non-Participating Providers *****
Home Health Care Benefits Home health care Services Note: There is a combined Benefit maximum of 90 visits per Insured, per Calendar Year for all Home Health and Home Infusion/Home Injectable Services. The above Services must be prior authorized by the Plan.	No copayment ★	Not covered [1]
Home Infusion/Home Injectable Therapy Benefits Home infusion/home injectable therapy benefits provided by a Home Infusion Agency. Note: There is a combined Benefit maximum of 90 visits per Insured, per Calendar Year for all Home Health and Home Infusion/Home Injectable Services. The above Services must be prior authorized by the Plan.	No copayment ★	Not covered [1]

* Unless otherwise specified, Copayments/Coinsurance are calculated on the Allowable Amount.

** Other Providers are not preferred Providers and so for Services from Other Providers you are responsible for all charges above the Allowable Amount. Other Providers include acupuncturists, ambulance companies, nursing homes, and certain labs (for a complete list of Other Providers see the Definitions section).

*** For Services by Non-Preferred and Non-Participating Providers you are responsible for all charges above the Allowable Amount.

[1] Services by Non-Participating Home Health Care/Home Infusion Agencies are not covered unless prior authorized by the Plan. When authorized by the Plan, these Non-Participating Agencies will be reimbursed at a rate determined by the Plan and the agency and your Copayment/Coinsurance will be at the Participating Agency Copayment/Coinsurance.

★ No benefit payment is made by the Plan for this Service until the Maximum per Insured Calendar Year Copayment/Coinsurance responsibility is met. Once the Maximum per Insured Calendar Year Copayment/Coinsurance responsibility is met, the Plan pays 100% of the Allowable Amount for this Service. See the Maximum per Insured Calendar Year Copayment/Coinsurance Responsibility section for more information.

Benefit	Copayment/Coinsurance Responsibility *	
	Services by Preferred, Participating, and Other Providers **	Services by Non-Preferred and Non-Participating Providers ***
Hospice Program Services		
Covered Services for Insureds who have been accepted into an approved Hospice Program.		
Continuous home care during a period of crisis	40%	Not covered [1]
General Inpatient care	40%	Not covered [1]
Inpatient respite care	No charge	Not covered [1]
Routine home care	No charge	Not covered [1]
Pre-hospice consultative visit	No charge	Not covered [1]

* Unless otherwise specified, Copayments/Coinsurance are calculated on the Allowable Amount.

** Other Providers are not preferred Providers and so for Services from Other Providers you are responsible for all charges above the Allowable Amount. Other Providers include acupuncturists, ambulance companies, nursing homes, and certain labs (for a complete list of Other Providers see the Definitions section).

*** For Services by Non-Preferred and Non-Participating Providers you are responsible for all charges above the Allowable Amount.

[1] Services by Non-Participating Hospice Agencies are not covered unless prior authorized by the Plan. When authorized by the Plan, these Non-Participating Agencies will be reimbursed at a rate determined by the Plan and the agency and your Coinsurance will be at the Participating Provider level.

★ No benefit payment is made by the Plan for this Service until the Maximum per Insured Calendar Year Copayment/Coinsurance responsibility is met. Once the Maximum per Insured Calendar Year Copayment/Coinsurance responsibility is met, the Plan pays 100% of the Allowable Amount for this Service. See the Maximum per Insured Calendar Year Copayment/Coinsurance Responsibility section for more information.

Benefit	Copayment/Coinsurance Responsibility *	
	Services by Preferred, Participating, and Other Providers **	**Services by Non-Preferred and Non-Participating Providers *****
Hospital Benefits (Facility Services)		
Inpatient Services		
Emergency Facility Services	40%	40% [1]
Non-Emergency Facility Services	40%	50% of up to $500 per day

* Unless otherwise specified, Copayments/Coinsurance are calculated on the Allowable Amount.

** Other Providers are not preferred Providers and so for Services from Other Providers you are responsible for all charges above the Allowable Amount. Other Providers include acupuncturists, ambulance companies, nursing homes, and certain labs (for a complete list of Other Providers see the Definitions section).

*** For Services by Non-Preferred and Non-Participating Providers you are responsible for all charges above the Allowable Amount.

[1] For Emergency Services by Non-Preferred Hospitals, your Copayment/Coinsurance will be at the Preferred Hospital Copayment/Coinsurance.

Benefit	Copayment/Coinsurance Responsibility *	
	Services by Preferred, Participating, and Other Providers **	**Services by Non-Preferred and Non-Participating Providers *****
Hospital Benefits (Facility Services) *continued*		
Outpatient Services		
Services for Illness or Injury	40%	50% of up to $500 per day [1]
Surgery Services	40%	50% of up to $500 per day [1]
Dialysis Services [2]	40%	50% of up to $300 per day

* Unless otherwise specified, Copayments/Coinsurance are calculated on the Allowable Amount.

** Other Providers are not preferred Providers and so for Services from Other Providers you are responsible for all charges above the Allowable Amount. Other Providers include acupuncturists, ambulance companies, nursing homes, and certain labs (for a complete list of Other Providers see the Definitions section).

*** For Services by Non-Preferred and Non-Participating Providers you are responsible for all charges above the Allowable Amount.

[1] For Emergency Services by Non-Preferred Hospitals, your Copayment/Coinsurance will be at the Preferred Hospital Copayment/Coinsurance.

[2] Prior authorization by Blue Shield Life is required for all dialysis Services.

Benefit	Copayment/Coinsurance Responsibility *	
	Services by Preferred, Participating, and Other Providers **	**Services by Non-Preferred and Non-Participating Providers *****
Hospital Benefits (Facility Services) *continued*		
Outpatient Emergency Room Services		
Services directly resulting in admission as an Inpatient are paid as part of the Inpatient Hospital admission	40%	40% [1]
Services not directly resulting in admission as an Inpatient	$100 per visit plus 40%	$100 per visit plus 40%

* Unless otherwise specified, Copayments/Coinsurance are calculated on the Allowable Amount.

** Other Providers are not preferred Providers and so for Services from Other Providers you are responsible for all charges above the Allowable Amount. Other Providers include acupuncturists, ambulance companies, nursing homes, and certain labs (for a complete list of Other Providers see the Definitions section).

*** For Services by Non-Preferred and Non-Participating Providers you are responsible for all charges above the Allowable Amount.

[1] For emergency room Services directly resulting in admission as an Inpatient to a Non-Preferred Hospital which Blue Shield Life determines are not emergency, your Copayment/Coinsurance will be the Non-Preferred Hospital Inpatient Services Copayment/Coinsurance.

Benefit	Copayment/Coinsurance Responsibility *	
	Services by Preferred, Participating, and Other Providers **	**Services by Non-Preferred and Non-Participating Providers *****
Medical Treatment for the Teeth, Gums, Jaw Joints, or Jaw Bones		
Office Visit		
If one of the first two office visits is used for medical treatment of teeth, gums, jaw joints, or jaw bones.	$40	No Copayment ★
Otherwise	No Copayment ★	No Copayment ★
Services with the office visit	No Copayment ★	No Copayment ★

* Unless otherwise specified, Copayments/Coinsurance are calculated on the Allowable Amount.

** Other Providers are not preferred Providers and so for Services from Other Providers you are responsible for all charges above the Allowable Amount. Other Providers include acupuncturists, ambulance companies, nursing homes, and certain labs (for a complete list of Other Providers see the Definitions section).

*** For Services by Non-Preferred and Non-Participating Providers you are responsible for all charges above the Allowable Amount.

★ No benefit payment is made by the Plan for this Service until the Maximum per Insured Calendar Year Copayment/Coinsurance responsibility is met. Once the Maximum per Insured Calendar Year Copayment/Coinsurance responsibility is met, the Plan pays 100% of the Allowable Amount for this Service. See the Maximum per Insured Calendar Year Copayment/Coinsurance Responsibility section for more information.

Benefit	Copayment/Coinsurance Responsibility *	
Mental Health and Substance Abuse Services **(All Services provided through the Plan's Mental Health Services Administrator [MHSA])**	**Services by MHSA Participating Providers ***	**Services by MHSA Non-Participating Providers ****
Inpatient Mental Health Services [1]		
Hospital Services	40%	50% of up to $500 per day [2]
Partial Hospitalization [3]	40% per episode of care [3]	50% of up to $500 per day
Professional (Physician Services)		
If one of the two office visits is used for Severe Mental Illnesses or Serious Emotional Disturbances of a Child.	$40	No Copayment ★
Otherwise	No Copayment ★	No Copayment ★
Outpatient Facility & Office Mental Health Services for Severe Mental Illnesses or Serious Emotional Disturbances of a Child [4]		
Hospital Outpatient department Services (including intensive Outpatient care and Outpatient electroconvulsive therapy [ECT])	40%	50% of up to $500 per day [2]
Office Services	No Copayment ★	No Copayment ★

* Unless otherwise specified, Copayments are calculated based on the Allowable Amount.

** For Services by MHSA Non-Participating Providers you are responsible for all charges above the Allowable Amount.

[1] All Inpatient Mental Health Services and Outpatient Partial Hospitalization and Outpatient electroconvulsive therapy Services (except for Emergency and urgent Services) must be prior authorized by the MHSA.

[2] For Emergency Services by MHSA Non-Participating Hospitals your Copayment/Coinsurance will be the MHSA Participating Hospital Copayment/Coinsurance based on billed charges.

[3] For Partial Hospitalization Services, an episode of care is the date from which the patient is admitted to the Partial Hospitalization Program to the date the patient is discharged or leaves the Partial Hospitalization Program. Any Services received between these two dates would constitute the episode of care. If the patient needs to be readmitted at a later date, this would constitute another episode of care.

[4] This Copayment/Coinsurance includes both Outpatient facility and Professional (Physician) Services.

★ No benefit payment is made by the Plan for this Service until the Maximum per Insured Calendar Year Copayment/Coinsurance responsibility is met. Once the Maximum per Insured Calendar Year Copayment/Coinsurance responsibility is met, the Plan pays 100% of the Allowable Amount for this Service. See the Maximum per Insured Calendar Year Copayment/Coinsurance Responsibility section for more information.

Benefit	Copayment/Coinsurance Responsibility *	
Mental Health and Substance Abuse Services *(continued)* **(All Services provided through the Plan's Mental Health Services Administrator [MHSA])**	**Services by MHSA Participating Providers ***	**Services by MHSA Non-Participating Providers ****
Outpatient Facility & Office Mental Health Services for other than Severe Mental Illnesses or Serious Emotional Disturbances of a Child Note: No Benefits are provided for Outpatient or out-of-Hospital Mental Health Services & substance abuse care from MHSA Non-Participating Providers, except for the initial visit. [1]	Not Covered [1]	Not covered [1]
Psychological Testing	No Copayment ★	No Copayment ★
Psychosocial support through LifeReferrals 24/7	No charge	No charge

* Unless otherwise specified, Copayments are calculated based on the Allowable Amount.

** For Services by MHSA Non-Participating Providers you are responsible for all charges above the Allowable Amount.

[1] For the initial Mental Health Service or substance abuse care visit to determine the condition and diagnosis of the Insured, Benefits will be provided and paid as if the condition was a Severe Mental Illness or a Serious Emotional Disturbances of a Child as shown above.

★ No benefit payment is made by the Plan for this Service until the Maximum per Insured Calendar Year Copayment/Coinsurance responsibility is met. Once the Maximum per Insured Calendar Year Copayment/Coinsurance responsibility is met, the Plan pays 100% of the Allowable Amount for this Service. See the Maximum per Insured Calendar Year Copayment/Coinsurance Responsibility section for more information.

Benefit	Copayment/Coinsurance Responsibility *	
	Services by Preferred, Participating, and Other Providers **	Services by Non-Preferred and Non-Participating Providers ***
Outpatient or Out-of-Hospital X-Ray, Pathology, and Laboratory Services	No Copayment ★ [1]	No Copayment ★ [1]
PKU Related Formulas & Special Food Products Benefits PKU related formulas & special food products The above Services must be prior authorized by the Plan.	No copayment ★	Not covered [4]
Podiatric Services If one of the two office visits is used for Podiatric Services Otherwise	 $40 per visit No Copayment ★	 No Copayment ★ No Copayment ★

* Unless otherwise specified, Copayments/Coinsurance are calculated on the Allowable Amount.

** Other Providers are not preferred Providers and so for Services from Other Providers you are responsible for all charges above the Allowable Amount. Other Providers include acupuncturists, ambulance companies, nursing homes, and certain labs (for a complete list of Other Providers see the Definitions section).

*** For Services by Non-Preferred and Non-Participating Providers you are responsible for all charges above the Allowable Amount.

[1] Coinsurance will be assessed per provider and per date of Service.

[2] If billed by your provider, you will also be responsible for an office visit Copayment.

[3] For Services by certified occupational therapists and certified respiratory therapists, which are Other Providers, you are responsible for all charges above the Allowable Amount.

[4] Services by Non-Participating Home Health Care/Home Infusion Agencies are not covered unless prior authorized by the Plan. When authorized by the Plan, these Non-Participating Agencies will be reimbursed at a rate determined by the Plan and the agency and your Copayment/Coinsurance will be at the Participating Agency Copayment/Coinsurance.

★ No benefit payment is made by the Plan for this Service until the Maximum per Insured Calendar Year Copayment/Coinsurance responsibility is met. Once the Maximum per Insured Calendar Year Copayment/Coinsurance responsibility is met, the Plan pays 100% of the Allowable Amount for this Service. See the Maximum per Insured Calendar Year Copayment/Coinsurance Responsibility section for more information.

Benefit	Copayment/Coinsurance Responsibility *	
	Prescriptions filled by a Participating Retail or Mail Order Pharmacy	**Prescriptions filled by a Non-Participating Pharmacy [3]**
Outpatient Prescription Drugs [1, 2, 3, 4, 5, & 6]		
Formulary Generic Drugs at a Retail Pharmacy (up to 30 day supply)	$10	Not covered
Formulary Generic Drugs through the Mail Order Pharmacy (up to a 60 day supply)	$20	Not covered
Home Self-Administered Injectables	40%	Not covered

[1] The Insured's Calendar Year deductible does not apply to the Outpatient Prescription Drug benefit.

[2] The Insured's Maximum Calendar Year Copayment/Coinsurance responsibility does not apply to the Outpatient Prescription Drug benefit.

[3] Except for covered emergencies and Drugs for emergency contraception, no benefits are provided for Drugs received from Non-Participating Pharmacies.

[4] Copayment / Coinsurance apply per prescription or refill.

[5] There are no Benefits for covered Brand Name Drugs under the Vital Shield 2900.

[6] The Outpatient Prescription Drug benefit is separate from the Vital Shield 2900.

* Copayment / Coinsurance is calculated based on the contracted rate for covered prescriptions between Blue Shield Life and the Participating Pharmacy, including Specialty Pharmacies, or the Participating Mail Order Pharmacy.

Benefit	Copayment/Coinsurance Responsibility *	
	Services by Preferred, Participating, and Other Providers **	**Services by Non-Preferred and Non-Participating Providers *****
Preventive Care Services [1]		
Annual Physical Examination including only the annual routine physical examination office visit; urinalysis; eye and ear screening; and pediatric and adult immunizations and the immunizing agent		
If one of the two office visits is used for the Annual Physical Examination	$40	Not covered
Otherwise	No Copayment ★	Not covered
Annual Gynecological Examination including only the annual gynecological examination office visit		
If one of the two office visits is used for the Annual Physical Examination	$40	
Otherwise	No Copayment ★	Not covered
Well Baby Examinations including only the well baby examination office visit; tuberculin test; and pediatric immunizations and the immunizing agent		
If one of the two office visits is used for the Well Baby Examination	$40	Not covered
Otherwise	No Copayment ★	Not covered

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** Other Providers are not preferred Providers and so for Services from Other Providers you are responsible for all charges above the Allowable Amount. Other Providers include acupuncturists, ambulance companies, nursing homes, and certain labs (for a complete list of Other Providers see the Definitions section).

*** For Services by Non-Preferred and Non-Participating Providers you are responsible for all charges above the Allowable Amount.

[1] No benefits are provided for Preventive Care Services when rendered by Non-Preferred or Non-Participating Providers.

★ No benefit payment is made by the Plan for this Service until the Maximum per Insured Calendar Year Copayment/Coinsurance responsibility is met. Once the Maximum per Insured Calendar Year Copayment/Coinsurance responsibility is met, the Plan pays 100% of the Allowable Amount for this Service. See the Maximum per Insured Calendar Year Copayment/Coinsurance Responsibility section for more information.

Benefit	Copayment/Coinsurance Responsibility *	
	Services by Preferred, Participating, and Other Providers **	**Services by Non-Preferred and Non-Participating Providers *****
Preventive Care Services *continued*		
Colorectal Cancer Screening Services	40%	Not Covered
Mammography; routine Papanicolaou (Pap) test or other Food and Drug Administration (FDA) approved cervical cancer screening test; and the human papillomavirus (HPV) screening test only	40%	Not Covered
Certain Osteoporosis Screening Services	40%	Not Covered
NurseHelp 24/7	No Charge	Not Covered

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*** For Services by Non-Preferred and Non-Participating Providers you are responsible for all charges above the Allowable Amount.

Benefit	Copayment/Coinsurance Responsibility *	
	Services by Preferred, Participating, and Other Providers **	**Services by Non-Preferred and Non-Participating Providers *****
Professional (Physician) Services		
Office visit		
If one of the two office visits is used for Professional (Physician) Services	$40	No Copayment ★
Otherwise	No Copayment ★	No Copayment ★
Services with the office visit	No Copayment ★	No Copayment ★
Services in the Emergency Room of a Hospital	No Copayment ★	No Copayment ★
Visits to the home, Hospital except for those rendered in the Emergency Room, skilled nursing facility, and Ambulatory Surgery Center, including surgery, chemotherapy, and kidney dialysis	No Copayment ★	No Copayment ★
Prosthetic Appliances		
For Surgically implanted and other prosthetic devices, including prosthetic bras, provided to restore and achieve symmetry incident to a mastectomy.	40%	50%
For Blom-Singer and artificial larynx prostheses for speech therapy following a laryngectomy are covered as a surgical professional benefit.	40%	50%
Radiological Procedures Requiring Prior Authorization	No copayment ★	No Copayment ★
Outpatient, non-Emergency radiological procedures including CT scans, MRIs, MRAs. PET scans, and cardiac diagnostic procedures utilizing nuclear medicine		
Note: Blue Shield Life requires prior authorization for all these Services.		

* Unless otherwise specified, Copayments/Coinsurance are calculated on the Allowable Amount.

** Other Providers are not preferred Providers and so for Services from Other Providers you are responsible for all charges above the Allowable Amount. Other Providers include acupuncturists, ambulance companies, nursing homes, and certain labs (for a complete list of Other Providers see the Definitions section).

*** For Services by Non-Preferred and Non-Participating Providers you are responsible for all charges above the Allowable Amount.

★ No benefit payment is made by the Plan for this Service until the Maximum per Insured Calendar Year Copayment/Coinsurance responsibility is met. Once the Maximum per Insured Calendar Year Copayment/Coinsurance responsibility is met, the Plan pays 100% of the Allowable Amount for this Service. See the Maximum per Insured Calendar Year Copayment/Coinsurance Responsibility section for more information.

Benefit	Copayment/Coinsurance Responsibility *	
	Services by Preferred, Participating, and Other Providers **	**Services by Non-Preferred and Non-Participating Providers *****
Professional (Physician) Services		
Office visit		
If one of the two office visits is used for Professional (Physician) Services	$40	No Copayment ★
Otherwise	No Copayment ★	No Copayment ★
Services with the office visit	No Copayment ★	No Copayment ★
Services in the Emergency Room of a Hospital	No Copayment ★	No Copayment ★
Visits to the home, Hospital except for those rendered in the Emergency Room, skilled nursing facility, and Ambulatory Surgery Center, including surgery, chemotherapy, and kidney dialysis	No Copayment ★	No Copayment ★
Prosthetic Appliances		
For Surgically implanted and other prosthetic devices, including prosthetic bras, provided to restore and achieve symmetry incident to a mastectomy.	40%	50%
For Blom-Singer and artificial larynx prostheses for speech therapy following a laryngectomy are covered as a surgical professional benefit.	40%	50%
Radiological Procedures Requiring Prior Authorization	No copayment ★	No Copayment ★
Outpatient, non-Emergency radiological procedures including CT scans, MRIs, MRAs. PET scans, and cardiac diagnostic procedures utilizing nuclear medicine		
Note: Blue Shield Life requires prior authorization for all these Services.		

* Unless otherwise specified, Copayments/Coinsurance are calculated on the Allowable Amount.

** Other Providers are not preferred Providers and so for Services from Other Providers you are responsible for all charges above the Allowable Amount. Other Providers include acupuncturists, ambulance companies, nursing homes, and certain labs (for a complete list of Other Providers see the Definitions section).

*** For Services by Non-Preferred and Non-Participating Providers you are responsible for all charges above the Allowable Amount.

★ No benefit payment is made by the Plan for this Service until the Maximum per Insured Calendar Year Copayment/Coinsurance responsibility is met. Once the Maximum per Insured Calendar Year Copayment/Coinsurance responsibility is met, the Plan pays 100% of the Allowable Amount for this Service. See the Maximum per Insured Calendar Year Copayment/Coinsurance Responsibility section for more information.

Benefit	Copayment/Coinsurance Responsibility *	
	Services by Preferred, Participating, and Other Providers **	**Services by Non-Preferred and Non-Participating Providers *****
Skilled Nursing Facilities		
Services by a Skilled Nursing Facility Unit of a Hospital	40%	50%
Services by a free–standing Skilled Nursing Facility	40% [1]	40% [1]
Note: There is a combined Benefit maximum of 100 days per Insured, per Calendar Year for all skilled nursing Services.		

* Unless otherwise specified, Copayments/Coinsurance are calculated on the Allowable Amount.

** Other Providers are not preferred Providers and so for Services from Other Providers you are responsible for all charges above the Allowable Amount. Other Providers include acupuncturists, ambulance companies, nursing homes, and certain labs (for a complete list of Other Providers see the Definitions section).

*** For Services by Non-Preferred and Non-Participating Providers you are responsible for all charges above the Allowable Amount.

[1] For Services by free-standing skilled nursing facilities (nursing homes), which are Other Providers, you are responsible for all charges above the Allowable Amount.

Benefit	Copayment/Coinsurance Responsibility *	
	Services by Preferred, Participating, & Other Providers **	**Services by Non-Preferred & Non-Participating Providers *****
Transplant Benefits		
Organ Transplants		
Hospital Services	40%	50% of up to $500 per day
Professional (Physician) Services	40%	50%
Special Transplant Benefits [1]		
Facilities Services in a Special Transplant Facility	40%	Not covered
Professional (Physician) Services	40%	Not covered
Note: The Plan requires prior authorization for all Special Transplant Services. Also, all Services must be provided at a Special Transplant Facility designated by Blue Shield Life.		

* Unless otherwise specified, Copayments/Coinsurance are calculated on the Allowable Amount.

** Other Providers are not preferred Providers and so for Services from Other Providers you are responsible for all charges above the Allowable Amount. Other Providers include acupuncturists, ambulance companies, nursing homes, and certain labs (for a complete list of Other Providers see the Definitions section).

*** For Services by Non-Preferred and Non-Participating Providers you are responsible for all charges above the Allowable Amount.

[1] Special Transplant Benefits are limited to the procedures listed in the Covered Services section. See the Special Transplant Benefits Covered Services section for information on Services and requirements.

Your Blue Shield Life Vital Shield 2900 and How to Use It -

PLEASE READ THE FOLLOWING SO YOU WILL KNOW FROM WHOM OR WHAT GROUP OF PROVIDERS, HEALTH CARE MAY BE PROVIDED.

The Blue Shield Life Vital Shield 2900 has a common goal with you and with health care professionals - quality health care coverage at a reasonable cost. You can control your out-of-pocket costs by carefully choosing the providers from whom you receive covered Services.

You should read your SUMMARY OF BENEFITS and this Policy carefully. Your Policy tells you which Services are covered by the Plan and which are excluded. The SUMMARY OF BENEFITS also lists your Copayments and Coinsurance amounts as well as information on your Calendar Year Deductible and Maximum Calendar Year Copayment / Coinsurance responsibility.

This Plan has two different payment levels depending on the Physician or Hospital from which you receive covered Services. Blue Shield Life has a statewide network of nearly 50,000 Physician Members and contracted Hospitals known as Preferred Providers. Many other health care professionals, including optometrists and podiatrists are also Preferred Providers.

The highest benefits of the Blue Shield Life Vital Shield 2900 are provided when you receive covered Services from a Preferred Provider. You will Incur higher out-of-pocket costs when you receive covered Services from a Non-Preferred Provider.

Note: choosing a Preferred Provider will assure the lowest level of Insured's payments available under this Plan. See the "Definitions" section for more information.

Preferred Providers have agreed to accept the Plan's payment, plus payment of any applicable deductibles, the Insured's Copayments and Coinsurances, or amounts in excess of specified benefit maximums as payment-in-full for covered Services, except as provided under the section entitled ACTS OF THIRD PARTIES. This is not true of Non-Preferred Providers. If you receive Services from a Non-Preferred Provider, the Plan's payment may be substantially less than the amount the provider bills. You are responsible for the difference between the amount the Non-Preferred Provider bills and the amount the Plan pays.

In addition, certain services are not covered when received from Non-Preferred Providers. It is therefore to your advantage to obtain medical and Hospital Services from Preferred Providers.

Failure to meet these responsibilities may result in your Incurring a substantial financial liability. Some services may not be covered unless prior review and other requirements are met.

Blue Shield Life, or the MHSA, will render a decision on all requests for prior authorization, and pre-admission review within five (5) business days from receipt of the request. The treating provider will be notified of the decision within 24 hours followed by written notice to the provider and Subscriber within two (2) business days of the decision. For urgent Services in situations in which the routine decision making process might seriously jeopardize the life or health of an Insured, or when the Insured is experiencing severe pain, Blue Shield Life, or the MHSA, will respond as soon as possible to accommodate the Insured's condition not to exceed 72 hours from receipt of the request.

Preferred Providers submit claims for payment after their Services have been received. You or your Non-Preferred Providers also submit claims for payment after Services have been received.

Providers do not receive financial incentives or bonuses from the Plan.

When you need health care, present your Blue Shield Life Identification Card to your Physician, Hospital or other licensed health care provider. Your Identification Card has your Subscriber and group number on it. Be sure to include your Insured and group numbers on all claims you submit to Blue Shield Life. Preferred Providers usually bill the Plan directly. See section on Notice and Proof of Claim in this Policy for information on filing a claim if a provider has not billed the Plan directly. Blue Shield Life will notify you of its determination within thirty (30) days after receipt of the claim.

The Blue Shield Life Vital Shield 2900 is specifically designed for you to use the Blue Shield Life Provider Network of Preferred Providers. Refer to the "Covered Services" section of this Policy for Copayment and Coinsurance information. Preferred Providers are listed in the Preferred Provider Directories.

If you wish to obtain a copy of the Preferred Provider Directory, you may request a copy by contacting the Plan's Customer Service Department at 1-888-852-5345. You may also verify this information by accessing Blue Shield Life's Internet site located at http://www.blueshieldca.com.

Note: A Preferred Provider's status may change. It is your obligation to verify whether the Physician, Hospital, or Alternate Care Services provider you choose is a Preferred Pro-

vider in case there have been any changes since your Preferred Provider Directory has been published.
Insureds who reasonably believe that they have an emergency medical condition which requires an emergency response are encouraged to appropriately use the "911" emergency response system where available.

For all Mental Health and substance abuse Services: The MHSA is a specialized health care service plan that will underwrite and deliver the Plan's Mental Health and substance abuse Services through a separate network of Mental Health Services Administrator (MHSA) Participating Providers.

Note that MHSA Participating Providers are only those Providers who participate in the MHSA network and have contracted with the MHSA to provide Mental Health and substance abuse Services to Insureds. A Blue Shield Life Provider Network Preferred/Participating Provider may not be an MHSA Participating Provider. MHSA Participating Providers agree to accept the MHSA's payment, plus your payment of Copayment, Coinsurance or amounts in excess of benefit maximums specified, as payment-in-full for covered Mental Health and substance abuse Services. This is not true of MHSA Non-Participating Providers; therefore, it is to your advantage to obtain Mental Health and substance abuse Services from MHSA Participating Providers.

It is your responsibility to ensure that the Provider you select for Mental Health and substance abuse Services is an MHSA Participating Provider. MHSA Participating Providers are indicated in the Behavioral Health Provider Directory. Additionally, Insureds may contact the MHSA directly for information on, and to select an MHSA Participating Provider by calling 1-877-214-2928. You may also search for an MHSA Participating Provider by accessing Blue Shield Life's Internet site located at http://www.blueshieldca.com.

Blue Shield Life Network of Preferred Providers

PLEASE READ THE FOLLOWING SO YOU WILL KNOW FROM WHOM OR WHAT GROUP OF PROVIDERS, HEALTH CARE MAY BE OBTAINED.

This Plan is most effective and advantageous when covered Services are received from Preferred Providers. You receive the maximum benefits of the Plan when you receive Services from these providers.

Insureds are paid directly by Blue Shield Life if Services are received from a Non-Preferred Provider. Payments to Insureds for Services are in amounts identical to those made directly to providers. See the section entitled NOTICE AND PROOF OF CLAIM in this Policy for information on filing a claim if a provider has not billed the Plan directly. Blue Shield Life will notify you of its determination within thirty (30) days after receipt of the claim.

Insureds are not responsible to Preferred Providers for payment for covered Services, except for payment of any applicable deductibles, Copayments, Coinsurances, or amounts in excess of specified benefit maximums, except as provided under the section entitled ACTS OF THIRD PARTIES.

Continuity of Care by a Terminated Provider

Insureds who are being treated for acute conditions, serious chronic conditions, pregnancies (including immediate postpartum care), or terminal illness; or who are children from birth to 36 months of age; or who have received authorization from a now-terminated provider for surgery or another procedure as part of a documented course of treatment can request completion of care in certain situations with a provider who is leaving the Blue Shield Life provider network. Contact Customer Service to receive information regarding eligibility criteria and the policy and procedure for requesting continuity of care from a terminated provider.

Financial Responsibility for Continuity of Care Services

If an Insured is entitled to receive Services from a terminated provider under the preceding Continuity of Care provision, the responsibility of the Insured to that provider for Services rendered under the Continuity of Care provision shall be no greater than for the same Services rendered by a Preferred Provider in the same geographic area.

Premiums

Monthly Premiums are as stated in the Appendix. Blue Shield Life offers a variety of options and methods by which you may pay your Premiums. Please call Customer Service at 1-888-852-5345 to discuss these options or visit the Blue Shield Life internet site at http://www.blueshieldca.com.

Payments by mail are to be sent to:

Blue Shield Life
P.O. Box 51827
Los Angeles, CA 90051-6127

Additional Premiums may be charged in the event that a state or any other taxing authority imposes upon Blue Shield Life a tax or license fee, which is calculated upon, base Premiums or Blue Shield Life's gross receipts or any portion of either. Premiums increase according to the Subscriber's age, as stated in the Appendix. Premiums may also increase from time to time as determined by Blue Shield Life. You will receive thirty (30) days written notice of any changes in the monthly Premiums for this Plan.

Plan Changes

The benefits of this Plan, including but not limited to Covered Services, deductible, Copayment, Co-

insurance, and annual copayment/coinsurance maximum amounts, are subject to change at any time. Blue Shield will provide at least 30 days written notice of any such change.

Benefits for Services or supplies furnished after the Effective Date of any change in benefits will be based on the change. There is no vested right to obtain benefits. Benefits for Services or supplies furnished after the Effective Date of any benefit modification shall be provided based on that modification.

Conditions of Coverage

Enrollment and Limitation of Enrollment

1. Enrollment in this Plan is limited to individuals only.

2. Enrollment of the Subscriber is not effective until Blue Shield Life approves an application and accepts the applicable Premiums. Only Blue Shield Life's Underwriting Department can approve an application.

3. An applicant, upon completion and approval by Blue Shield Life of the application, is entitled to the benefits of this Policy upon the Effective Date.

4. By completing an application, the Subscriber agrees to cooperate with Blue Shield Life by providing, or providing access to, documents and other information that the Plan may request to corroborate the information for coverage. If the Subscriber fails or refuses to provide these documents or information to Blue Shield Life, coverage under this plan may be cancelled.

5. The Subscriber must be a Resident of California. Upon change of residence to another jurisdiction, this Policy will terminate. Coverage may be transferred to a Blue Cross or Blue Shield Plan for that jurisdiction, if any. Please see the section entitled TRANSFER OF COVERAGE for additional information.

Duration of the Policy

This Policy shall be renewed upon receipt of prepaid Premiums. Renewal is subject to Blue Shield Life's right to amend this Policy. Any change in Premiums or benefits, including but not limited to Covered Services, deductible, Copayment, Coinsurance, and annual copayment/coinsurance maximum amounts, are effective after 30 days notice from date of mailing to the Subscriber's address of record with Blue Shield Life.

Termination / Cancellation / Reinstatement of the Policy

1. Blue Shield Life may terminate this Policy together with all like Policies by giving 90 days written notice. No Insured shall be terminated individually by Blue Shield Life for any cause other than as provided under this PART. A Subscriber desiring to terminate this Policy shall give Blue Shield Life 30 days written notice.

   This Policy may be cancelled by Blue Shield Life for false representations to, or concealment of material facts from, Blue Shield Life in any health statement, application, or any written instruction furnished to Blue Shield Life by the Insured at any time before or after issuance of this Policy, or fraud or deception in enrollment. The Policy may also be cancelled if the Subscriber fails or refuses to provide access to documents and other information that was provided in the application for coverage. Cancellation in such instances shall be effective as of the original Effective Date of coverage, without prior notice to the Subscriber.

   Blue Shield Life may terminate this Policy for cause immediately upon written notice for the following:

   a. Material information that is false or misrepresented information provided on the enrollment application or given to the Plan;
   b. Permitting use of your Insured identification card by someone other than yourself to obtain Services;

   c. Obtaining or attempting to obtain Services under this Policy by means of false, materially misleading, or fraudulent information, acts or omissions; or

   d. Abusive or disruptive behavior which: (1) threatens the life or well being of Plan personnel and providers of Services; or (2) substantially impairs the ability of Blue

Shield Life to arrange for Services to the Insured; or (3) substantially impairs the ability of providers of Service to furnish Services to the Insured or to other patients.

e. Blue Shield Life may terminate this Policy for cause upon thirty (30) days written notice if the Subscriber moves out of California. See the section entitled TRANSFER OF COVERAGE for additional information.

Blue Shield Life shall, within 31 days of the notice of termination or cancellation, return to the Subscriber the amount of prepaid Premiums, if any, minus any monies paid by Blue Shield Life for Incurred claims that Blue Shield Life determines will not have been earned as of such terminating date. However, Blue Shield Life reserves the right to recoup all payments from the Subscriber for Incurred charges, which exceed the Premiums, paid by the Subscriber, if this Policy is cancelled for fraud or deception.

2. Cancellation of the Policy for Nonpayment of Premiums:

If the Policy is being cancelled because you failed to pay the required Premiums when due, then coverage will end retroactively back to the last day of the month for which Premiums were paid. This retroactive period will not exceed 60 days from the date of mailing of the Notice Confirming Termination of Coverage. The Plan will notify you in a Prospective Notice of Cancellation if your Premiums have not been received. This notice will provide you with the following information:

a. That Premiums due have not been paid and that the Policy will be cancelled if you do not pay the required Premiums within 15 days from the date the Prospective Notice of Cancellation is mailed;

b. The specific date and time when coverage for you will end if Premiums are not paid; and

c. Information regarding the consequences of any failure to pay the Premiums within 15 days.

Within five (5) business days of canceling or not renewing the Policy, the Plan will mail you a Notice Confirming Termination of Coverage, which will inform you of the following:

d. That the Policy has been cancelled, and the reasons for cancellation;

e. The specific date and time when coverage for you ended; and

f. Information regarding the availability of reinstatement of coverage under the Policy.

3. Reinstatement of the Policy after Cancellation

If the Policy is cancelled for nonpayment of Premiums, the Plan will permit reinstatement of the Policy or coverage twice during any twelve-month period, without a change in Premiums and without consideration of the medical condition of you, if the amounts owed are paid within 15 days of the date the Notice Confirming Termination of Coverage is mailed to you. If your request for reinstatement and payment of all outstanding amounts is not received within the required 15 days, or if the Policy is cancelled for nonpayment of Premiums more than twice during the preceding twelve-month period, then the Plan is not required to reinstate you, and you will need to reapply for coverage. In this case, the Plan may impose different Premiums and consider your medical condition.

Transfer of Coverage

1. If a Subscriber moves out of California, coverage under this Policy will terminate. If a Subscriber moves to an area served by another Blue Cross and/or Blue Shield

Plan and notifies Blue Shield Life of his new address, the Subscriber's coverage may be transferred to the plan serving his new address.

2. The new plan must offer the Subscriber at least its group conversion policy. This is a type of policy normally provided to subscribers who leave a group and apply for new coverage as individuals.

3. Conversion policies provide coverage without a medical examination or health statement.

4. If the Subscriber accepts the conversion policy, the new plan will credit the Subscriber for the length of his enrollment in this Plan toward any of the new plan's waiting periods. Any physical or mental conditions covered by this Plan will be covered by the new plan without a new waiting period if the new plan offers this feature to others carrying the same type of coverage.

5. The required dues or Premium amount and benefits available from the new plan may vary significantly from this Plan.

6. In addition, the new plan may offer other types of coverage outside the transfer program, which may:

   a. Require a medical examination or health statement to exclude coverage for pre-existing conditions, and

   b. Not credit the time enrolled in this Plan.

Renewal of the Policy

Blue Shield Life shall renew this Policy, except under the following conditions:

1. Non-payment of Premiums;

2. Fraud, misrepresentation, or omission;

3. Termination of plan type by Blue Shield Life;

4. Subscriber moves out of the service area or the Subscriber is no longer a Resident of California;

5. If a bona fide association arranged for the Subscriber's coverage under this Policy, when that Subscriber's membership in the association ceases.

Maximum Aggregate Payment

The maximum aggregate of benefits payable is as shown in the Summary of Benefits. The maximum aggregate payment amount is determined by totaling all covered benefits provided to you whether you are a Subscriber while covered under this plan or while covered under any prior or subsequent health plan with Blue Shield of California or any of its affiliated companies, including Blue Shield Life. Benefits in excess of this amount are not covered under this plan.

Medical Necessity

The Benefits of this Plan are provided only for Services which are Medically Necessary.

1. Services which are Medically Necessary include only those which have been established as safe and effective, are furnished under generally accepted professional standards to treat illness, injury or medical condition, and which, as determined by the Plan, are:

   a. Consistent with the Plan's medical policy;

   b. Consistent with the symptoms or diagnosis;

   c. Not furnished primarily for the convenience of the patient, the attending Physician or other provider; and

   d. Furnished at the most appropriate level which can be provided safely and effectively to the patient.

2. If there are two (2) or more Medically Necessary Services that may be provided for the illness, injury, or medical condition, Blue Shield Life will provide benefits based on the most cost-effective Service.

3. Hospital Inpatient Services which are Medically Necessary include only those Services which satisfy the above requirements, require the acute bed-patient (overnight) setting, and which could not have been provided in the Physician's office, the Outpatient department of a Hospital, or in another lesser facility without adversely affecting the patient's condition or the quality of medical care rendered. Inpatient services not Medically Necessary include hospitalization:

   a. For diagnostic studies that could have been provided on an Outpatient basis;

   b. For medical observation or evaluation;

   c. For personal comfort;

   d. In a pain management center to treat or cure chronic pain; and

e. For Inpatient Rehabilitation that can be provided on an Outpatient basis.

4. The Plan reserves the right to review all claims to determine whether services are Medically Necessary, and may use the services of Physician consultants, peer review committees of professional societies or Hospitals, and other consultants.

Second Medical Opinion Policy

If you have a question about your diagnosis, or believe that additional information concerning your condition would be helpful in determining the most appropriate plan of treatment, you may make an appointment with another Physician for a second medical opinion. Your attending Physician may also offer to refer you to another Physician for a second opinion.

Remember that the second opinion visit is subject to all Plan Policy benefit limitations and exclusions. Additionally, please see the section on "Your Blue Shield Life Vital Shield 2900 and How to Use It" regarding advantages from selecting a Preferred Physician for these services.

Utilization Review

State law requires that insurers disclose to Insureds and providers the process used to authorize or deny health care services under the Plan. The Plan has completed documentation of this process ("Utilization Review"), as required under Section 10123.135 of the California Insurance Code. To request a copy of the document describing this Utilization Review process, call the Plan's Customer Service Department at 1-888-852-5345.

Health Education and Health Promotion

Health education and health promotion services provided by Blue Shield Life include the Member Newsletter. Additionally, Blue Shield Life's Internet site is located at http://www.blueshieldca.com. Insureds using a personal computer and modem with World Wide Web access may view and download healthcare information.

Retail-Based Health Clinics

Retail-based health clinics are Outpatient facilities, usually attached or adjacent to retail stores, pharmacies, etc…, which provide limited, basic medical treatment for minor health issues. They are staffed by nurse practitioners under the direction of a Physician and offer services on a walk-in basis. Covered Services received from retail-based health clinics will be paid on the same basis and at the same Benefit levels as other covered Services shown in the Summary of Benefits. Retail-based health clinics may be found in the Preferred Provider Directory or the Online Physician Directory located at http://www.blueshieldca.com. See the Blue Shield Life Preferred Providers section for information on the advantages of choosing a Preferred Provider

NurseHelp 24/7 and LifeReferrals 24/7

NurseHelp 24/7 and LifeReferrals 24/7 programs provide Members with no charge, confidential, unlimited telephone support for information, consultations, and referrals for health and psychosocial issues. Members may obtain these services by calling 1-866-543-3728, a 24-hour, toll-free telephone number. There is no charge for these services.

These programs include:

NurseHelp 24/7 – Members may call a registered nurse toll free via 1-866-543-3728, a 24-hours a day, to receive confidential advice and information about minor illnesses and injuries, chronic conditions, fitness, nutrition, and other health related topics.

Psychosocial support through LifeReferrals 24/7 – Members may call 1-866-543-3728 on an unlimited, 24-hour basis for confidential psychosocial support services. Professional counselors will provide support through assessment, referrals and counseling. Note: see the sections entitled Preventive Care Services and Mental Health and Substance Abuse Services for important information concerning this feature.

Benefits Management Program

The Plan has established the Benefits Management Program to assist you or your provider in identifying the most appropriate and cost-effective course of treatment for which benefits will be provided under this Plan and for determining whether the services are Medically Necessary. However, you and your provider make the final decision concerning treatment. The Benefits Management Program includes prior authorization review for certain Services; pre-admission review (except for emergency admissions), emergency admission notification, Hospital Inpatient review; discharge planning; and case management if determined to be applicable and appropriate by the Plan.

Certain portions of the Benefits Management Program also contain Additional and Reduced Payment requirements for either not contacting the Plan or not following the Plan's recommendations and may result in non-payment if the Plan determines the service was not a covered Service. Please read the following sections thoroughly so you understand your responsibilities in reference to the Benefits Management Program.

The Plan requires prior authorization for selected Inpatient and Outpatient Services, all home health care, home infusion / home injectable services, and PKU related formulas and Special Food Products; admission into an approved Hospice Program; and certain radiology procedures. Pre-admission

review is required for all Inpatient Hospital and Skilled Nursing Facility Services (except for Emergency Services) and notification for Inpatient Emergency Services [1]. In these situations, you or your provider need to call the Plan as described in the following sections.

[1] See the paragraph entitled EMERGENCY ADMISSION NOTIFICATION later in this section for notification requirements.

By obtaining prior authorization for certain Services or pre-admission review prior to receiving Services, you and your provider can verify if: (1) the Plan considers the proposed treatment Medically Necessary, (2) if Plan benefits will be provided for the proposed treatment, and (3) if the proposed setting is the most appropriate as determined by the Plan. You and your provider may be informed about Services that could be performed on an Outpatient basis in a Hospital or Outpatient Facility.

Prior Authorization

Before Services are provided, you or your provider can determine whether a procedure or treatment program is covered and may also receive a recommendation for an alternative Service. Failure to contact Blue Shield Life as described below or failure to follow the recommendations of Blue Shield Life for these services will result in a reduced payment per procedure as described in the section entitled ADDITIONAL AND REDUCED PAYMENTS FOR FAILURE TO USE THE BENEFITS MANAGEMENT PROGRAM or may result in non-payment if Blue Shield Life determines that the service is not a covered Service.

Except for radiological procedures when performed in an outpatient setting on a non-emergency basis (item 3. below), your or your Physician must call 1-800-343-1691 for prior authorization for the Services listed in this section.

You or your Physician must call 1-888-642-2583 for prior authorization for radiological procedures when performed in an outpatient setting on a non-emergency basis (item 3. below).

The Plan requires prior authorization for the following Services:

1. Select injectable drugs administered in the physician office setting.*

   * Prior authorization is based on Medical Necessity, appropriateness of therapy, or when effective alternatives are available.

   Note: Your Preferred or Non-Preferred Physician must obtain prior authorization for select injectable drugs administered in the physician's office. Failure to obtain prior authorization or to follow the recommendations of Blue Shield Life for select injectable drugs may result in non-payment by Blue Shield Life if the service is determined not to be a covered Service; in that event you may be financially responsible for services rendered by a Non-Preferred Physician.

2. Home Health Care, Home Infusion / Injectable Care and PKU related formulas and Special Food Products.

3. The following radiological procedures when performed in an outpatient setting on a non-emergency basis:

   a. CT (Computerized Tomography) scans;

   b. MRIs (Magnetic Resonance Imaging);

   c. MRAs (Magnetic Resonance Angiography);

   d. PET (Positron Emission Tomography) scans; and/or

   e. Any cardiac diagnostic procedure utilizing Nuclear Medicine.

   Prior Authorization is not required for these radiological services when obtained outside of California. See the "Out-Of-Area Program: The BlueCard Program" section of this Policy for an explanation of how payment is made for out of state services.

4. Admission into an approved Hospice Program as specified under Hospice Program Services in the Covered Services section.

5. Clinical Trial for Cancer

   Insureds who have been accepted into an approved clinical trial for cancer as defined under the Covered Services section must obtain prior authorization from the Plan in order for the routine patient care delivered in a clinical trial to be covered.

6. Surgery which may be considered to be Cosmetic in nature rather than Reconstructive (e. g. eyelid surgery, rhinoplasty, abdominoplasty, or breast reduction) and those Reconstructive Surgeries which may result in only minimal improvement in function or appearance. The Reconstructive Surgery Benefit is limited to Medically Necessary surgeries and procedures as described in the section entitled COVERED SERVICES.

7. Arthroscopic surgery of the temporomandibular joint (TMJ).

review is required for all Inpatient Hospital and Skilled Nursing Facility Services (except for Emergency Services) and notification for Inpatient Emergency Services [1]. In these situations, you or your provider need to call the Plan as described in the following sections.

[1] See the paragraph entitled EMERGENCY ADMISSION NOTIFICATION later in this section for notification requirements.

By obtaining prior authorization for certain Services or pre-admission review prior to receiving Services, you and your provider can verify if: (1) the Plan considers the proposed treatment Medically Necessary, (2) if Plan benefits will be provided for the proposed treatment, and (3) if the proposed setting is the most appropriate as determined by the Plan. You and your provider may be informed about Services that could be performed on an Outpatient basis in a Hospital or Outpatient Facility.

Prior Authorization

Before Services are provided, you or your provider can determine whether a procedure or treatment program is covered and may also receive a recommendation for an alternative Service. Failure to contact Blue Shield Life as described below or failure to follow the recommendations of Blue Shield Life for these services will result in a reduced payment per procedure as described in the section entitled ADDITIONAL AND REDUCED PAYMENTS FOR FAILURE TO USE THE BENEFITS MANAGEMENT PROGRAM or may result in non-payment if Blue Shield Life determines that the service is not a covered Service.

Except for radiological procedures when performed in an outpatient setting on a non-emergency basis (item 3. below), your or your Physician must call 1-800-343-1691 for prior authorization for the Services listed in this section.

You or your Physician must call 1-888-642-2583 for prior authorization for radiological procedures when performed in an outpatient setting on a non-emergency basis (item 3. below).

The Plan requires prior authorization for the following Services:

1. Select injectable drugs administered in the physician office setting.*

   * Prior authorization is based on Medical Necessity, appropriateness of therapy, or when effective alternatives are available.

   Note: Your Preferred or Non-Preferred Physician must obtain prior authorization for select injectable drugs administered in the physician's office. Failure to obtain prior authorization or to follow the recommendations of Blue Shield Life for select injectable drugs may result in non-payment by Blue Shield Life if the service is determined not to be a covered Service; in that event you may be financially responsible for services rendered by a Non-Preferred Physician.

2. Home Health Care, Home Infusion / Injectable Care and PKU related formulas and Special Food Products.

3. The following radiological procedures when performed in an outpatient setting on a non-emergency basis:

   a. CT (Computerized Tomography) scans;

   b. MRIs (Magnetic Resonance Imaging);

   c. MRAs (Magnetic Resonance Angiography);

   d. PET (Positron Emission Tomography) scans; and/or

   e. Any cardiac diagnostic procedure utilizing Nuclear Medicine.

   Prior Authorization is not required for these radiological services when obtained outside of California. See the "Out-Of-Area Program: The BlueCard Program" section of this Policy for an explanation of how payment is made for out of state services.

4. Admission into an approved Hospice Program as specified under Hospice Program Services in the Covered Services section.

5. Clinical Trial for Cancer

   Insureds who have been accepted into an approved clinical trial for cancer as defined under the Covered Services section must obtain prior authorization from the Plan in order for the routine patient care delivered in a clinical trial to be covered.

6. Surgery which may be considered to be Cosmetic in nature rather than Reconstructive (e. g. eyelid surgery, rhinoplasty, abdominoplasty, or breast reduction) and those Reconstructive Surgeries which may result in only minimal improvement in function or appearance. The Reconstructive Surgery Benefit is limited to Medically Necessary surgeries and procedures as described in the section entitled COVERED SERVICES.

7. Arthroscopic surgery of the temporomandibular joint (TMJ).

8. Dialysis Services (see the benefit description in the section entitled COVERED SERVICES).

9. Special Transplant Benefits (see the benefit description in the section entitled COVERED SERVICES).

10. Bariatric Surgery for Residents of Designated Counties (see the benefit description in the section entitled COVERED SERVICES).

11. Hospital and Skilled Nursing Facility admissions (see the subsequent section entitled HOSPITAL AND SKILLED NURSING FACILITY ADMISSIONS for more information).

12. Outpatient psychiatric Partial Hospitalization and Outpatient electroconvulsive therapy (ECT) Services for the treatment of mental illness.

13. Other services and procedures as determined by Blue Shield Life. A list of services and procedures requiring prior authorization can be obtained by your provider by going to www.blueshieldca.com or by calling 1-800-343-1691.

NOTE:

Failure to obtain prior authorization or to follow the recommendations of Blue Shield Life for Home Health Care and Home Infusion / Home Injectable Care services may result in non-payment if the service is determined not be a covered Service.

Failure to contact Blue Shield Life as described above or failure to follow the recommendations of Blue Shield Life for the radiological procedures as described in item 3. above will result in a reduced payment per procedure as described in the section entitled ADDITIONAL AND REDUCED PAYMENTS FOR FAILURE TO USE THE BENEFITS MANAGEMENT PROGRAM or may result in non-payment if Blue Shield Life determines that the services is not a covered Service.

Failure to obtain prior authorization for Hospice Program Services or to follow the recommendations of Blue Shield Life will result in non-payment of services by Blue Shield Life.

Failure to obtain prior authorization for a Clinical Trial for Cancer will result in non-payment of services by Blue Shield Life.

Failure to obtain prior authorization or to follow the recommendations of Blue Shield Life for services described in items 6. through 12. above may result in non-payment of services by Blue Shield Life.

Pre-admission Review

Hospital and Skilled Nursing Facility Admissions

Prior Authorization must be obtained from Blue Shield Life for all Hospital and Skilled Nursing Facility admissions (except for Admissions required for Emergency Services). Included are Hospitalizations for continuing Inpatient Rehabilitation and skilled nursing care transplants, bariatric surgery, and Inpatient Mental Health or substance abuse Services described later in this section..

Prior Authorization for Other than Mental Health or Substance Abuse Admissions

Whenever your Physician recommends a Hospital or Skilled Nursing Facility admission, you or your Physician must contact the Plan's Medical Management Unit at 1-800-343-1691 at least five (5) business days prior to the admission. However, in case of an admission for Emergency Services, the Plan must receive Emergency Admission Notification within 24 hours or by the end of the first business day following the admission, or as soon as it is reasonably possible to do so.

Medical Management will discuss the benefits available, review the medical information provided and may recommend that to obtain the full benefits of this Plan that the Services be performed on an Outpatient basis.

Examples of procedures that may be recommended to be performed on an Outpatient basis if medical conditions do not indicate Inpatient care include:

1. Biopsy of lymph node, deep axillary;

2. Hernia repair, inguinal;

3. Esophagogastroduodenoscopy with biopsy;

4. Excision of ganglion;

5. Repair of tendon;

6. Heart catheterization;

7. Diagnostic bronchoscopy;

8. Creation of arterial venous shunts (for hemodialysis).

Failure to contact Blue Shield Life as described or failure to follow the recommendations of Blue Shield Life will result in an Additional Payment per admission as described in the section entitled ADDITIONAL AND REDUCED PAYMENTS FOR FAILURE TO USE THE BENEFITS MANAGEMENT PROGRAM or may result in reduction or

non-payment if Blue Shield Life determines the admission is not a covered Service [1].

[1] For admission for Special Transplant Benefits and for Bariatric Services for Residents of Designated Counties, failure to receive prior authorization in writing and/or failure to have the procedure performed at a Blue Shield Life designated facility will result in non-payment of services by Blue Shield Life. See the sections entitled TRANSPLANT BENEFITS and BARIATRIC SURGERY SERVICES for details.

Prior Authorization for Inpatient Mental Health or Substance Abuse Services, and Outpatient Partial Hospitalization and Outpatient ECT Services

All Inpatient Mental Health and substance abuse Services and Outpatient psychiatric Partial Hospitalization Services, except for Emergency Services, must be prior authorized by the Mental Health Services Administrator (MHSA).

For an admission for Emergency Mental Health or substance abuse Services, the MHSA should receive Emergency Admission Notification within 24 hours or by the end of the first business day following the admission, or as soon as it is reasonably possible to do so, or the Subscriber may be responsible for the Additional Payment as described below.

For prior authorization of Inpatient Mental Health and substance abuse Services and Outpatient psychiatric Partial Hospitalization Services, call the MHSA at 1-877-214-2898.

Failure to contact Blue Shield Life or the MHSA as described above or failure to follow the recommendations of Blue Shield Life will result in an Additional Payment per admission as described in the section entitled ADDITIONAL AND REDUCED PAYMENTS FOR FAILURE TO USE THE BENEFITS MANAGEMENT PROGRAM and may result in reduction or non-payment if Blue Shield Life or the MHSA determines that the admission is not a covered Service. For Outpatient psychiatric Partial Hospitalization and Outpatient ECT Services, failure to contact Blue Shield or the MHSA as described above or to follow the recommendations of Blue Shield will result in non-payment of Services by Blue Shield.

Note: Blue Shield Life or the MHSA will render a decision of all requests for prior authorization within five (5) business days from receipt of the request. The treating provider will be notified of the decision within 24 hours followed by written notice to the provider and Insured within two (2) business days of the decision. For urgent services in situations in which the routine decision making process might seriously jeopardize the life or health of the Insured or when the Insured is experiencing severe pain, Blue Shield Life will respond as soon as possible to accommodate the Insured's condition not to exceed 72 hours from the receipt of the request.

Emergency Admission Notification

If an Insured is admitted for Emergency Services, the Insured or the attending Physician must notify Blue Shield Life within 24 hours or by the end of the first business day following the admission, or as soon as it is reasonably possible to do so or the first $500 of the Allowable Amount for the Emergency Services will not be covered..

Hospital Inpatient Review

The Plan monitors Inpatient stays. The stay may be extended or reduced as warranted by your condition. Also, for mastectomies or mastectomies with lymph node dissections, solely your Physician in consultation with you will determine the length of Hospital stays. When a determination is made that the Insured no longer requires the level of care available only in an Acute Care Hospital, written notification is given to you and your Doctor of Medicine. You will be responsible for any Hospital charges Incurred beyond 24 hours of receipt of notification.

Discharge Planning

If further care at home or in another facility is appropriate following discharge from the Hospital, the Plan will work with the Physician and Hospital discharge planners to determine whether benefits are available under this Plan to cover such care.

Case Management

The Benefits Management Program may also include case management, which provides assistance in making the most efficient use of Plan benefits. Individual case management may also arrange for alternative care benefits in place of prolonged or repeated hospitalizations, when it is determined to be appropriate through a Blue Shield Life review. Such alternative care benefits will be available only by mutual consent of all parties and, if approved, will not exceed the benefit to which you would otherwise have been entitled under this Plan. The Plan is not obligated to provide the same or similar alternative care benefits to any other person in any other instance. The approval of alternative care benefits will be for a specific period of time and will not be construed as a waiver of the Plan's right to thereafter administer this health Plan in strict accordance with its express terms.

Additional and Reduced Payments for Failure to use the Benefits Management Program

For non-emergency services, Additional Payments may be required, or payments may be reduced, as described below, when an Insured fails to follow the procedures described under the sections entitled PRIOR AUTHORIZATION and HOSPITAL AND SKILLED NURSING FACILITY ADMISSIONS of the Benefit Management Program. These

Additional Payments will be required in addition to any applicable Calendar Year deductible, Copayment / Coinsurance, and amounts in excess of Benefit dollar maximums specified and will not be included in the calculation of the Insured's Maximum Calendar Year Copayment / Coinsurance responsibility.

1. Failure to contact Blue Shield Life as described in the section entitled Prior Authorization for Other than Mental Health or Substance Abuse Admissions of the Benefits Management Program or failure to follow the recommendations of Medical Management will result in an Additional Payment per Hospital or Skilled Nursing Facility admission as described below or may result in reduction or non-payment if Blue Shield Life determines that the admission is not a covered Service.

   a. The first $500 of the Allowable Amount per admission will not be covered.

2. Failure to contact the MHSA as described in the section entitled Prior Authorization for Mental Health or Substance Abuse Services, and Outpatient Partial Hospitalization and Outpatient ECT Services of the Benefits Management Program or failure to follow the recommendations of the MHSA will result in an Additional Payment per admission as described below and may also result in reduction or non-payment if the MHSA determines that the admission is not a covered Service.

   a. The first $500 of the Allowable Amount per admission will not be covered.

3. Failure to obtain prior authorization or to follow the recommendations of Blue Shield Life for covered Medically Necessary enteral formulas and Special Food Products for the treatment of phenylketonuria (PKU) will result in a 50% reduction in the amount payable by Blue Shield Life after the calculation of the Calendar Year deductible and any applicable Copayment / Coinsurance required by this Plan. You will be responsible for the applicable Calendar Year deductible, any Copayments / Coinsurance, and the additional 50% of the charges that are payable under this Plan.

4. Failure to obtain prior authorization for the radiological procedures listed in the Benefits Management program section under Prior Authorization or to follow the recommendations of Blue Shield Life will result in Reduced Payment amounts describe below per procedure and may result in non-payment for procedures which are determined not to be covered Services.

   a. For covered Services that are not authorized in advance, the amount payable will be reduced by 50% after the calculation of the deductible and any applicable Copayment / Coinsurance required by this Plan. You will be responsible for the remaining 50% and applicable Calendar Year deductible and any Copayments / Coinsurance.

   b. For Services provided by a Non-Preferred Provider, the Subscriber will also be responsible for all charges in excess of the Allowable Amount.

Deductible

Calendar Year Medical Plan Deductible

The Calendar Year per Insured medical plan deductible amount is shown in the Summary of Benefits. After the Calendar Year per Insured medical plan deductible is satisfied for those Services to which the appropriate deductible applies, Benefits will be provided for covered Services. The Calendar Year per Insured medical plan deductible amount must be made up of charges covered by the Plan. Charges in excess of the Allowable Amount do not apply toward the deductibles. The medical plan deductibles must be satisfied once during each Calendar Year by or on behalf of the Insured. The Calendar Year medical plan deductible amount does not count toward the Maximum Calendar Year Copayment/Coinsurance responsibility.

The Calendar Year medical deductible applies to all covered Services Incurred during a Calendar Year except for those Services as shown in the Summary of Benefits.

Payment

The Insured's Copayment and Coinsurance amounts, applicable deductible, and copayment maximum amounts for covered Services are shown in the Summary of Benefits. The Summary of Benefits also contains information on benefit and Copayment/Coinsurance maximums and restrictions.

Complete benefit descriptions may be found in the Principal Benefits and Coverages (Covered Services) section. Plan exclusions and limitations may be found in the Principal Limitations, Exceptions, Exclusions, and Reductions section.

Out-of-Area Program: The BlueCard® Program

Benefits will be provided, according to paragraphs 1., 2., and 3. below for covered Services received by Subscribers who are temporarily traveling outside of California within the United States. (Temporary traveling is defined as a Subscriber who spends in the aggregate not more than 180 days each Calendar Year outside the State of California.) The Plan calculates the Insured's Coinsurance as a percentage of the Allowable Amount, as defined in this Policy. When covered Services are received in another state, the Insured's Copayment and Coinsurance will be based on the local Blue Cross and/or Blue Shield plan's arrangement with its providers.

1. Covered Services received from a Provider who has contracted with the local Blue Cross and/or Blue Shield plan are paid at the Preferred Provider level. Insureds are responsible for the remaining Copayment and Coinsurance.

2. Non-emergency covered Services received from providers who have not contracted with the local Blue Cross and/or Blue Shield plan are paid at the Non-Preferred level of the local Blue Cross and/or Blue Shield plan's Allowable Amount. Insureds are responsible for the remaining Copayment and Coinsurance as well as any charges in excess of the local Blue Cross and/or Blue Shield plan's Allowable Amount.

3. Emergency Services received from providers who have not contracted with the local Blue Cross and/or Blue Shield plan are paid at the Preferred Provider level of billed charges, except that services of a physician are paid based on the Allowable Amount. Insureds are responsible for the remaining Copayment and Coinsurance.

If you do not see a Participating Provider through the BlueCard Program, you will have to pay for the entire bill for your medical care and submit a claim to the local Blue Cross and/or Blue Shield plan or to Blue Shield Life for payment. Blue Shield Life will notify you of its determination within thirty (30) days after the receipt of the claim. Blue Shield Life will pay you at the Non-Preferred Provider benefit level. Remember that your Copayment is higher when you see a Non-Preferred Provider. You will be responsible for paying the entire difference between the amount paid by Blue Shield Life and the amount billed.

Charges for Services which are not covered, and charges by Non-Preferred Providers in excess of the amount covered by the plan, are the Insured's responsibility and are not included in Copayment and Coinsurance calculations.

To receive the maximum benefits of your plan, please follow the procedure below.

When you require covered Services while temporarily traveling outside of California:

1. call *BlueCard Access*® at 1-800-810-BLUE (2583) to locate physicians and hospitals that participate with the local Blue Cross and/or Blue Shield plan or go on-line www.bcbs.com and select the "Find a Doctor or Hospital" tab; and,

2. visit the participating physician or hospital and present your membership card.

The participating physician or hospital will verify your eligibility and coverage information by calling *BlueCard Eligibility* at 1-800-676-BLUE. Once verified and after Services are provided, a claim is submitted electronically and the participating physician or hospital is paid directly. You may be asked to pay for your applicable Copayment and/or Coinsurance at the time you receive the service.

You will receive an Explanation of Benefits, which will show your payment responsibility. You are responsible for the Copayment and/or Coinsurance amounts shown in the Explanation of Benefits.

Pre-admission review is required for all inpatient hospital services and notification is required for inpatient emergency services. Prior Authorization is required for selected inpatient and outpatient services. To receive pre-admission review from Blue Shield Life, the out-of-area provider should call 1-800-343-1691.

If you need Emergency Services, you should seek immediate care from the nearest medical facility. The benefits of this plan will be provided for covered Services received anywhere in the world for the emergency care of an illness or injury.

Care for Covered Urgent Care and Emergency Services outside the United States

Benefits will also be provided for covered Services received while temporarily traveling outside of the United States through the BlueCard Worldwide® Network. If you need urgent care while out of the country, call either the toll-free *BlueCard Access* number at 1-800-810-2583 or call collect at 1-804-673-1177, 24 hours a day, seven days a week. In an emergency, go directly to the nearest hospital. If your coverage requires pre-certification or prior authorization, you should call Blue Shield Life at 1-800-343-1691. For inpatient hospital care at participating hospitals, show your I.D. card to the hospital staff upon arrival. You are responsible for the usual out-of-pocket expenses (non-covered charges, Co-insurance, and Copayments).

When you receive services from a physician, you will have to pay the doctor and then submit a claim. Also for hospitalization, if you do not use the BlueCard Worldwide Network, you will have to pay the entire bill for your medical care and submit a claim form (with a copy of the bill) to Blue Shield Life.

Before traveling abroad, call your local Customer Service office for the most current listing of participating hospitals world-wide or you can go to www.bcbs.com and select "Find a Doctor or Hospital".

Calculation of your Copayment and/or Coinsurance maximum responsibilities under the BlueCard Program:

When you obtain health care services through the BlueCard Program outside of California, the amount you pay for covered services is calculated on the lower of:

1. the billed charges for your covered services, or

2. the negotiated price that the local Blue Cross Blue Shield plan passes on to us.

Often, this "negotiated price" will consist of a simple discount, which reflects the actual price paid by the local Blue Cross and/or Blue Shield plan. But sometimes it is an estimated price that factors into the actual price expected settlements, withholds, any other contingent payment arrangements and non-claims transactions with your health care provider or with a specified group of providers. The negotiated price may also be billed charges reduced to reflect an average expected saving with your health care provider or with a specified group of providers. The price that reflects average savings may result in greater variation (more or less) from the actual price paid than will the estimated price. The negotiated price will also be adjusted in the future to correct for over- or underestimation of past prices. However, the amount you pay is considered a final price.

Statutes in a small number of states may require the local Blue Cross and/or Blue Shield plan use a basis for calculating Insured liability for covered Services that does not reflect the entire savings realized or expected to be realized on a particular claim or to add a surcharge. Should any state statutes mandate Insured liability calculation methods that differ from the usual BlueCard Program method noted above or require a surcharge, Blue Shield Life would then calculate your liability for any covered health care services in accordance with the applicable state statute in effect at the time you received your care.

For any other providers, the amount you pay, if not subject to a flat dollar copayment, is calculated on the provider's billed charge for your covered services.

Maximum per Insured Calendar Year Copayment/Coinsurance Responsibility

1. The per Insured maximum Copayment/Coinsurance responsibility each Calendar Year for covered Services * rendered by Preferred Providers, MHSA Participating Providers, and Other Providers is show in the Summary of Benefits.

2. The per Insured maximum Copayment/Coinsurance responsibility each Calendar Year for covered Services * rendered by any combination of Preferred Providers, Non-Preferred Providers, MHSA Participating and Non-Participating Providers, and Other Providers is shown in the Summary of Benefits.

Once the Maximum Calendar Year Copayment/Coinsurance Responsibility has been met, Blue Shield Life will pay 100% of the Allowable Amount for covered Services for the remainder of that Calendar Year, except as described below.

* Note: Certain Services and amounts are not included in the calculation of the Maximum Calendar Year Copayment/Coinsurance. These are items shown in the Summary of Benefits.

Charges for these items may cause an Insured's payment responsibility to exceed the maximums.

Copayments, Coinsurance, and charges for Services not accruing to the Insured's maximum Calendar Year Copayment/Coinsurance Responsibility continue to be the Insured's responsibility after the Calendar Year Copayment/Coinsurance Maximum is reached.

Principal Benefits and Coverages (Covered Services)

Benefits are provided for the following Medically Necessary covered Services, subject to the applicable deductible, Copayments and Coinsurance, and charges in excess of the Benefit maximums, Preferred Provider provisions, and Benefits Management Program provisions. Coverage for these Services is subject to all terms, conditions, limitations and exclusions of the Policy, to any conditions or limitations set forth in the benefit descriptions below, and to the Principal Limitations, Exceptions, Exclusions, and Reductions listed in this Policy.

The Copayments and Coinsurance, if applicable, are shown in the Summary of Benefits.

Note: Except as may be specifically indicated, for Services received from Non- Preferred and Non-Participating Providers, Insureds will be responsible for all charges above the Allowable Amount in addition to the indicated dollar or percentage Insured Copayment.

Ambulance Services

Benefits are provided for (1) Medically Necessary ambulance Services (surface and air) when used to transport an Insured from place of illness or injury to the closest medical facility where appropriate treatment can be received, or (2) Medically Necessary ambulance transportation from one medical facility to another.

Ambulatory Surgery Center Benefits

Ambulatory surgery Services means surgery which does not require admission to a Hospital (or similar facility) as a registered bed patient.

Outpatient routine newborn circumcisions are covered when performed in an ambulatory surgery center. For the purposes of this Benefit, routine circumcisions are circumcisions performed within 31 days of birth unrelated to illness or injury. Routine circumcisions after this time period are covered for sick babies when authorized by the Plan.

Outpatient Services including general anesthesia and associated facility charges in connection with dental procedures are covered when performed in an Ambulatory Surgery Center because of an underlying medical condition or clinical status and the Insured is under the age of seven or developmentally disabled regardless of age or when the Insured's health is compromised and for whom general anesthesia is Medically Necessary regardless of age. This Benefit excludes dental procedures and Services of a dentist or oral surgeon.

Note: Reconstructive Surgery and associated covered Services are only covered when determined by the Plan to be Medically Necessary and only to correct or repair abnormal structures of the body which result in more than a minima improvement in function or appearance. In accordance with the Woman's Health & Cancer Rights Act, Reconstructive Surgery on either breast provided to restore and achieve symmetry incident to a mastectomy is covered. For coverage of prosthetic devices incident to a mastectomy, see Reconstructive Surgery under Professional (Physician) Benefits. Any such Services must be received while the Policy is in force with respect to the Insured. Benefits will be provided in accordance with guidelines established by the Plan and developed in conjunction with plastic and reconstructive surgeons.

No benefits will be provided for the following surgeries or procedures unless determined by the Plan to be Medically Necessary to correct or repair abnormal structures of the body caused by congenital defects, developmental abnormalities, trauma, infection, tumors, or disease, and which will result in more than minimal improvement in function or appearance:

- Surgery to excise, enlarge, reduce, or change the appearance of any part of the body;
- Surgery to reform or reshape skin or bone;
- Surgery to excise or reduce skin or connective tissue that is loose , wrinkled, sagging, or excessive on any part of the body;
- Hair transplantation; and
- Upper eyelid blepharoplasty without documented significant visual impairment or symptomatology.

This limitation shall not apply when breast reconstruction i performed subsequent to a Medically Necessary Mastec tomy, including surgery on either breast to achieve or restor symmetry.

Bariatric Surgery Services

Benefits are provided for Hospital and professional Service in connection with Medically Necessary bariatric surgery t treat morbid or clinically severe obesity as described below.

All bariatric surgery services must be prior authorized, i writing, by Blue Shield Life's Medical Director. Prior au thorization is required for all Insureds, whether residents of designated or non-designated county.

Services for Residents of Designated Counties in Califor nia

For Insureds who reside in a California county designated as having facilities contracting with Blue Shield Life to pro vide bariatric Services, Blue Shield Life will provide Bene fits for certain Medically Necessary bariatric surgery proce dures only if:

1. Services are performed at a Preferred Bariatric Surgery Services Hospital and by a Preferred Bariatric Surgery Services Physician that have contracted with Blue Shiel Life to provide the procedure; and
2. Services are consistent with Blue Shield Life's medica policy; and
3. Prior authorization is obtained, in writing, from Blu Shield Life's Medical Director.

* See the list of designated counties below.

The Plan reserves the right to review all requests for prio authorization for these bariatric benefits and to make a deci sion regarding benefits and to make a decision regarding benefits based on a) the medical circumstances of each pa tient, and b) consistency between the treatment proposed an the Plan's medical policy.

For Insureds who reside in a designated county, failure t obtain prior written authorization as described above and/o failure to have the procedure performed at a Preferred Bariat ric Surgery Services Hospital by a Preferred Bariatric Sur gery Services Physician will result in denial of claims for thi benefit.

The following are designated counties in which the Plan has contracted with facilities to provide bariatric Services:

Imperial	San Bernardino
Kern	San Diego
Los Angeles	Santa Barbara
Orange	Ventura
Riverside	

Bariatric Travel Expenses Reimbursement for Residents of Designated Counties in California
Insureds who reside in designated counties and who have obtained written authorization from Blue Shield Life to receive bariatric Services at a Preferred Bariatric Surgery Services Hospital may be eligible to receive reimbursement for associated travel expenses.

To be eligible to receive travel expense reimbursement, the Insureds' home must be 50 or more miles from the nearest Preferred Bariatric Surgery Services Hospital. All requests for travel expense reimbursement must be prior approved by Blue Shield Life. Approved travel-related expenses will be reimbursed as follows:

1. Transportation to and from the facility up to a maximum of $130 per trip:
   a. For the Person for a maximum of three (3) trips;
      i. One (1) trip for a pre-surgical visit,
      ii. One (1) trip for the surgery, and
      iii. One (1) trip for a follow-up visit.

   b. For one (1) companion for a maximum of two (2) trips;
      i. One (1) trip for the surgery, and
      ii. One (1) trip for a follow-up visit.
2. Hotel accommodations not to exceed $100 per day:
   a. For the Person and one (1) companion for a maximum of two (2) days per trip,
      i. One (1) trip for a pre-surgical visit, and
      ii. One (1) trip for a follow-up visit.

   b. For one (1) companion for a maximum of four (4) days for the duration of the surgery admission.

   All hotel accommodation is limited to one (1), double-occupancy room. Expenses for in-room and other hotel services are specifically excluded.

3. Related expenses judged reasonable by Blue Shield Life not to exceed $25 per day per Person up to a maximum of four (4) days per trip. Expenses for tobacco, alcohol, drugs, telephone, television, delivery, and recreation are specifically excluded.

Submission of adequate documentation including receipts is required before reimbursement will be made.

Covered bariatric travel expenses are not subject to the Calendar Year deductible and do not accrue to the maximum Calendar Year Copayment responsibility.

Note: bariatric surgery Services for residents of non-designated counties will be paid as any other Inpatient surgery as described elsewhere in this section when:

1. Services are consistent with the Plan's medical policy; and,
2. Prior authorization is obtained, in writing, from the Plan's Medical Director.

For Insureds who reside in non-designated counties, travel expenses associated with bariatric surgery Services are not covered.

Clinical Trial for Cancer
Benefits are provided for routine patient care for Insureds who have been accepted into an approved clinical trial for cancer when prior authorized by Blue Shield Life, and:

1. The clinical trial has a therapeutic intent and the Insured's treating Physician determines that Participation in the clinical trial has a meaningful potential to benefit the Insured with a therapeutic intent; and

2. The Insured's treating Physician recommends participation in the clinical trial; and

3. The Hospital and/or Physician conducting the clinical trial is a Participating Provider, unless the protocol for the trial is not available through a Participating Provider.

Services for routine patient care will be paid on the same basis and at the same benefit levels as other covered Services shown in the Covered Services section.

Routine patient care consists of those Services that would otherwise be covered by the Plan if those Services were not provided in connection with an approved clinical trial, but does not include:

1. Drugs or devices that have not been approved by the federal Food and Drug Administration (FDA);

2. Services other than health care services, such as travel, housing, companion expenses and other non-clinical expenses;

3. Any item or service that is provided solely to satisfy data collection and analysis needs and that is not used in the clinical management of the Insured;
4. Services that, except for the fact that they are being provided in a clinical trial, are specifically excluded under the Plan; or

5. Services customarily provided by the research sponsor free of charge for any enrollee in the trial.

An approved clinical trial is limited to a trial that is approved by one of the following:

1. One of the National Institutes of Health;

2. The federal Food and Drug Administration (FDA), in the form of an investigational new drug application;
3. The United States Department of Defense;

4. The United States Department of Veterans Affairs; or

5. Involves a drug that is exempt under federal regulations from a new drug application.

Diabetes Care
Diabetes Care Supplies

Diabetes Equipment
Benefits are provided for the following devices, equipment, and supplies for the management and treatment of diabetes when Medically Necessary:

a. Blood glucose monitors, including those designed to assist the visually impaired;

b. Insulin pumps and all related necessary supplies;

c. Podiatric devices to prevent or treat diabetes-related complications, including extra-depth orthopedic shoes;

d. Visual aids, excluding eyewear, and/or video-assisted devices, designed to assist the visually impaired with proper dosing of Insulin.

For coverage of diabetic testing supplies including blood and/or urine testing strips or tablets, lancets and lancet puncture devices and pen delivery systems for the administration of Insulin, refer to the section entitled OUTPATIENT PRESCRIPTION GENERIC DRUGS.

Diabetes Outpatient Self-Management Training
Benefits are provided for diabetes Outpatient self-management training, education and medical nutrition therapy that is Medically Necessary to enable an Insured to properly use the devices, equipment and supplies, and any additional Outpatient self-management training, education and medical nutrition therapy when directed or prescribed by the Insured's Physician. Services will be covered when provided by Physicians, registered dieticians, or registered nurses that are certified diabetes educators.

Dialysis Services
Benefits are provided for Medically Necessary dialysis Services, including renal dialysis, hemodialysis, peritoneal dialysis, and related procedures.

Including in this Benefit are Medically Necessary dialysis related laboratory tests, equipment, medications, supplies, and dialysis self-management training for home dialysis.

Note: Prior Authorization by Blue Shield Life is required for all dialysis services. See the section entitled BENEFIT MANAGEMENT PROGRAM for additional information.

Family Planning Services
Benefits are provided for the following Family Planning Services without illness or injury being present.

Note: No benefits are provided for Family Planning Services from Non-Participating Providers.

1. Family planning counseling and consultation Services, including Physician office visits for diaphragm fittings;

2. Injectable contraceptives when administered by a Physician;

3. Voluntary sterilization (tubal ligation and vasectomy) and elective abortions. No benefits are provided for contraceptives, except as may be provided under the Outpatient Prescription Drug Benefit section.

Home Health Care Benefits
Benefits are provided for the Services of a Participating Home Health Care Agency or Home Infusion Agency when Medically Necessary, ordered by an attending Physician, and included in a written treatment plan, when prior authorized by the Plan.

Benefits for home health care and home infusion/injectable care will be payable up to a per Insured per Calendar Year Benefit as shown in the Summary of Benefits. For the purpose of this Benefit, a visit shall be considered a single visit of any length, except for visits from home health aides for whom a visit of four hours or less shall be considered as one visit.

(Note: See the Hospice Program Services section for Services provided when an Insured is admitted into a Hospice Program through a Participating Hospice Agency.)

Intermittent and part-time visits by a home health agency to provide Skilled Nursing services up to 4 visits per day, 2 hours per visit not to exceed 8 hours per day by any of the following professional providers are subject to any applicable Copayments and/or Coinsurance:

1. Registered nurse;
2. Licensed vocational nurse;
3. Physical therapist, Occupational therapist, or Speech therapist;
4. Certified home health aide in conjunction with the services of 1, 2 or 3 above;
5. Medical social services provided by a licensed medical social worker for consultation and evaluation.

Skilled Nursing Services are defined as a level of care that includes services that can only be performed safely and correctly by a licensed nurse (either a registered nurse or a licensed vocational nurse).

Other Services: Physician, Hospital, ambulance, hemodialysis, medical supplies, drugs and medicines used during a covered visit, and related pharmaceutical and laboratory Services to the extent Benefits would have been provided for had the Insured remained in the Hospital, will be provided as stated under Covered Services and are not subject to the home health care and home infusion/injectable care Benefit maximum.

Home Infusion / Home Injectable Therapy Benefits

Benefits are provided for home infusion therapy, visits for chemotherapy for cancer, catheterizations, and associated drugs and supplies; parenteral and enteral nutritional Services, related supplies used during a covered visit, and pharmaceuticals administered intravenously, when Medically Necessary, and prescribed by a Doctor of Medicine. Benefits are also provided for infusion therapy provided in infusion suites associated with a Participating Home Health Care Agency and Home Infusion Agency. All Services must be prior authorized by the Plan.

Benefits for home health care and home infusion/injectable care will be payable up to a per Insured per Calendar Year Benefit as shown in the Summary of Benefits. For the purpose of this Benefit, a visit shall be considered a single visit of any length.

Certain injectable medications are subject to conditions and limitations applicable to other Benefits of this Plan.

Insulin, disposable Insulin syringes, and certain Home Self-Administered Injectables are covered under the Outpatient Prescription Generic Drug Benefit section.

Note: Services rendered by Non-Preferred Home Health Care and Home Infusion Agencies are not covered, unless prior authorized by the Plan.

Other Services: Physician, Hospital, ambulance, hemodialysis, medical supplies, drugs and medicines used during a covered visit, and related pharmaceutical and laboratory Services to the extent Benefits would have been provided for had the Insured remained in the Hospital, will be provided as stated under Covered Services and are not subject to the home health care and home infusion/injectable care Benefit maximum.

Hospice Program Services

Benefits are provided for the following Services through a Participating Hospice Agency when an eligible Insured requests admission to and is formally admitted to an approved Hospice Program. The Insured must have a Terminal Illness as determined by their Physician's certification and the admission must receive prior approval from the Plan. (Note: Insured with a Terminal Illness who have not elected to enroll in a Hospice Program can receive a pre-hospice consultative visit from a Participating Hospice Agency.) Covered Services are available on a 24-hour basis to the extent necessary to meet the needs of individuals for care that is reasonable and necessary for the palliation and management of Terminal Illness and related conditions. Insureds can continue to receive covered Services that are not related to the palliation and management of the Terminal Illness from the appropriate provider. Note: Hospice services provided by a Non-Participating hospice agency are not covered except in certain circumstances in counties in California in which there are no Participating Hospice Agencies and only when authorized by the Plan.

All of the Services listed below must be received through a Participating Hospice Agency.

1. Pre-hospice consultative visit regarding pain and symptom management, hospice, and other care options including care planning (Insureds do not have to be enrolled in the Hospice Program to receive this Benefit).
2. Interdisciplinary Team care with development and maintenance of an appropriate Plan of Care and management of Terminal Illness and related conditions.
3. Skilled Nursing Services, certified health aide Services, and homemaker Services under the supervision of a qualified registered nurse.

4. Bereavement Services.

5. Social Services / Counseling Services with medical social services provided by a qualified social worker. Dietary counseling, by a qualified provider, shall also be provided when needed.

6. Medical Direction with the medical director being also responsible for meeting the general medical needs for the Terminal Illness of the Insured to the extent that these needs are not met by the Insured's other providers.

7. Volunteer Services.

8. Short-term Inpatient care arrangements.

9. Pharmaceuticals, medical equipment, and supplies that are reasonable and necessary for the palliation and management of Terminal Illness and related conditions.

10. Physical therapy, occupational therapy, and speech-language pathology Services for purposes of symptom control, or to enable the enrollee to maintain activities of daily living and basic functional skills.

11. Nursing care Services that are covered on a continuous basis for as much as 24-hours a day during Periods of Crisis as necessary to maintain a Insured at home. Hospitalization is covered when the Interdisciplinary Team makes the determination that skilled nursing care is required at a level that cannot be provided in the home. Either Homemaker Services or Home Health Aide Services or both, may be covered on a 24-hour continuous basis during Periods of Crisis but the care provided during these periods must be predominantly nursing care.

12. Respite Care Services are limited to an occasional basis and to no more than five consecutive days at a time.

Insureds are allowed to change their Participating Hospice Agency only once during each Period of Care. Insureds can receive care for two (2) 90-day periods followed by an unlimited number of 60-day periods. The care continues through another Period of Care if the Participating Provider recertifies that the Insured is Terminally Ill.

Definitions:

Bereavement Services – services available to the immediate surviving family members for a period of at least one (1) year after the death of the Insured These services shall include an assessment of the needs of the bereaved family and the development of a care plan that meets these needs, both prior to, and following the death of the Insured.

Continuous Home Care – home care provided during a Period of Crisis. A minimum of eight (8) hours of continuous care, during the 24-hour day, beginning and ending at midnight is required. This care could be four (4) hours in the morning and another four (4) hours in the evening. Nursing care must be provided for more than half of the period of care and must be provided by either a registered nurse or licensed practical nurse. Homemaker Services or Home Health Aide Services may be provided to supplement the nursing care. When fewer than eight (8) hours of nursing care are required, the services are covered as routine home care rather than Continuous Home Care.

Home Health Aide Services - services providing for the personal care of the Terminally Ill Insured and the performance of related tasks in the Insured's home in accordance with the Plan of Care in order to increase the level of comfort and to maintain personal hygiene and a safe, healthy environment for the patient. Home Health Aide Services shall be provided by a person who is certified by the state Department of Health Services as a home health aide pursuant to Chapter 8 of Division 2 of the Health and Safety Code.

Homemaker Services – services that assist in the maintenance of a safe and healthy environment and services to enable the Insured to carry out the treatment plan.

Hospice Service or Hospice Program – a specialized form of interdisciplinary health care that is designed to provide palliative care, alleviate the physician, emotional, social, and spiritual discomforts of a Insured who is experiencing the last phases of life due to the existence of a Terminal Disease, to provide supportive care to the primary caregiver and the family of the hospice patient, and which meets all of the following criteria:

a. Considers the Insured and the Insured's family in addition of the Insured, as the unit of care.

b. Utilizes and Interdisciplinary Team to assess the physical, medical, psychological, and social and spiritual needs of the Insured and their family.

c. Requires the Interdisciplinary Team to develop an overall Plan of Care and to provide coordinated care which emphasizes supportive Services, including, but not limited to, home care, pain control, and short-term Inpatient Services. Short-term Inpatient Services are intended to ensure both continuity of care and appropriateness of services for those Insureds who cannot be managed at home because of acute complications or the temporary absence of a capable primary caregiver.

d. Provides for the palliative medical treatment of pain and other symptoms associated with a Terminal Disease, but does not provide for efforts to cure the disease.

e. Provides for Bereavement Services following the Insured's death to assist the family to cope with social and emotional needs associated with the death.

f. Actively utilizes volunteers in the delivery of Hospice Services

g. Provides Services in the Insured's home or primary place of residence to the extent appropriate based on the medical needs of the Insured.

h. Is provided through a Participating Hospice.

Interdisciplinary Team – the hospice care team that includes, but is not limited to, the Insured and their family, a physician and surgeon, a registered nurse, a social worker, a volunteer, and a spiritual caregiver.

Medical Direction – Services provided by a licensed physician and surgeon who is charged with the responsibility of acting as a consultant to the Interdisciplinary Team, a consultant to the Insured's Participating Provider, as requested, with regard to pain and symptom management, and liaison with physicians and surgeons in the community. For purposes of this section, the person providing these Services shall be referred to as the "medical director".

Period of Care – the time when the Participating Provider recertifies that the Insured still needs and remains eligible for hospice care even if the Insured lives longer than one (1) year. A Period of Care starts the day the Insured begins to receive hospice care and ends when the 90 or 60-day period has ended.

Period of Crisis – a period in which the Insured requires continuous care to achieve palliation or management of acute medical symptoms.

Plan of Care – a written plan developed by the attending physician and surgeon, the "medical director" (as defined under "Medical Direction") or physician and surgeon designee, and the Interdisciplinary Team that addresses the needs of an Insured and family admitted to the Hospice Program. The Hospice shall retain overall responsibility for the development and maintenance of the Plan of Care and quality of Services delivered.

Respite Care Services – short-term Inpatient care provided to the Insured only when necessary to relieve the family members or other persons caring for the Insured.

Skilled Nursing Services – nursing Services provided by or under the supervision of a registered nurse under a Plan of Care developed by the Interdisciplinary Team and the Insured's provider to the Insured and his family that pertain to the palliative, supportive services required by the Insured with a Terminal Illness. Skilled Nursing Services include, but are not limited to, Subscriber or Dependent assessment, evaluation, and case management of the medical nursing needs of the Insured, the performance of prescribed medical treatment for pain and symptom control, the provision of emotional support to both the Insured and his family, and the instruction of caregivers in providing personal care to the enrollee. Skilled Nursing Services provide for the continuity of Services for the Insured and his family and are available on a 24-hour on-call basis.

Social Service / Counseling Services – those counseling and spiritual Services that assist the Insured and his family to minimize stresses and problems that arise from social, economic, psychological, or spiritual needs by utilization appropriate community resources, and maximize positive aspects and opportunity for growth.

Terminal Disease or Terminal Illness – a medical condition resulting in a prognosis of life of one (1) year or less, if the disease follows its natural course.

Volunteer Services – services provided by trained hospice volunteers who have agreed to provide service under the direction of a hospice staff member who has been designated by the Hospice to provide direction to hospice volunteers. Hospice volunteers may provide support and companionship to the Insured and his family during the remaining days of the Insured's life and to the surviving family following the Insured's death.

Hospital Benefits

Other than Mental Health Services and substance abuse care, Hospice Program Services, Skilled Nursing Facility Benefits, Dialysis Benefits, and Bariatric Surgery Services for residents of designated counties which are described in other sections.

Inpatient Services for Treatment of Illness or Injury

1. Any accommodation up to the Hospital's established semi-private room rate, or, if Medically Necessary as certified by a Doctor of Medicine, the intensive care unit.

2. Benefits are provided for Services required to treat involuntary Complications of Pregnancy on the Insured's Effective Date of coverage. Complications of Pregnancy include, but are not limited to, Medically Necessary Cesarean Section, miscarriage, toxemia of pregnancy (preeclampsia and eclampsia), hyperemesis gravidarum, ectopic (tubal or extra-uterine) pregnancy, nephritis or pyelitis of pregnancy, placenta abruptio or puerperal infection.

Emergency Services and Complications of Pregnancy are paid just as any other illness.

No benefits are provided for services subsequent to termination of coverage under this Policy.

3. Use of operating room and specialized treatment rooms.

4. In conjunction with a covered delivery, routine nursery care for a newborn of the Insured or covered spouse or Domestic Partner.

5. Reconstructive Surgery and associated covered Services when determined by the Plan to be Medically Necessary and only to correct or repair abnormal structures of the body and which result in more than a minimal improvement in function or appearance. In accordance with the Women's Health & Cancer Rights Act, Reconstructive Surgery on either breast provided to repair and achieve symmetry incident to a mastectomy is covered. For coverage of prosthetic devices incident to a mastectomy, see Reconstructive Surgery under Professional (Physician) Benefits. Any such Services must be received while the Policy is in force with respect to the Insured. Benefits will be provided in accordance with guidelines established by the Plan and developed in conjunction with plastic and reconstructive surgeons.

   No benefits will be provided for the following surgeries or procedures unless determined by the Plan to be Medically Necessary to correct or repair abnormal structures of the body caused by congenital defects, developmental abnormalities, trauma, infection, tumors, or disease, and which will result in more than minimal improvement in function or appearance:

   - Surgery to excise, enlarge, reduce or change the appearance of any part of the body;
   - Surgery to reform or reshape skin or bone;
   - Surgery to excise or reduce skin or connective tissue that is loose, wrinkled, sagging, or excessive on any part of the body;
   - Hair transplantation; and
   - Upper eyelid blepharoplasty without documented significant visual impairment of symptomatology.

   This limitation shall not apply when breast reconstruction is performed subsequent to a Medically Necessary mastectomy, including surgery on either breast to achieve or restore symmetry.

6. Surgical supplies, dressings and cast materials, and anesthetic supplies furnished by the Hospital

7. Rehabilitation when furnished by the Hospital, and Rehabilitative Care when furnished by the Hospti9al and approved in advance by the Plan under its Benefits Management Program.

8. Drugs and oxygen.

9. Administration of blood and blood plasma, including the cost of blood, blood plasma, and blood processing.

10. X-Ray examination and laboratory tests.

11. Radiation therapy and chemotherapy for cancer including catheterization, infusion devices, and associated drugs and supplies.

12. Use of medical appliances and equipment.

13. Subacute Care.

14. Inpatient Services including general anesthesia and associated facility charges in connection with dental procedures when hospitalization is required because of an underlying medical condition or clinical status and the Insured in under the age of seven or developmentally disables regardless of age or when the Insured's health is compromised ad for whom general anesthesia is Medically Necessary regardless of age. Excludes dental procedures and Services of a dentist or oral surgeon.

15. Medically Necessary Inpatient substance abuse detoxification Services required to treat potentially life-threatening symptoms of acute toxicity or acute withdrawal are covered when an Insured is admitted through the emergency room, or when Medically Necessary Inpatient substance abuse detoxification is prior authorized by the Plan.

Outpatient Services for Treatment of Illness or Injury or for Surgery

1. Medically Necessary Services provided in the Outpatient Facility of a Hospital.

2. Outpatient care provided by the admitting Hospital within 24 hours before admission, when care is related to the condition for which Inpatient admission was made.

3. Radiation therapy and chemotherapy for cancer, including catheterization, infusion devices, and associated drugs and supplies.

4. Reconstructive Surgery and associated covered Services when determined by the Plan to be Medically Necessary and only to correct or repair abnormal structures of the body and which result in more than a minimal improvement in function or appearance. In accordance with the Women's Health & Cancer Rights Act, Reconstructive Surgery on either breast provided to repair and achieve symmetry incident to a mastectomy is covered. For coverage of prosthetic devices incident to a mastectomy, see Reconstructive Surgery under Professional (Physician) Benefits. Any such Services must be received while the Policy is in force with respect to the Insured. Benefits will be provided in accordance with guidelines established by the Plan and developed in conjunction with plastic and reconstructive surgeons.

   No benefits will be provided for the following surgeries or procedures unless determined by the Plan to be Medically Necessary to correct or repair abnormal structures of the body caused by congenital defects, developmental abnormalities, trauma, infection, tumors, or disease, and which will result in more than minimal improvement in function or appearance:

   - Surgery to excise, enlarge, reduce or change the appearance of any part of the body;
   - Surgery to reform or reshape skin or bone;
   - Surgery to excise or reduce skin or connective tissue that is loose, wrinkled, sagging, or excessive on any part of the body;
   - Hair transplantation; and
   - Upper eyelid blepharoplasty without documented significant visual impairment of symptomatology.

   This limitation shall not apply when breast reconstruction is performed subsequent to a Medically Necessary mastectomy, including surgery on either breast to achieve or restore symmetry.

5. Outpatient Services including general anesthesia and associated facility charges in connection with dental procedures when performed in the Outpatient Facility of a Hospital because of an underlying medical condition or clinical status and the Insured is under age of seven or developmentally disabled regardless of age or when the Insured's health is compromised and for whom general anesthesia is Medically Necessary regardless of age. Excludes dental procedures and Services of a dentist or oral surgeon.

6. Outpatient routine newborn circumcisions. *

   * For the purpose of this Benefit, routine newborn circumcisions are circumcisions performed within 31 days of birth unrelated to illness or injury. Routine circumcisions after this time period are covered for sick babies when authorized by the Plan.

Covered lab and X-Ray Services provided in an Outpatient Hospital setting are paid as descried under the Outpatient/Out-of-Hospital X-Ray, Pathology, and Laboratory Benefits, Outpatient Rehabilitation Benefits, and Speech Therapy Benefits sections.

Emergency Room Services for Treatment of Illness or Injury

Benefits are provided for Medically Necessary Services provided in the Emergency Room of a Hospital.

Note: Emergency Room Services resulting in an admission to a Non-Preferred Hospital which the Plan determines are not emergencies, will be paid as part of the Inpatient Hospital Services. The Insured Copayment/Coinsurance for non-emergency Inpatient Hospital Services from a Non-Preferred Hospital is shown in the Summary of Benefits.

For Emergency Room Services directly resulting in an admission to a different Hospital, the Insured is responsible for the emergency room Insured Copayment/Coinsurance plus the appropriate admitting Hospital Services Insured Copayment/Coinsurance as shown in the Summary of Benefits.

Medical Treatment of the Teeth, Gums or Jaw Joints and Jaw Bones

Benefits are provided for Hospital and professional Services for conditions of the teeth, gums or jaw joints and jaw bones including adjacent tissues only to the extent that they are provided for:

1. The treatment of tumors of the gums;

2. The treatment of damage to the natural teeth caused solely by an Accidental Injury is limited to Medically Necessary services until the services result in initial, palliative stabilization of the Insured as determined by the Plan;

   Note: Dental services provided after initial medical stabilization, prosthodontics, orthodontia, and/or cosmetic services are not covered. This benefit does not include damage to the natural teeth that is not accidental, e.g. resulting from chewing or biting;

3. Medically Necessary non-surgical treatment (e.g., splint and physical therapy) of Temporomandibular Joint Syndrome (TMJ);

4. Surgical and arthroscopic treatment of TMJ if prior history shows conservative medical treatment has failed;

5. Medically Necessary treatment of maxilla and mandible (Jaw Joints and Jaw Bones); or

6. Orthognathic Surgery (surgery to reposition the upper and/or lower jaw) which is Medically Necessary to correct a skeletal deformity.

No benefits are provided for:

1. Services performed on the teeth, gums (other than tumors) and associated periodontal structures, routine care of teeth and gums, diagnostic Services, preventive or periodontic Services, dental orthoses and prostheses, including hospitalization incident thereto;

2. Orthodontia (dental services to correct irregularities or malocclusion of the teeth) for any reason, including treatment to alleviate TMJ;

3. Dental implants (endosteal, subperiosteal or transosteal);

4. Any procedure (e.g. vestibuloplasty) intended to prepare the mouth for dentures or for the more comfortable use of dentures;

5. Alveolar ridge surgery of the jaws if performed primarily to treat diseases related to the teeth, gums or periodontal structures, or to support natural or prosthetic teeth;

6. Fluoride treatments except when used with radiation therapy to the oral cavity.

See Principal Limitations, Exceptions, Exclusions, and Reductions, General Exclusions for additional Services that are not covered.

Mental Health and Substance Abuse Services

The Plan's Mental Health Services Administrator (MHSA) administers and delivers the Plan's Mental Health and substance abuse Services. Prior authorization is not required for Inpatient mental Health and substance abuse Services when obtained outside of California. See the "Out-of-Area Program: The BlueCard Program" section of this Policy for an explanation of how payment is made for out of state Services.

All Non-Emergency Inpatient Mental Health Services and Outpatient Partial Hospitalization and Outpatient electroconvulsive therapy (ECT) Services must be prior authorized by the MHSA. For prior authorization, Insureds should contact the MHSA at 1-877-214-2928. (See the Benefits Management Program section for complete information.)

Benefits are provided for the following Medically Necessary covered Mental Health and substance abuse Services, subject to applicable Copayments, Coinsurance and charges in excess of any benefit maximums, MHSA Participating Provider provisions and Benefits Management Program provision.

Benefits are provided, as described below, for the diagnosis and treatment of Mental Health and substance abuse conditions. All Non-Emergency Inpatient Mental Health Services and all Outpatient Partial Hospitalization Services must be prior authorized by the MHSA.

The Copayments and Coinsurance for covered Mental Health and substance abuse Services, if applicable, are shown in the Summary of Benefits.

Note: For all Inpatient Hospital care except for Emergency Services, failure to contact eh MHSA prior to obtaining Services will result in the Insured being responsible for and additional payment as outlined in the "Hospital and Skilled Nursing Facility Admissions" paragraphs of the Benefits Management Program section. For Outpatient psychiatric Partial Hospitalization and Outpatient ECT Services, failure to contact Blue Shield or the MHSA as described above or to follow the recommendations of Blue Shield will result in non-payment of Services by Blue Shield.

1. Inpatient Mental Health Services

Benefits are provided for psychiatric Inpatient Services in connection with hospitalization for the treatment of mental illness (including treatment of Severe Mental Illnesses of an Insured of any age and of Serious Emotional Disturbances of a Child). Residential care is not covered.

Note: See Hospital Benefits, Inpatient Services for Treatment of Illness or Injury for information on Medically Necessary Inpatient substance abuse detoxification.

2. Outpatient Facility and Office Care

Benefits are provided for Outpatient facility and office care for Severe Mental Illnesses or Serious Emotional Disturbances of a Child and for other than Severe Mental Illnesses of Serious Emotional Disturbances of a Child are for substance abuse care.

Outpatient or office Mental Health Services and substance abuse care for other than Severe Mental Illnesses or Serious Emotional Disturbances of a Child are limited to a combined per Insured per Calendar Year visit maximum as shown in the Summary of Benefits. Note: this does not apply to Outpatient Partial Hospitalization Services.

The initial Mental Health Services of substance abuse care visit to determine the condition and diagnosis of the Insured will be paid as if the condition was a Severe Mental Illness or a Serious Emotional Disturbance of a Child.

If the outcome of the initial visit determines that the condition is other than a Severe Mental Illness or a Serious Emotional Disturbance of a Child, the visit will count towards the Calendar Year maximum.

No benefits are provided for Outpatient or office care from MHSA Non-Participating Providers for Mental Health Services for other than Severe Mental Illnesses or Serious Emotional Disturbances of a Child or for treatment of substance abuse, except for the initial visit. Note: this does not apply to Outpatient Partial Hospitalization Services.

3. Outpatient Hospital Partial Hospitalization and Outpatient ECT Services

Benefits are provided for Hospital and professional Services in connection with psychiatric Partial Hospitalization and ECT for the treatment of mental illness (including treatment of Severe Mental Illness of a Member of any age and of Serious Emotional Disturbances of a Child.

4. Psychological testing

Psychological testing is a covered Benefit when provided to diagnose a mental illness.

No benefits are provided for:

1. telephone psychiatric consultations;
2. testing for intelligence or learning disabilities

5. Psychosocial Support

Notwithstanding the Benefits provided elsewhere in this section, the Insured may also call 1-866-543-3728 or an unlimited, 24 hour basis for confidential psychosocial support Services available through LifeReferrals 24/7. Professional counselors will provide support through assessment, referrals, and counseling.

In California, support may include, as appropriate, a referral to a counselor for a maximum of three no charge, face-o-face visits per episode of major life events. An episode shall mean a single event, or multiple events which occur within a six month period and are determined by a counselor to be related. Major life events include work related problems, marital and relationship issues, family problems, emotional and personal issues, and death and dying issues. These visits will not accrue to the Benefit maximums that are applicable to Mental Health and Substance Abuse Services.

In the event that the Services required of an Insured are most appropriately provided by a psychiatrist or the condition is not likely to be resolved in a brief treatment regimen, the Insured will be referred to the MHSA intake line to access their Mental Health and Substance Abuse Services which are described elsewhere in this section.

Outpatient or Out-of-Hospital X-Ray, Pathology, and/or Laboratory Services

Benefits are provided for diagnostic X-Ray Services, diagnostic examinations, clinical pathology, and laboratory Services, when provided to diagnose illness or injury. Certain routine laboratory Services when performed as part of a preventive health screening are covered under the Preventive Care Benefits section.

Benefits are also provided for genetic testing for certain conditions when the Insured has risk factors such as family history or specific symptoms. The testing must be expected to lead to increased or altered monitoring for early detection of disease, a treatment plan or other therapeutic intervention, and determined to be Medically Necessary and appropriate in accordance with Blue Shield Life medical policy.

See the section on Radiological Procedures Requiring Prior Authorization and Benefit Management Program section for information on procedures that require prior authorization by the Plan.

Outpatient Prescription Generic Drugs

This plan's prescription drug coverage provides less coverage on average than the standard benefit set by the federal government for Medicare Part D (also called creditable coverage). It is important to know that generally you may only enroll in a Part D plan from November 15th. through December 31st. of each year, and if you do not enroll when first eligible you may be subject to payment of higher Part D premiums when you enroll at a later date. For more information about drug coverage, call Customer Service at 1-888-852-5345, Monday through Thursday, 8:00 a.m. to 5:00 p.m., or Friday 9:00 a.m. to 5:00 p.m. The TTY telephone number is 1-866-346-7197.

This benefit includes access to Blue Shield's Participating Pharmacy Network. By presenting your Blue Shield Identification Card to a Participating Pharmacy you will pay Blue Shield's contracted rate for covered medication. This will significantly reduce your out of pocket costs for covered medications. Please see the section entitled "Obtaining Outpatient Prescription Drugs at a Participating Pharmacy" for more details.

The following prescription drug benefit is separate from the Blue Shield Life Vital Shield 2900 coverage.

The Calendar year Maximum Copayment and Coinsurance does not apply to the Outpatient Prescription Generic Drug

benefit; however, the general provisions and exclusions of the Blue Shield Life Vital Shield 2900 shall apply.

Note: Except for covered emergencies and Drugs for emergency contraception, no benefits are provided for drugs received from Non-Participating Pharmacies.

There are no benefits for Brand Name Drugs under the Outpatient Prescription Generic Drug benefit.

1. Outpatient Prescription Generic Drug Benefit
   Subject to the terms and conditions of this Section, benefits are provided for Outpatient prescription Generic Drugs, which are prescribed by a licensed Physician and are obtained from a Participating Pharmacy. Benefits are provided for Formulary Drugs, which are Generic Drugs listed on Blue Shield's Prescription Drug Formulary. Blue Shield's Pharmacy and Therapeutics Committee update this Formulary on a periodic basis. Selected Generic Drugs and Generic Drug dosages and most Generic Home Self-Administered Injectables require prior authorization by Blue Shield for Medical Necessity, appropriateness of therapy or when effective, lower cost alternatives are available (The more costly alternative will be authorized when Medically Necessary). Your Physician may request prior authorization from Blue Shield. Coverage for selected Generic Drugs may be limited to a specific quantity as described in the section entitled LIMITATION ON QUANTITY OF GENERIC DRUGS THAT MAY BE OBTAINED PER PRESCRIPTION OR REFILL.

2. Outpatient Drug Formulary
   Medications are selected for inclusion in Blue Shield's Outpatient Drug Formulary based on safety, efficacy, FDA bioequivalency data and then cost. New drugs and clinical data are reviewed regularly to update the Formulary. However, only Generic Drugs listed on the Blue Shield Life Formulary are covered under this Outpatient Prescription Generic Drug benefit. Blue Shield's Pharmacy and Therapeutics Committee during scheduled meetings four times a year reviews drugs considered for inclusion or exclusion from the Formulary.

   Insureds may call Blue Shield's Customer Service Department at the number listed on their Blue Shield Life Identification Card to inquire if a specific Generic Drug is included in the Formulary. The Customer Service Department can also provide Insureds with a printed copy of the Formulary. Insureds may also access the Formulary through the Blue Shield Life web site at http://www.blueshieldca.com.

3. Definitions
   Brand Name Drugs — FDA approved Drugs under patent to the original manufacturer and only available under the original manufacturer's branded name. Note: Brand Name Drugs are not covered under the Blue Shield Life Vital Shield 2900.

   Drugs — (1) Drugs which are approved by the Food and Drug Administration (FDA), requiring a prescription either by Federal or California law, (2) Insulin and disposable Insulin needles and syringes; (3) pen delivery systems for the administration of Insulin as determined by Blue Shield to be Medically Necessary; (4) diabetic testing supplies (including lancets, lancet puncture devices, and blood and urine testing strips and test tablets); (5) oral contraceptives and diaphragms; (6) inhalers and inhaler spacers for the management and treatment of asthma.; and (7) smoking cessation Drugs which require a prescription. Coverage for such Drugs is limited to a single 12-week course of treatment per lifetime of the Insured. Note: The Blue Shield Life Vital Shield 2900 only provides coverage for Generic Drugs and the items listed in (2), (3), (4), and diaphragms.

   Note: No Prescription is necessary to purchase the items shown in (3) and (4) above; however, in order to be covered these items must be ordered by your Physician.

   Formulary — A comprehensive list of Drugs maintained by Blue Shield's Pharmacy and Therapeutics Committee for use under the Prescription Drug Program, which is designed to assist Physicians in prescribing Drugs that are Medically Necessary and cost effective. The Formulary is updated periodically. If not otherwise excluded, the Formulary includes all Generic Drugs.

   Generic Drugs — Drugs that (1) are approved by the Food and Drug Administration (FDA) as a therapeutic equivalent to the Brand Name Drug, (2) contain the same active ingredient as the Brand Name Drug, and (3) cost less than the Formulary Brand Name Drug equivalent.

   Home Self-Administered Injectables - Home Self-Administered Injectable medications are defined as those Drugs that are Medically Necessary; administered more often than once a month by the patient or family member; administered subcutaneously or intramuscularly; deemed safe for self-administration as determined by Blue Shield Life's Pharmacy and Therapeutics Committee; prior authorized by Blue Shield: and obtained from a Blue Shield Life Specialty Pharmacy. Intravenous (IV) medications (i.e. those medications administered directly into a vein) are not considered Home Self-Administered Injectable drugs. Home Self-

Administered Injectables are listed in the Plan's Prescription Drug Formulary. Note: Brand Name Home Self-Administered Injectables are not covered under the Blue Shield Life Vital Shield 2900.

Non-Formulary Drugs — Drugs determined by Blue Shield's Pharmacy and Therapeutics Committee as being duplicative or as having preferred Formulary Drug alternatives available. Benefits may be provided for Non-Formulary Drugs and are always subject to the Non-Formulary Copayment.

Non-Participating Pharmacy — a pharmacy that does not participate in the Blue Shield Life Pharmacy Network.

Participating Pharmacy — a pharmacy that participates in the Blue Shield Life Pharmacy Network. These Participating Pharmacies have agreed to a contracted rate for covered prescriptions for Blue Shield Life Subscribers.

To select a Participating Pharmacy, Insureds may access this information at http://www.blueshieldca.com or call the toll-free Customer Service telephone number on their Blue Shield Life Identification Card.

Specialty Pharmacy Network – select Participating Pharmacies contracted by Blue Shield Life to provide covered Home Self-Administered Injectables. These pharmacies offer 24-hour clinical services and provide prompt home delivery of Home Self-Administered Injectables.

To select a Specialty Pharmacy, the Insured may access this information at http://www.blueshieldca.com or call the toll-free Customer Services telephone number on their Blue Shield Life Identification Card.

4. Obtaining Outpatient Prescription Generic Drugs from Participating Pharmacies

   a. To obtain prescription Generic Drugs, the Insured must present his Blue Shield Life Identification Card. Note: Except for covered emergencies and Generic Drugs for emergency contraception, claims for drugs obtained without using the Blue Shield Life Identification Card will be denied.

   b. Benefits are provided for Generic Home Self-Administered Injectables only when obtained from a Blue Shield Life Specialty Pharmacy, except in the case of an emergency. In the event of an emergency, covered Generic Drug Home Self-Administered Injectables that are needed immediately may be obtained from any Participating Pharmacy, or, if necessary, from a Non-Participating Pharmacy.

   c. Formulary Generic Drugs -
   The Insured is responsible for paying the Formulary Generic Drug Copayment/Coinsurance for each new and refill Formulary Generic Drug prescription. The pharmacist will collect from the Insured the Copayment/Coinsurance at the time the Drugs are obtained. If the Plan's contracted rate for the prescription is less than the Insured's Copayment/Coinsurance amount, the Insured is responsible for payment of the contracted rate only. The Copayment/Coinsurance for Formulary Generic Drugs is shown in the Summary of Benefits.

   d. Prescription Generic drugs obtained at a non-participating pharmacy are not covered unless Medically Necessary for a covered emergency. If the Insured must obtain Generic Drugs from a non-participating pharmacy due to a covered emergency, the submission of a Prescription Drug Claim form noting "Emergency Request" on the form is required. Claim forms are provided upon request from the Blue Shield Life Service Center. Claims must be submitted to:

   Blue Shield Life
   Pharmacy Services
   P.O. Box 7168
   San Francisco, CA 94120

   Claims must be received within 1 year from the date of service to be considered for payment. Reimbursement for covered emergency claims will be made for the purchase price of covered prescription Drug(s) less any applicable Copayments(s)/Coinsurance.

   When the Plan receives Notice of Claim, the Plan will send you an Insured's Statement of Claim form for filing proof of a claim. For consideration of a claim due to a covered emergency, you must note "Emergency Request" on the Insured's Statement of Claim form and it should be submitted to:

   Blue Shield Life
   Pharmacy Services
   P.O. Box 7168
   San Francisco, CA 94120

The Plan must receive written proof of claim within 90 days after the date of service for which claim is being made. Send a copy of your itemized bill or pharmacy statement along with your completed Insured's Statement of Claim form.

A claim will not be reduced or denied for failure to provide proof within this time if it is shown that it was not reasonably possible to furnish proof, and that proof was provided as soon as it was reasonably possible. However, no claim will be paid if proof is received more than one (1) year after the date of loss, unless the Insured was legally unable to notify the Plan. Reimbursement for covered emergency claims will be made for the purchase price of covered prescription Drug(s) less any applicable Copayments(s) and Coinsurance.

e. The Insured is responsible for paying Copayment/Coinsurance as shown in the Summary of Benefits for Generic Home Self-Administered Injectables, including any combination kit or package containing both oral and Home Self-Administered Injectable Drugs.

5. Obtaining Outpatient Prescription Drugs through the Mail Service Prescription Drug Program

a. For the Insured's convenience, when Generic Drugs have been prescribed for a chronic condition and the Insured's medication dosage has been stabilized, he may obtain the Generic Drugs through Mail Service Prescription Generic Drug Program. The Insured should submit the applicable mail service Copayment/Coinsurance as indicated in the Summary of Benefits, an order form, and his Blue Shield Life Identification number to the address indicated on the Mail Service envelope. Insureds should allow 14 days to receive the Generic Drugs. The Insured's Physician must indicate a prescription quantity, which is equal to the amount to be dispensed. Generic Home Self-Administered Injectables, except for Insulin, are not covered through the Mail Service Prescription Generic Drug Program.

b. Mail Service Generic Drugs –
The Insured is responsible for the Mail Service Formulary Generic Drug Copayment for each covered prescription. If the Plan's contracted rate for the prescription is less than the Insured's Copayment/Coinsurance amount, the Insured is responsible for payment of the contracted rate only. To obtain the Participating Pharmacy contracted rate, please contact the mail service pharmacy at 1-866-346-7200. The Copayment/Coinsurance for Mail Service Drugs is shown in the Summary of Benefits.

c. If the Insured, or Physician (regardless of any "Dispense as Written" instructions) requests a Formulary Brand Name Drug when a Formulary Generic Drug is available and the Brand Name Drug Deductible has been satisfied, the Insured is responsible for paying the difference between the cost to Blue Shield of the Formulary Brand Name Drug and its Formulary Generic Drug equivalent, as well as the applicable Mail Service Formulary Generic Name Drug Copayment.

6. Limitation on Quantity of Generic Drugs That May Be Obtained Per Prescription or Refill

a. Outpatient Prescription Generic Drugs are limited to a quantity not to exceed a 30-day supply. Some prescriptions are limited to a maximum allowable quantity based on Medical Necessity and appropriateness of therapy as determined by Blue Shield Life's Pharmacy and Therapeutics Committee.

b. Mail Service Prescription Generic Drugs are limited to a quantity not to exceed a 60 day supply. If the Insured's Physician indicates a prescription quantity of less than a 60-day supply that amount will be dispensed and refill authorizations cannot be combined to reach a 60 day supply.

c. Prescriptions may be refilled at a frequency that is considered to be Medically Necessary.

7. Exclusions for Outpatient Prescription Generic Drug Benefit

a. No benefits are provided under the Outpatient Prescription Generic Drug Benefit for the following (please note, certain Services excluded below may be covered under other benefits/portions of your Policy - you should refer to the applicable section to determine if Drugs are covered under that Benefit):

b. Any Drugs provided or administered while the Insured is an Inpatient, or in a Physician's office (see the Professional (Physician) Benefit and Hospital Benefits sections of your Policy);

c. Take home Drugs received from a Hospital, convalescent home, Skilled Nursing Facility, or similar facility (see the Hospital Benefits and skilled Nursing Facilities Benefits sections of your Policy);

d. Drugs, (except as specifically listed as covered under this Outpatient Prescription Generic Drug section), which can be obtained without a prescription or for which there is a non-prescription Drug that is an identical chemical equivalent (i.e. same active ingredient and dosage) to a prescription Drug;

e. Drugs for which the Insured is not legally obligated to pay, or for which no charge is made;

f. Drugs that are considered to be experimental or investigational;

g. Medical devices or supplies except as specifically listed as covered herein; see the section entitled PROSTHETIC APPLIANCE AND DURABLE MEDICAL EQUIPMENT for complete information;

h. Blood or blood products (see the Hospital Benefits section of your Policy);

i. Drugs when prescribed for cosmetic purposes, including but not limited to Drugs used to retard or reverse the effects of skin aging or to treat hair loss;

j. Dietary or Nutritional Products see the PKU Related Formulas and Special Food Products section of your Policy;

k. Injectable Drugs which are not self-administered, and all injectable Drugs for the treatment of infertility. Other Injectable Medications may be covered under the Home Health Care Benefits, Family Planning Service, Hospice Program Services, and Home Infusion/Home Injectables Therapy Benefits sections of the Plan. No benefits are provided for Brand Name Home Self-Administered Injectables;

l. Appetite suppressants, or Drugs for weight reduction except when Medically Necessary for the treatment of morbid obesity. In such cases the Drug will be subject to prior authorization from Blue Shield Life;

m. Contraceptive devices (except diaphragms), injections and implants;

n. Compounded medications if: (1) there is a Formulary alternative, or, (2) there are no FDA-approved indications. Compounded medications that do not include at least one (1) Drug, as defined, are not covered;

o. Replacement of lost, stolen, or destroyed Prescription Drugs;

p. Drugs obtained from a Non-Participating Pharmacy, except Generic Drugs for Emergency coverage;

q. Drugs prescribed for treatment of dental conditions. This exclusion shall not apply to antibiotics prescribed to treat infection nor to medications prescribed to treat pain;

r. Pharmaceuticals that are reasonable and necessary for the palliation and management of Terminal Illness and related conditions if they are provided to an Insured enrolled in a Hospice Program through a Participating Hospice Agency;

s. Brand Name Drugs except for Insulin and disposable Insulin needles and syringes,

pen delivery systems for the administration of Insulin as determined by Blue Shield Life to be Medically Necessary diabetic testing supplies (including lancets, lancet puncture devices, and blood and urine testing strips and test tablets); and diaphragms; or

t. Immunizations and vaccinations by any mode of administration (oral, injection, or otherwise) solely for the purpose of travel.

PKU Related Formulas and Special Food Products

Benefits are provided for enteral formulas and Special Food Products that are Medically Necessary to avert the development of serious physical or mental disabilities or to promote normal development or function as a consequence of phenylketonuria (PKU). All benefits must be prior authorized by the Plan and must be prescribed and/or ordered by the appropriate health care professional.

Podiatric Services

Podiatric Services include office visits and other covered Services customarily provided by a licensed doctor of podiatric medicine. Covered surgical procedures provided in conjunction with this Benefit, are described under the Professional (Physician) Benefits section. Covered lab, pathology, and X-Ray Services provided in conjunction with this Benefit, are described under the Outpatient or Out-of-Hospital X-Ray, Pathology, and Laboratory Benefits section.

Preventive Care Services

Preventive Care Services are those primary preventive medical Services provided by a Physician for the early detection of disease when no symptoms are present and for those items specifically listed below.

Note: No benefits for Preventive Care Services are provided from Non-Preferred Providers.

1. Annual Physical Examination:
   For the Subscriber age three (3) and over, benefits are provided for one (1) health appraisal examination in each Calendar Year.

   Benefits for the Annual Physical Examination include only the following Services:

   a. Annual routine physical examination office visit;

   b. Urinalysis;

   c. Eye and ear screenings, provided by a family practitioner or general practitioner, for Subscribers through age 16 to determine the need for referral to a specialist for eye refraction or audiogram. No benefits are provided for routine examinations by Optometrists or Audiologists, or for routine eye refraction.; and

   d. Pediatric and adult immunizations and the immunizing agent, as recommended by the American Academy of Pediatrics and the United States Public Health Service through its U.S. Preventive Services Task Force and/or the Advisory Committee on Immunization Practices (ACIP) of the Centers for Disease Control and Prevention (CDC) except for immunizations and vaccinations by any mode of administration (oral, injection, or otherwise) solely for the purpose of travel.

   If the Insured's Physician provides or orders any covered Outpatient or out-of-Hospital X-Ray, laboratory, or pathology Services beyond those listed in this Annual Physical Examination benefit, the Insured will be responsible for additional Copayment(s) and/or Coinsurance as provided for in the section entitled OUTPATIENT OR OUT-OF-HOSPITAL X-RAY, PATHOLOGY, AND/OR LABORATORY SERVICES in the SUMMARY OF BENEFITS.

2. Annual Gynecological Examination:
   Benefits for the annual gynecological exam include only the following Services:

   a. Annual gynecological examination office visit:

   b. Mammography, and

   c. Routine Papanicolaou (Pap) test of other Food and Drug Administration (FDA) approved cervical cancer and human papillomavirus virus (HPV) screening tests.

   If the Insured's Physician provides or orders any covered Outpatient or out-of-Hospital X-Ray, pathology, or laboratory Services beyond those listed in this Annual Gynecological Examination benefit, the Insured will be responsible for additional Copayment(s) and/or Coinsurance as provided for in section entitled OUTPATIENT OR OUT-OF-HOSPITAL X-RAY, PATHOLOGY, AND/OR LABORATORY SERVICES in the SUMMARY OF BENEFITS.

3. Colorectal Cancer Screening:
   For Subscribers age 50 and older, benefits are provided for the following Colorectal Cancer Screening Services:

a. Annual fecal occult blood test (FOBT) for Subscribers who are aged 50 and older;

b. Flexible sigmoidoscopy every five (5) years;

c. Double contrast barium enema every five (5) to ten (10) years; and

d. Colonoscopy every ten (10) years as determined by the Insured's Physician.

If the Insured's Physician provides or orders any covered Outpatient or out-of-Hospital X-Ray, pathology, or laboratory Services beyond those listed in the Colorectal Cancer Screening benefit, the Insured will be responsible for additional Coinsurance as provided for in the section entitled OUTPATIENT OR OUT-OF-HOSPITAL X-RAY, PATHOLOGY, AND/OR LABORATORY SERVICES in the SUMMARY OF BENEFITS.

4. Osteoporosis Screening:
Benefits are provided for osteoporosis screening for Subscribers age 65 and older, or age 60 and older if the Insured is at increased risk.

5. Well-Baby Examination:
Benefits are provided when a Physician provides routine pediatric care to a Subscriber less than three (3) years of age.

Well-baby examination benefits include only the following Services:

a. Well baby examination office visits;

b. Tuberculin test; and

c. Pediatric immunizations and the immunizing agent, as recommended by the American Academy of Pediatrics and the United States Public Health Service through its U.S. Preventive Services Task Force and/or the Advisory Committee on Immunization Practices (ACIP) of the Centers for Disease Control and Prevention (CDC).

If the Insured's Physician provides or orders any covered Outpatient or out-of-Hospital X-Ray, pathology, or laboratory Services beyond those listed in this Well-Baby Examination, the Insured will be responsible for additional Copayment(s) and/or Coinsurance as provided for in the section entitled OUTPATIENT OR OUT-OF-HOSPITAL X-RAY, PATHOLOGY, AND/OR LABORATORY SERVICES in the SUMMARY OF BENEFITS.

6. Nurse Support:
As part of NurseHelp 24/7, Insureds may call a registered nurse via 1-866-543-3728, a 24-hour, toll-free telephone number to receive confidential advice and information about minor illnesses and injuries, chronic conditions, fitness, nutrition, and other health related topics.

Professional (Physician) Benefits
Other than Preventive Care, Mental Health and substance abuse care, Hospice Program Services, Dialysis Benefits, and Bariatric Surgery which are described in other sections.

Professional Services by providers other than Physicians are described elsewhere under Covered Services.

Covered lab, pathology, and X-Ray Services provided in conjunction with these Professional Services listed below, are described under the Outpatient or Out-of-Hospital X-Ray, Pathology, and Laboratory Benefits section.
Note: A Preferred Physician may offer extended hour and urgent care Services on a walk-in basis in a non-hospital setting such as the Physician's office or an urgent care center. Services received from a Preferred Physician at an extended hours facility will be reimbursed as Physician Office Visits. A list of urgent care providers may be found in the Blue Shield Life Preferred Provider Directory. This information may also be viewed by accessing the Plan's Internet site located at http://www.blueshieldca.com.

Benefits are provided for Services of Physicians for treatment of illness or injury, and for treatment of physical complications of a mastectomy, including lymphedemas, as indicated below.

1. Visits to the office, beginning with the first visit;

2. Services or consultants, including those for second medical opinion consultations;

3. Mammography and Papanicolaou test or other FDA (Food and Drug Administration) approved cervical cancer screening tests;

4. Asthma self-management training and education to enable an Insured to properly use asthma-related medication and equipment such as inhalers, spacers, nebulizers, and peak flow monitors;

5. Visits to the home, Hospital, Skilled Nursing Facility, and Emergency Room;

6. Routine newborn care in the Hospital including physical examination of the baby and counseling with the mother concerning the baby during the Hospital stay;

7. Surgical procedures. When multiple surgical procedures are performed during the same operation, Benefits for the secondary procedure(s) will be determined based on the Plan's Medical Policy. No benefits are provided for secondary procedures which are incidental to, or an integral part of, the primary procedure;

8. Reconstructive Surgery and associated covered Services when determined by the Plan to be Medically Necessary and only to correct or repair abnormal structures of the body and which result in more than a minimal improvement in function or appearance. In accordance with the Women's Health & Cancer Rights Act, Reconstructive Surgery on either breast and surgically and non-surgically implanted prosthetic devices (including prosthetic bras) provided to restore and achieve symmetry incident to a mastectomy are covered. Any such Services must be received while the Policy is in force with respect to the Insured. Benefits will be provided in accordance with the guidelines established by the Plan and developed in conjunction with plastic and reconstructive surgeons.

   No benefits will be provided for the following surgeries or procedures unless determined by the Plan to be Medically Necessary to correct or repair abnormal structures of the body caused by congenital defects, developmental abnormalities, trauma, infection, tumors, or disease, and which will result in more than minimal improvement in function or appearance:

   - Surgery to excise, enlarge, reduce, or change the appearance of any part of the body;
   - Surgery to reform or reshape skin or bone;
   - Surgery to excise or reduce skin or connective tissue that is loose, wrinkled, sagging, or excessive on any part of the body;
   - Hair transplantation; and
   - Upper eyelid blepharoplasty without documented significant visual impairment or symptomatology.

   This limitation shall not apply when breast reconstruction is performed subsequent to a Medically Necessary mastectomy, including surgery on either breast to achieve or restore symmetry

9. Chemotherapy for cancer, including catheterization, and associated drugs and supplies;

10. Extra time spent with a Physician is detained to treat an Insured in critical condition;

11. Necessary preoperative treatment;

12. Treatment of burns; and

13. Medically Necessary consultations with Internet Ready Preferred Physicians via Blue Shield Life approved Internet portal. Internet based consultations are available to Insured only through Preferred Physicians who have agreed to provide Internet based consultations via the Blue Shield Life approved Internet portal ("Internet Ready"). Internet based consultations for Psychiatric Care or substance abuse care are not covered. Insured must be current patients of the Preferred Physician. Refer to the Online Physician Directory to determine whether a Preferred Physician is Internet Ready and how to initial an Internet based consultation. This information may be accessed at http://www.blueshieldca.com.

    Internet based consultations are not available to Insureds accessing care outside of California.

14. Benefits are provided for Services required to treat involuntary Complications of Pregnancy on the Insured's Effective Date of coverage. Complications of Pregnancy include, but are not limited to, Medically Necessary Cesarean Section, miscarriage, toxemia of pregnancy (preeclampsia and eclampsia), hyperemesis gravidarum, ectopic (tubal or extra-uterine) pregnancy, nephritis or pyelitis of pregnancy, placenta abruptio or puerperal infection.

    Emergency Services and Complications of Pregnancy are paid just as any other illness.

    No benefits are provided for services subsequent to termination of coverage under this Policy.

15. Outpatient routine newborn circumcisions. *
    * For the purposes of this Benefit, routine newborn circumcisions are circumcisions performed within 31 days of birth unrelated to illness or injury. Routine circumcisions after this time period are covered for sick babies when authorized by the Plan.

Prosthetic Appliances

Medically Necessary Prostheses for surgically implanted and other prosthetic devices (including prosthetic bras) provided to restore and achieve symmetry incident to a mastectomy, are covered. See Reconstructive Surgery under Professional (Physician) Benefits.

Additionally, Blom-Singer and artificial larynx prostheses for speech therapy following a laryngectomy are covered as a surgical professional benefit.

Benefits are provided at the most cost effective level of care that is consistent with professionally recognized standards of practice. If there are two (2) or more professionally recognized appliances equally appropriate for a condition, Benefits will be based on the most cost-effective appliance.

Benefits for any other Prosthetic Appliances are specifically excluded. See the section entitled GENERAL EXCLUSIONS for additional information.

Radiological Procedures Requiring Prior Authorization

The following radiological procedures, when performed on an Outpatient, non-emergency basis, require prior authorization by the Plan under the Benefits Management Program. Failure to obtain this authorization will result in the Service being paid at a reduced amount or may result in non-payment for procedures that are determined not to be a Covered Service.

1. CT (Computerized Tomography) scans;
2. MRIs (Magnetic Resonance Imaging);
3. MRAs (Magnetic Resonance Angiography);
4. PET (Positron Emission Tomography) scans; and/or
5. Any cardiac diagnostic procedure utilizing Nuclear Medicine.

Skilled Nursing Facilities

(Other than Hospice Program Services which are described elsewhere under Covered Services.) Benefits are provided for Medically Necessary Services Provided by a Skilled Nursing Facility Unit of a Hospital or by a free-standing Skilled Nursing Facility.

Benefits are provided for confinement in a Skilled Nursing Facility Skilled Nursing Facility Unit of a Hospital up to the Benefit maximum as shown in the Summary of Benefits. The Benefit maximum is per Insured per Calendar Year, except that room and board charges in excess of the facility's established semi-private room rate are excluded.

Benefits are limited to a per Insured, per Calendar Year maximum as shown in the Summary of Benefits.

Transplant Benefits

Organ Transplants

Benefits are provided for Hospital and professional Services provided in connection with human organ transplants, only to the extent that:

1. They are provided in connection with the transplant of a cornea, kidney, or skin; and
2. The recipient of such transplant is a Subscriber.

Benefits are provided for Services incident to obtaining the human organ transplant material from a living donor or an organ transplant "bank" and will be charged against the maximum aggregate payment amount.

Special Transplant Benefits

Benefits are provided for certain procedures, listed below, only if (1) performed at a Special Transplant Facility contracting as a Blue Shield Life Provider to provide the procedure or in the case of Insureds accessing this Benefit outside of California, the procedure is performed at a transplant facility designated by Blue Shield Life, (2) prior authorization is obtained, in writing, from the Plan's Medical Director, and (3) the recipient of the transplant is a Subscriber.

The Plan reserves the right to review all requests for prior authorization of these Special Transplant Benefits, and to make a decision regarding benefits based on (1.) the medical circumstances of each Insured, and (2.) consistency between the treatment proposed and the Plan's medical policy.

Failure to obtain prior written authorization as described above and/or failure to have the procedure performed at a contracting Special Transplant Facility will result in denial of claims for this benefit.

Benefits are provided for Services incident to obtaining the transplant material from a living donor or an organ transplant bank. Benefits will be charged against the maximum aggregate payment amount.

The following procedures are eligible for coverage under this provision:

1. Human heart transplants;
2. Human lung transplants;
3. Human heart and lung transplants in combination;

4. Human liver transplants;

5. Human kidney and pancreas transplants in combination;

6. Human bone marrow transplants; including, autologous bone marrow transplantation (ABMT) or autologous peripheral stem cell transplantation used to support high-dose chemotherapy when such treatment is Medically Necessary and is not Experimental or Investigational;

7. Pediatric human small bowel transplants; and

8. Pediatric and adult human small bowel and liver transplants in combination.

Benefits are provided for Services incident to obtaining the human organ transplant material from a living donor or an organ transplant "bank" and will be charged against the maximum aggregate payment amount.

Principal Limitations, Exceptions, Exclusions, and Reductions

General Exclusions

Unless exceptions to the following exclusions are specifically made elsewhere in this Policy, no benefits are provided for Services:

1. For or incident to Services and supplies for treatment of the teeth and gums (except for tumors) and associated periodontal structures, including, but not limited to, diagnostic, preventive, orthodontic, and other Services such as dental cleaning, tooth whitening, X-Rays, topical fluoride treatment except when used with radiation therapy to the oral cavity, fillings, and root canal treatment; treatment of periodontal disease or periodontal surgery for inflammatory conditions; tooth extractions; dental implants; braces, crowns, dental orthoses and prostheses; except as specifically provided under Medical Treatment of Teeth, Gums, Jaw Joints or Jaw Bones Benefits and Hospital Benefits;

2. For or incident to Services rendered in the home or hospitalization or confinement in a health facility primarily to treat or cure chronic pain, except those benefits which would have been provided had the individual been treated on an Outpatient basis. For example, charges for room and board during such hospitalization are not a benefit except as Medically Necessary;

3. For Rehabilitation except as specifically provided under Hospital Benefits, or Home Health Care Benefits;

4. For or incident to services rendered in the home or hospitalization or confinement in a health facility primarily for rest, Custodial, Maintenance, Domiciliary Care, or Residential Care except as provided under Hospice Program Services (see Hospice Program Services benefit for exception);

5. Performed in a Hospital by Hospital officers, residents, interns and others in training;

6. For routine eye refraction, surgery to correct refractive error (such as but not limited to radial keratotomy / refractive keratoplasty), lenses and frames for eye glasses, contact lenses (except as provided in the Prosthetic Appliances section), and video-assisted visual aids or video magnification equipment for any purpose;

7. For eyeglasses, and contact lenses, or hearing aids;

8. For or incident to Speech Therapy, speech correction, or speech pathology, or speech abnormalities that are not likely the result of a diagnosed, identifiable medical condition, injury, or illness except as specifically listed under Home Health Care Benefits;

9. For or incident to vocational, educational, recreational, art, dance, reading or music therapy; weight control programs; or exercise programs;

10. For transgender or gender dysphoria conditions, including but not limited to intersex surgery (transsexual operations) or any related

services or any resulting medical complications, except for treatment of medical complications that are Medically Necessary;

11. For callus, corn paring or excision, toenail trimming and except as may be provided through a Participating Hospice Agency; treatment (other than surgery) of chronic conditions of the foot, e.g., weak or fallen arches; flat or pronated foot; pain or cramp of the foot; for special footwear required for foot disfigurement (e.g., non-custom made or over-the-counter shoe inserts or arch supports), except as specifically listed as covered herein; bunions; muscle trauma due to exertion; or any type of massage procedure on the foot;

12. Which are Experimental or Investigational in Nature, except for Services for Insureds who have been accepted into an approved clinical trial for cancer as provided under Covered Services;

13. For learning disabilities or behavioral problems;

14. For or incident to hospitalization primarily for radiological, laboratory, or any other diagnostic studies or medical observation;

15. For convenience items such as telephones, TVs, guest trays, and personal hygiene items;

16. For Cosmetic Surgery or any resulting complications; except that Medically Necessary Services to treat complications of Cosmetic Surgery (e.g. infections or hemorrhages) will be a benefit but only upon review and approval by a Plan Physician consultant. Without limiting the foregoing, no benefits will be provided for the following surgeries or procedures:
    - Lower eyelid blepharoplasty;
    - Spider veins;
    - Procedures to smooth the skin (i.e., chemical face peels, laser resurfacing, and abrasive procedures);
    - Hair removal by electrolysis or other means; and
    - Reimplantation of breast implants originally provided for cosmetic augmentation;

17. Incident to an organ transplant, except as specifically listed;

18. For or incident to the treatment of Infertility, including the cause of Infertility, or any form of assisted reproductive technology, including but not limited to reversal of surgical sterilization, or any resulting complications, except for Medically Necessary treatment of medical complications;

19. For any services related to assisted reproductive technology, including but not limited to the harvesting or stimulation of the human ovum, in vitro fertilization, Gamete Intrafallopian Transfer (G. I. F. T.) procedure, artificial insemination (including related medications, laboratory, and radiology services), services or medications to treat low sperm count, or services incident o or resulting from procedures for a surrogate mother who is otherwise not eligible for covered Pregnancy and Maternity Care under a Blue Shield Life Plan;

20. For Papanicolaou (Pap) Tests or other FDA (Food and Drug Administration) approved cervical cancer screening tests, mammography and colorectal cancer screenings, except as specifically listed;

21. For routine health appraisals, well-baby care, vision and hearing tests, physical examinations and immunizations, except as specifically listed under Preventive Care; for immunizations and vaccinations by any mode of administration (oral, injection, or otherwise) solely for the purpose of travel; or for physical examinations required for licensure, employment, or insurance unless the examination is substituted for the Annual Physical Examination;

22. For or incident to sexual dysfunction, sexual inadequacies; except as provided for treatment of organically based conditions;

23. For or incident to family planning, except as specifically listed;

24. For dental care or services incident to the treatment, prevention or relief of pain, or dysfunction of the temporomandibular Joint and/or muscles of mastication except as specifically provided under the sections entitled MEDICAL TREATMENT OF TEETH, GUMS, JAW JOINTS, OR JAW BONES and HOSPITAL BENEFIT;

25. Performed by a Close Relative or by a person who ordinarily resides in the Subscriber's home;

26. Incident to any injury or disease arising out of, or in the course of, any employment for salary, wage or profit if such injury or disease is covered by any workers' compensation law, occupational disease law or similar legislation. However, if the Plan provides payment for such Services, it shall be entitled to establish a lien upon such other benefits up to the amount paid by the Plan for the treatment of such injury or disease;

27. In connection with private duty nursing, except as provided under the Home Health Care Benefits and except as provided through a Participating Hospice Agency;

28. For or incident to hospitalization or confinement in a pain management center to treat or cure chronic pain except as Medically Necessary;

29. For substance abuse treatment or rehabilitation on an inpatient, partial hospitalization or outpatient basis, except as specifically listed;

30. For Outpatient Mental Health Services, except as specifically listed;

31. For penile implant devices and surgery and any related Services, except for any resulting complications and Medically Necessary services as provided under Reconstructive Surgery Benefits;

32. For which the Insured is not legally obligated to pay or Services for which no charge is made to the Insured;

33. For or incident to out-of-country services; for medical equipment, drugs and other substances obtained outside the United States except as provided for covered emergency or urgent care;

34. For Reconstructive Surgery and procedures in situations: 1) where there is another more appropriate surgical procedure that is approved by a Plan Physician consultant, or 2) when the surgery or procedure offers only a minimal improvement in function or in the appearance of the enrollees, e.g., spider veins, or 3) as limited in the Reconstructive Surgery Benefit section.;

35. For prescription and non-prescription food and nutritional supplements, except as provided under the Home Infusion/Home Injectable Therapy Benefits and except as provided through a Participating Hospice Agency;

36. For drugs and medicines which cannot be lawfully marketed without approval of the U.S. Food and Drug Administration (the FDA); however, drugs and medicines which have received FDA approval for marketing for one or more uses will not be denied on the basis that they are being prescribed for an off-label use if the conditions set forth in California Insurance Code, Section 10123.195 have been met;

37. For home testing devices and monitoring equipment except for use of the glucose monitor for self-management of diabetes;

38. For contraceptives and contraceptive devices, except as specifically included in the sections entitled FAMILY PLANNING SERVICES and OUTPATIENT PRESCRIPTION GENERIC DRUG; oral contraceptives and diaphragms are excluded, except as may be provided under the Outpatient Prescription Generic Benefit; no benefits are provided for contraceptive implants;

39. For genetic testing except as described in the section entitled OUTPATIENT OR OUT-OF-HOSPITAL X-RAY, PATHOLOGY, AND/OR LABORATORY SERVICES;

40. For any type of communicator, voice enhancer, voice prosthesis, electronic voice producing machine, or any other language assistive devices, except as specifically listed under in the section entitled PROSTHETIC APPLIANCES;

41. For non-prescription (over-the-counter) medical equipment or supplies that can be purchased without a licensed provider's prescription order, even if a licensed provider writes a prescription order for a non-prescription item, except as specifically provided under Home Health Care Benefits and Diabetes Care;

42. For or incident to Services and supplies related to pregnancy and maternity care, routine circumcisions, and prenatal diagnosis of genetic disorders of the fetus by means of diagnostic genetic testing;

43. Incident to bariatric surgery services except as specifically provided under the section entitled BARIATRIC SURGERY SERVICES;

44. For or incident to acupuncture or acupressure Services;

45. For or incident to spinal manipulations and adjustments;

46. For or incident to Durable Medical Equipment and supplies needed to operate or maintain Durable Medical Equipment;

47. For or incident to orthotic appliances and devices and supplies needed to operate or maintain orthotic appliances and devices;

48. For or incident to Prostheses and supplies needed to operate or maintain Prostheses except as provided in the section entitled PROSTHETIC APPLIANCES;

49. For or incident to professional charges for Outpatient and office visits for Mental Health other than for severe mental illnesses or serious emotional disturbances of a child;

50. For or incident to internet consultations;

51. For or incident to circumcision unless as a result of illness or injury;

52. For or incident to rehabilitative services and therapy including, but not limited to, occupational , physical, and respiratory therapies;

53. For or incident to Speech Therapy;

54. For or incident to allergy testing and/or treatment;

55. Not specifically listed as a benefit.

See the Grievance Process section for information on filing a grievance, your right to seek assistance from the State of California Department of Insurance, and your rights to external independent medical review.

Medical Necessity Exclusion

All services must be Medically Necessary. The fact that a Physician or Other Provider may prescribe, order, recommend, or approve a service does not, in itself, make it Medically Necessary, even though it is not specifically listed as an exclusion or limitation. The Plan may limit or exclude

benefits for services that are not Medically Necessary.

Pre-Existing Conditions

Pre-existing Conditions are covered only after you have been continuously covered for six (6) consecutive months, including your waiting period. Your waiting period begins on the date the Plan receives your application.

However, if you had prior Creditable Coverage and you applied for this Plan within sixty-three (63) days after termination of the prior Creditable Coverage, then the Plan will credit the time you were covered under the prior Creditable Coverage toward this Plan's Pre-existing Condition exclusion.

To receive credit for your prior Creditable Coverage, submit to Blue Shield Life a certificate from your prior employer, insurer, or health plan which shows the period of time you were covered under the prior Creditable Coverage. If you are unable to obtain the certificate, you should contact the Plan's Customer Service area for assistance.

Limitations for Duplicate Coverage

When you are eligible for Medicare

1. Your Blue Shield Life plan will provide benefits before Medicare when you become eligible for Medicare benefits prior to age 65, until the first to occur of the following:

   a. The date of your actual enrollment under Medicare, or
   b. The date that you receive notice from Blue Shield Life of your eligibility for such enrollment.

2. Your Blue Shield Life plan will provide benefits after Medicare even if you are eligible but do not enroll once you are age 65 or older. Blue Shield Life will:

   a. Estimate what Medicare would have paid for services received (based upon the reasonable value or Blue Shield Life's Allowable Amount), and
   b. Provide your Blue Shield Life plan benefits as if you were enrolled to receive benefits from Medicare.

When your Blue Shield Life plan provides benefits after Medicare, the combined benefits from Medicare and your Blue Shield Life plan will equal, but not exceed, what Blue Shield Life would have paid if you were not eligible to receive Medicare benefits (based on the lower of Blue Shield Life's Allowable Amount of the Medicare allowed amount). Your Blue Shield Life plan deductible, copayments, and/or coinsurance will be applied before plan benefits are provided.

When you are eligible for Medi-Cal

Your Blue Shield Life plan always provides benefits first.

When you are a qualified veteran

If you are a qualified veteran your Blue Shield Life plan will pay the reasonable value or Blue Shield Life's Allowable Amount for covered services provided to you at a Veteran's Administration facility for a condition that is not related to military service. If you are a qualified veteran who is not on active duty, your Blue Shield Life plan will pay the reasonable value or Blue Shield Life's Allowable Amount for covered services provided to you at a Department of Defense facility, even if provided for conditions related to military service.

When you are covered by another governmental agency

If you are also entitled to benefits under any other federal or state governmental agency, or

by any municipality, county, or other political subdivision:

1. The combined benefits from that coverage and your Blue Shield Life plan will equal, but not exceed, what Blue Shield Life would have paid if you were not eligible to receive benefits under that coverage (based on the reasonable value or Blue Shield Life's Allowable Amount).

2. Your Blue Shield Life plan deductible, co-payments, and/or coinsurance will be applied before payment of plan benefits.

Contact the Customer Service department at the telephone number shown at the end of this document if you have any questions about how Blue Shield Life coordinates your plan benefits in the above situations.

Exception for Other Coverage

Participating Providers and Preferred Providers may seek reimbursement from other third party payers for the balance of their reasonable charges for Services rendered under this Policy.

Claims Review

The Plan reserves the right to review all claims to determine if any exclusions or limitations apply, and may use the services of Physician consultants, peer review committees of professional societies or Hospitals, and other consultants.

Reductions - Acts of Third Parties

If an Insured is injured through the act or omission of another person (a "third party"), the Plan shall, with respect to services required as a result of that injury, provide the benefits of this Policy and have an equitable right to restitution or other available remedy to recover the reasonable costs of the Services provided to the Insured paid by the Plan on a fee-for-service basis. The Insured is required to:

1. Notify the Plan in writing of any actual or potential claim or legal action which such Insured anticipates bringing or has brought against the third party arising from the alleged acts or omissions causing the injury or illness, not later than 30 days after submitting or filing a claim or legal action against the third party; and

2. Agree in writing to fully cooperate with the Plan to execute any forms or documents needed to assist them in exercising their equitable right to restitution or other available remedies; and

3. Provide the Plan with a lien, in the amount of reasonable costs of benefits provided and calculated in accordance with California Civil Code section 3040. The lien may be filed with the third party, the third party's agent or attorney, or the court, unless otherwise prohibited by law.

An Insured's failure to comply with items one (1) through three (3) above, shall not in any way act as a waiver, release, or relinquishment of the rights of the Plan.

Further, if the Insured received services from a Participating Hospital for such injuries, the Hospital has the right to collect from the Insured the difference between the amount paid by Blue Shield Life and the Hospital's reasonable and necessary charges for such services when payment or reimbursement is received by the Insured for medical expenses. The Plan Hospital's right to collect shall be in accordance with California Civil Code Section 3045.1.

General Provisions

Non-Assignability

Coverage or any benefits of this Policy may not be assigned without the written consent of Blue Shield Life.

Possession of a Blue Shield Life Identification care confers no right to Services or other benefits of this Policy. To be entitled to Services, the Insured must be a Subscriber who has been enrolled by Blue Shield Life and who has maintained enrollment under the terms of this Policy.

Preferred Providers are paid directly by the Plan. The Insured or the provider of Service may not request that payment be made directly to any other party.

If the Insured receives covered Services from a Non-Preferred Provider, payment will be made directly to the Insured, and the Insured is responsible for payment to the Non-Preferred Provider. The Insured or the provider of Service may not request that the payment be made directly to the provider of Service.

Plan Interpretation

Blue Shield Life shall have the power and discretionary authority to construe and interpret the provisions of this Policy, to determine the benefits of this Policy and determine eligibility to receive benefits under this Policy. Blue Shield Life shall exercise this authority for the benefit of all Insureds entitled to receive benefits under this Policy.

Confidentiality of Personal and Health Information

Blue Shield Life protects the confidentiality/privacy of your personal and health information. Personal and health information includes both medical information and individually identifiable information, such as your name, address, telephone number, or Social Security Number. Blue Shield Life will not disclose this information without your authorization, except as permitted by law.

A STATEMENT DESCRIBING BLUE SHIELD LIFE'S POLICIES AND PROCEDURES FOR PRESERVING THE CONFIDENTIALITY OF MEDICAL RECORDS IS AVAILABLE AND WILL BE FURNISHED TO YOU UPON REQUEST.

Blue Shield Life's policies and procedures regarding our confidentiality/privacy practices are contained in the "Notice of Privacy Practices", which you may obtain either by calling the Customer Service Department at the number listed in the back of this booklet or accessing Blue Shield Life's Internet site located at http://www.blueshieldca.com and printing a copy.

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

Correspondence Address:
Blue Shield Life Privacy Official
P. O. Box 272540
Chico, CA95927-2540

Toll-Free Telephone Number:
1-888-266-8080

E-mail Address:
BlueShieldca_Privacy@blueshieldca.com

Access to Information

Blue Shield Life may need information from medical providers, from other carriers or other entities, or from you, in order to administer benefits and eligibility provisions of this Policy. You agree that any provider or entity can disclose to Blue Shield Life that information that is reasonably needed by Blue Shield Life. You agree to assist Blue Shield Life in obtaining this information, if needed, (including signing any necessary authorizations) and to cooperate by providing Blue Shield Life with information in your possession. Failure to assist Blue Shield Life in obtaining necessary information or refusal to provide information reasonably needed may result in the delay or denial of benefits until the necessary information is received. Any information received for this purpose by Blue Shield Life will be maintained as confidential and will not be disclosed without your consent, except as otherwise permitted by law.

Independent Contractors

Providers are neither agents nor employees of the Plan but are independent contractors. In no instance shall the Plan be liable for the negligence, wrongful acts, or omissions of any person receiving or providing services, including any Physician, Hospital, or Other Provider or their employees.

Entire Policy: Changes

This Policy, including the appendices, constitutes the entire agreement between parties. Any statement made by an Insured shall, in the absence of fraud, be deemed a representation and not a warranty. No change in this Policy shall be valid unless approved by a corporate officer of Blue Shield Life and a written endorsement issued. No representative has authority to change this Policy or to waive any of its provisions.

Time Limit on Certain Defenses

After an Insured has been covered under this Policy for two (2) consecutive years, Blue Shield Life will not use any misstatement, except a fraudulent misstatement, made by the applicant in an individual application to void the Policy, deny a claim, or reduce coverage.

Grace Period

After payment of the first Premium, the Policyholder is entitled to a grace period of 28 days for the payment of any Premium due. During this grace period, the Policy will remain in force. However, the Policyholder will be liable for payment of Premiums accruing during the period the Policy continues in force.

Notice and Proof of Claim

Notice and Claim Forms

In the event the provider of Services does not bill Blue Shield Life directly, you should use a Blue Shield Life Insured's Statement of Claim form in order to receive reimbursement. To receive a claim form, written notice of a claim must be given to Blue Shield Life within 20 days of the date of Service. If this is not possible, Blue Shield Life must be notified as soon as it is reasonably possible to do so.

When Blue Shield Life receives Notice of Claim, Blue Shield Life will send you an Insured's Statement of Claim form for filing proof of a claim. If Blue Shield Life fails to furnish the necessary claim forms within 15 days, you may file a claim without using a claim form by sending Blue Shield Life written proof of claim as described below.

Proof of Claim

Blue Shield Life must receive written proof of claim within 90 days after the date of service for which claim is being made from a contracted professional provider and no later than 180 days for claims from non-contracted professional providers. Send a copy of your itemized bill to the Blue Shield Life service center listed on the last page of this Policy.

A claim will not be reduced or denied for failure to provide proof within this time if it is shown that it was not reasonably possible to furnish proof, and that proof was provided as soon as it was reasonably possible. However, no claim will be paid if proof is received more than one (1) year after the date of loss, unless the Insured was legally unable to notify Blue Shield Life.

Payment of Benefits

Time and Payment of Claims

Claims will be paid promptly upon receipt of proper written proof and determination that benefits are payable.

Payment of Claims

Participating Providers and Preferred Providers are paid directly by Blue Shield Life.

If the Insured receives Services from a Non-Preferred Provider, payment will be made directly to the Subscriber, and the Insured is responsible for payment to the Non-Preferred Provider, except that Hospital charges are generally paid directly to the Hospital.

Refer to the section entitled OUTPATIENT PRESCRIPTION GENERIC DRUG for information on reimbursement of prescription drug claims.

Commencement of Legal Action

Any suit or action to recover benefits under this Plan, or damages concerning the provision of coverage or benefits, the processing of claims, or any other matter arising out of this Plan, may not be brought prior to the expiration of 60 days after written proof of claim has been furnished and must be commenced no later than three years after the date the coverage for benefits in question were first denied.

Organ and Tissue Donation

Many residents in the state of California are eligible to become organ and tissue donors. By deciding to be an organ and tissue donor, you can affect the well-being of one or more of the estimated 100,000 people in the United States of America who must face death daily while waiting for an organ transplant. One person on this list dies about every three hours – all the while waiting for an organ or tissue donation.

For more information on organ and tissue donation, or to register as a donor, visit the California Transplant Doctor Network's internet site at http://www.ctdn.org or Donate Life California's internet site at http://www.donatelifecalifornia.org. You may also call the regional organ procurement agency in the city nearest you for additional information on organ and tissue donation.

Choice of Providers

An Insured may select any Hospital or Physician to provide covered Services hereunder, including providers outside of California. Benefits differ depending on whether a Preferred Provider or a Non-Preferred Provider is selected. It is to the Insured's advantage to select Preferred Providers whenever possible. See the Definitions section for more information. A Directory of Preferred Physicians and Preferred Hospitals has been provided to the Insured. A listing of Participating Physicians and Preferred Hospitals may be viewed by accessing Blue Shield Life's Internet site located at http://www.blueshieldca.com. An extra copy is available upon request by calling the Plan at 1-888-852-5345, or writing to:

Blue Shield Life
PO Box 272610
Chico, CA 95927-2610

If the inability to perform by a Preferred Provider, the breach of the contract to furnish Services by a Preferred Provider, or the termination of a Preferred Provider's contract with Blue Shield Life may materially and adversely affect the Insured, Blue Shield Life will, within a reasonable time, advise the Insured in writing of such inability to perform, breach, or termination.

Endorsements and Appendices
Attached to and incorporated in this Policy by reference are appendices pertaining to Premiums. Endorsements may be issued from time to time subject to the notice provisions of the section entitled DURATION OF THE POLICY. Nothing contained in any endorsement shall affect this Policy, except as expressly provided in the endorsement.

Notices
Any notice required by this Policy may be delivered by United States mail, postage prepaid. Notices to the Subscriber may be mailed to the address appearing on the records of Blue Shield Life and notice to Blue Shield Life may be mailed to:

Blue Shield Life
50 Beale Street
San Francisco, CA 94105

Commencement or Termination of Coverage
Whenever this Policy provides for a date of commencement or termination of any part or all of the coverage herein, such commencement or termination shall be effective at 12:01 A.M. Pacific Time of that date.

Identification Cards
Identification cards will be issued by Blue Shield Life to all Insureds.

Legal Process
Legal process or service upon Blue Shield Life must be served upon a corporate officer of Blue Shield Life.

Notice
The Subscriber hereby expressly acknowledges its understanding that this Policy constitutes a contract solely between the Subscriber and Blue Shield Life (hereafter referred to as "the Plan"), which is an independent corporation operating under a license from the Blue Cross and Blue Shield Association ("Association"), an Association of independent Blue Cross and Blue Shield plans, permitting the Plan to use the Blue Shield Service Mark in the State of California and that the Plan is not contracting as the agent of the Association.

The Subscriber further acknowledges and agrees that it has not entered into this Policy based upon representations by any person other than the Plan and that neither the Association nor any person, entity or organization affiliated with the Association, shall be held accountable or liable to the Subscriber for any of the Plan's obligations to the Subscriber created under this Policy. This paragraph shall not create any additional obligations whatsoever on the part of the Plan, other than those obligations created under other provisions of this Policy.

Customer Service

For all Services other than Mental Health and substance abuse -
An Insured who has a question about services, providers, benefits, how to use this Plan, or concerns regarding the quality of care or access to care that you have experienced, may call the Plan's Customer Service Department at:

1-888-852-5345

The hearing impaired may contact the Plan's Customer Service Department through the Plan's toll-free TTY telephone number at:

1-800-241-1823

Customer Service can answer many questions over the telephone. Insureds may also submit questions to Customer Service by accessing Blue Shield Life's Internet site located at http://www.blueshieldca.com.

Note: Blue Shield Life has established a procedure for our Subscribers to request an expedited decision. An Insured, Physician, or representative of an Insured may request an expedited decision when the routine decision making process might seriously jeopardize the life or health of an Insured, or when the Insured is experiencing severe pain. Blue Shield Life shall make a decision and notify the Insured and Physician as soon as possible to accommodate the Insured's condition not to exceed 72 hours following the receipt of the request. An expedited decision may involve admissions, continued stay, or other healthcare services. If you would like additional information regarding the expedited decision process, or if you believe your particular situation qualifies for an expedited decision, please contact our Customer Service Department at the number noted on the last page of this Policy.

Blue Shield Life may refer inquiries or appeals to a local medical society, hospital utilization review committee, peer review committee of the California Medical Association or a medical specialty society, or other appropriate peer review committee for an opinion to assist in the resolution of these matters.

For all Mental Health and substance abuse Services -
The Plan's Mental Health Services Administrator (MHSA) should be contacted for questions about Mental Health and substance abuse Services, MHSA network Providers, or Mental Health and substance abuse benefits. You may contact the MHSA at the telephone number or address, which appear below:

1-877-214-2928

U. S. Behavioral Health Plan, California
3111 Camino Del Rio North, Suite 600
San Diego, CA 92108

The MHSA can answer many questions over the telephone.

The MHSA has established a procedure for our Insureds to request an expedited decision. An Insured, Physician, or representative of an Insured may request an expedited decision when the routine decision making process might seriously jeopardize the life or health of an Insured, or when the Insured is experiencing severe pain. The MHSA shall make a decision and notify the Insured and Physician as soon as possible to accommodate the Insured's condition not to exceed 72 hours following the receipt of the request. An expedited decision may involve admissions, continued stay, or other healthcare services. If you would like additional information regarding the expedited decision process, or if you believe your particular situation qualifies for an expedited decision, please contact the MHSA at the telephone number listed above.

Grievance Process

Blue Shield Life has established a grievance procedure for receiving, resolving and tracking Insured's grievances with Blue Shield Life.

For all Services other than Mental Health and substance abuse -

The Insured, a designated representative, or a provider on behalf of the Insured, may contact the Customer Service Department by telephone, letter, or online to request a review of an initial determination concerning a claim of Service. The Insured may contact Blue Shield Life at the telephone number as quoted in this Policy. If the telephone inquiry to Customer Service does not resolve the question or issue to the Insured's satisfaction, the Insured may request a grievance at that time, which the Customer Service Representative will initiate on the Insured's behalf.

The Insured, a designated representative, or a provider on behalf of the Insured, may also initiate a grievance by submitting a letter or completed "Grievance Form". The Insured may request this Form from Customer Service at the address as noted in this Policy. The completed Form should be submitted to:

Blue Shield Life
Customer Service Appeals and Grievance
P.O. Box 5588
El Dorado Hills, CA 95762-0011

The Insured may also submit the grievance online by visiting the web site at http://www.blueshieldca.com.

Blue Shield Life will acknowledge receipt of a grievance within five (5) calendar days. Grievances are resolved within thirty (30) days. The grievance system allows the Insured to file grievances for at least 180 days following any incident or action that is the subject of the Insured's dissatisfaction. See the previous Customer Service section for information on the expedited decision process.

For all Mental Health and substance abuse Services -

The Insured, a designated representative, or a provider on behalf of the Insured, may contact the MHSA by telephone, letter, or online to request an initial determination concerning a claim or Service. The Insured may contact the MHSA at the telephone as noted below. If the telephone inquiry to the MHSA's Customer Service Department does not resolve the question or issue to the Insured's satisfaction, the Insured may request a grievance at that time, which the Customer Service Representative will initiate on the Insured's behalf.

The Insured, a designated representative, or a provider on behalf of the Insured, may also initiate a grievance by submitting a letter or a completed "Grievance Form". The Insured may request this Form from the MHSA's Customer Service Department. If the Insured wishes, the MHSA's Customer Service staff will assist in the completing of the Grievance Form. Completed grievance forms must be mailed to the MHSA at the address provided below. The Insured may also submit the grievance to the MHSA online by visiting http://www.blueshieldca.com.

1-877-214-2928

U. S. Behavioral Health Plan, California
Attn: Customer Services
P. O. Box 880609
San Diego, CA 92168

The MHSA will acknowledge receipt of a grievance within five (5) calendar days. Grievances are resolved within thirty (30) days. The grievance system allows the Insured to file grievances for at least 180 days following any incident or action that is the subject of the Insured's dissatisfaction.

If the grievance involves an MHSA Non-Participating Provider, the Insured should contact the appropriate Blue Shield Life Customer Service Department.

For all Services -External Independent Medical Review

If your grievance involves a claim or services for which coverage was denied by Blue Shield Life or by a contracting provider in whole or in part on the grounds that the service is not Medically Necessary or is experimental/investigational (including the external review available under the Friedman-

Knowles Experimental Treatment Act of 1996), you may choose to make a request to the Department of Insurance to have the matter submitted to an independent agency for external review in accordance with California law. You normally must first submit a grievance to Blue Shield Life and wait for at least 30 days before you request external review; however, if your matter would qualify for an expedited decision as described above or involves a determination that the requested service is experimental / investigational; you may immediately request an external review following receipt of notice of denial.

You may initiate this review by completing an application for external review, a copy of which can be obtained by contacting Customer Service. The Department of Insurance will review the application and, if the request qualifies for external review, will select an external review agency and have your records submitted to a qualified specialist for an independent determination of whether the care is Medically Necessary. You may choose to submit additional records to the external review agency for review. There is no cost to you for this external review.

You and your Physician will receive copies of the opinions of the external review agency. The decision of the external review agency is binding on Blue Shield Life; if the external reviewer determines that the service is Medically Necessary, Blue Shield Life will promptly arrange for the service to be provided or the claim in dispute to be paid.

This external review process is in addition to any other procedures or remedies available to you and is completely voluntary on your part; you are not obligated to request external review. However, failure to participate in external review may cause you to give up any statutory right to pursue legal action against Blue Shield Life regarding the disputed service. For more information regarding the external review process, or to request an application form, please contact Customer Service.

California Department of Insurance Review

The California Department of Insurance is responsible for regulating health insurance. The Department's Consumer Communications Bureau has a toll-free number (1-800-927-HELP (4357) or TDD 1-800-482-4833) to receive complaints regarding health insurance from either the Insured or his or her provider.

If you have a complaint against Blue Shield of California Life & Health Insurance Company, you should contact Blue Shield Life first and use their grievance process. If you need the Department's help with a complaint or grievance that has not been satisfactorily resolved by Blue Shield Life, you may call the Department's toll-free telephone number from 8:00 a.m. to 6:00 p.m., Monday through Friday (excluding holidays). You may also submit a complaint in writing to: California Department of Insurance, Consumer Communications Bureau, 300 S. Spring Street, South Tower, Los Angeles, California 90013 or through the website http://interactive.web.insurance.ca.gov/contactCSD/ContactUs.jsp.

Definitions

Plan Provider Definitions
Whenever any of the following terms are capitalized in this Policy, the terms will have the meaning below:

Alternate Care Services Providers — Durable Medical Equipment suppliers, individual certified orthotists, prosthetists and prosthetist-orthotists.

Doctor of Medicine — a licensed medical doctor (M.D.) or doctor of osteopathic medicine (D.O.).

Hospice or Hospice Agency – an entity which provides Hospice Services to Terminally Ill persons and holds a license, currently in effect as a Hospice pursuant to Health and Safety Code Section 1747, or a home health agency licensed pursuant to Health and Safety Code Sections 1726 and 1747.1 which has Medicare certification.

Hospital —

1. A licensed institution primarily engaged in providing, for compensation from patients, medical, diagnostic and surgical facilities for care and treatment of sick and injured persons on an Inpatient basis, under the supervision of an organized medical staff, and which provides 24 hour a day nursing service by registered nurses. A facility which is principally a rest home, or nursing home, or home for the aged is not included.

2. A psychiatric Hospital accredited by the Joint Commission on Accreditation of Healthcare Organizations.

3. A "psychiatric health facility" as defined in Section 1250.2 of the California Health and Safety Code.

MHSA Non-Participating Provider — a provider who does not have an agreement in effect with the MHSA for the provision of Mental Health and substance abuse Services. Note: MHSA Non-Participating Providers may include Blue Shield Life Preferred/Participating Providers if the Provider does not also have an agreement with the MHSA.

MHSA Participating Provider — a provider who has an agreement in effect with the MHSA for the provision of Mental Health and substance abuse Services.

Non-Participating Home Health Care and Home Infusion Agency — agencies which have not contracted with Blue Shield Life Provider Network and whose services are not covered unless prior authorized by the Plan.

Non-Participating / Non-Preferred Provider — any provider who has not contracted with Blue Shield Life to accept Blue Shield Life's payment, plus any applicable Copayment, Coinsurance or amount in excess of specified benefit maximums, as payment-in-full for covered Services, except as provided in the section entitled PREVENTIVE CARE SERVICES.

Note: this definition does not apply to Mental Health and substance abuse Services. For Non-Participating Providers for Mental Health and substance abuse Services see the Mental Health Services Administrator (MHSA) Non-Participating Providers definition.

Non-Preferred Bariatric Surgery Services Providers – any provider that has not contracted with Blue Shield Life to furnish bariatric surgery services and accept reimbursement at negotiated rates, and that has not been designated as a contracted bariatric surgery services provider by Blue Shield life. Non-Preferred Bariatric Surgery Services Providers may include Blue Shield Life Preferred / Participating Providers if the Provider does not also have an agreement with Blue Shield Life to provide bariatric surgery services.

Note: bariatric surgery services are not covered for Members who reside in designated counties in California if the service is provided b a Non-Preferred Bariatric Surgery Services Provider. (See the section entitled BARIATRIC SURGERY SERVICES for more information.)

Other Provider —

1. Independent Practitioners — licensed vocational nurses; licensed practical nurses; registered nurses; licensed psychiatric nurses; registered dieticians; certified nurse midwives; licensed occupational therapists; certified respiratory therapists; enterostomal therapists; licensed speech therapists or pathologists; certified acupuncturist; dental technicians; and laboratory technicians.

2. Healthcare Organizations — nurses registries; licensed mental health, freestanding public health, rehabilitation, and Outpatient clinics not MD owned; portable x-ray companies; blood banks, speech and hearing centers; dental labs; dental supply companies; nursing homes; ambulance companies; Easter Seal Society; American Cancer Society; Catholic Charities; and Skilled Nursing Facilities.

Outpatient Facility — a licensed facility, not a Physician's office or Hospital, that provides medical and/or surgical Services on an Outpatient basis.

Participating Ambulatory Surgery Center – an Outpatient surgery facility which:

1. Is either licensed by the State of California as an ambulatory surgery center or is a licensed facility accredited by an ambulatory surgery center accrediting body; and

2. Provides Services as a free-standing ambulatory surgery center which licensed separately and bills separately from a Hospital and is not otherwise affiliated with a Hospital; and

3. Has contracted with Blue Shield Life to provide Services on an Outpatient basis.

Participating Home Health Care and Home Infusion Agency — an agency which has contracted with Blue Shield Life Provider Network to furnish Services and accept reimbursement at negotiated rates, and which has been designated as a Participating Home Health Care and Home Infusion Agency by the Plan. (See Non-Participating Home Health Care and Home Infusion Agency definition.

Participating Provider — All Preferred Providers are Participating Providers. These providers include Physicians, Hospitals, Alternate Care Services Providers, Ambulatory Surgery Centers, a Certified Registered Nurse Anesthetist, and Home Health Care and Home Infusion agencies that have contracted with Blue Shield Life Provider Network to furnish Services and to accept the Plan's payment, plus applicable Copayments and Coinsurance, or amounts in excess of specified benefit maximums, as payment in full for covered Services, except as provided under in the section entitled PROFESSIONAL (PHYSICIAN) SERVICES.

Note: this definition does not apply to Mental Health and substance abuse Services or Hospice Program Services. For Participating Providers for Mental Health and substance abuse Services and Hospice Program Services, see the Mental Health Services Administrator (MHSA) Participating Providers and Participating Hospice or Participating Hospice Agency definition.

Physician — a licensed Doctor of Medicine, clinical psychologist, research psychoanalyst, dentist, licensed clinical social worker, optometrist, chiropractor, podiatrist, audiologist, registered physical therapist, or licensed marriage and family therapist.

Physician Member — a Doctor of Medicine who has contracted with Blue Shield Life Provider Network, has agreed to furnish Services to Insureds covered by Blue Shield Life, and has agreed to accept Blue Shield Life's payment as payment-in-full for covered Services, except for Copayments, Coinsurance or amounts in excess of specified benefit maximums, and except as provided in the section entitled PREVENTATIVE CARE SERVICES.

Preferred Bariatric Surgery Services Provider – a Preferred Hospital or a Physician Member that has contracted with Blue Shield Life to furnish bariatric surgery Services and accept reimbursement at negotiated rates, and that has been designated as a contracted bariatric surgery Services provider by Blue Shield Life.

Preferred Dialysis Center – a dialysis services facility contracted as a Blue Shield Life Provider Network to provide dialysis services on an Outpatient basis and accept reimbursement at negotiated rates.

Preferred Hospital — a Hospital which has contracted with Blue Shield Life Provider Network and which has agreed to furnish Services and accept reimbursement at negotiated rates, and which has been designated as a Preferred Hospital by the Plan.

Preferred Provider – A Preferred Provider is a Participating Provider who has contracted with the Blue Shield Life Provider Network to furnish Services and to accept the Plan's payment, except for applicable Copayments, Coinsurance or amounts in excess of specified benefit maximums, and except as provided in the section entitled PREVENTIVE CARE SERVICES.

Note, for Participating Providers for Mental Health and substance abuse Services, see the Mental Health Services Administrator (MHSA) Participating Providers definition.

Preferred Physicians — a Physician who has agreed to accept Blue Shield Life's payment, plus any Insured payments of any applicable Copayment, and/or Coinsurance as payment-in-full for covered Services. Please refer to the Summary of Benefits for Copayment and/or Coinsurance information.

Skilled Nursing Facility — a facility licensed by the California Department of Health Services as a "Skilled Nursing Facility" or any similar institution licensed under the laws of any other state, territory, or foreign country.

All Other Definitions

Whenever any of the following terms are capitalized in this Policy, the terms will have the meaning below:

Accidental Injury — definite trauma resulting from a sudden, unexpected and unplanned event, occurring by chance, caused by an independent external source

Activities of Daily Living (ADL) — mobility skills required for independence in normal everyday living. Recreational, leisure, or sports activities are not included.

Acute Care — care rendered in the course of treating an illness, injury or condition marked by a sudden onset or change of status requiring prompt attention, which may include hospitalization, but which is of limited duration and which is not expected to last indefinitely.

Allowable Amount — the Blue Shield Life Allowance (as defined below) for the Service (or Services) rendered, or the provider's billed charge, whichever is less. The Blue Shield Life Allowance, unless otherwise specified for a particular Service elsewhere in this Policy, is:

1. For a Participating Provider, the amount that the Provider and Blue Shield Life have agreed by contract will be accepted as payment in full for the Services rendered; or

2. For a non-participating provider anywhere within or outside of the United States who provides Emergency Services:

   a. For physicians – the Reasonable and Customary Charge;
   b. All other providers - the provider's billed charge for covered Services, unless the provider and the local Blue Cross and/or Blue Shield plan have agreed upon some other amount; or

3. For a non-participating provider in California, including an Other Provider, who provides Services on other than an emergency basis, the amount Blue Shield Life would have allowed for a Participating Provider performing the same service in the same geographical area; or

4. For a provider anywhere, other than in California, within or outside of the United States, which has a contract with the local Blue Cross and/or Blue Shield plan, the amount that the provider and the local Blue Cross and/or Blue Shield plan have agreed by contract will be accepted as payment in full for service rendered; or

5. For a non-participating provider (i.e., that does not contract with a local Blue Cross and/or Blue Shield plan)

anywhere, other than in California, within or outside of the United States, who provides Services on other than an emergency basis, the amount that the local Blue Cross and/or Blue Shield would have allowed for a Non-Participating Provider performing the same services.

Blue Shield Life — the Blue Shield of California Life & Health Insurance Company, a California corporation licensed as a life and disability insurer.

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

Chronic Care — care (different from Acute Care) furnished to treat an illness, injury or condition, which does not require hospitalization (although confinement in a lesser facility may be appropriate), which may be expected to be of long duration without any reasonably predictable date of termination, and which may be marked by reoccurrence requiring continuous or periodic care as necessary.

Close Relative — the spouse or Domestic Partner, child, brother, sister or parent of a Subscriber.

Coinsurance — the percentage of the Allowable Amount or billed charges that an Insured is required to pay for certain Services after meeting any applicable deductible.

Complications of Pregnancy — conditions, which require medical treatment prior to or subsequent to termination of pregnancy and which, are distinct from but adversely affected by or related to pregnancy.

Copayment — the dollar amount that an Insured is required to pay for certain Services after meeting any applicable deductible.

Cosmetic Surgery — surgery that is performed to alter or reshape normal structures of the body to improve appearance.

Creditable Coverage —

1. Any individual or group policy, contract or program, that is written or administered by a disability insurer, health care service plan, fraternal benefits society, self-insured employer plan, or any other entity, in this state or elsewhere, and that arranges or provides medical, hospital, and surgical coverage not designed to supplement other private or governmental plans. The term includes continuation or conversion coverage but does not include accident only, credit, disability income, Medicare supplement, long-term care, dental, vision, coverage issued as a supplement to liability insurance, insurance arising out of a workers' compensation or similar law, automobile medical payment insurance, or insurance under which benefits are payable with or without regard to fault and that is statutorily required to be contained in any liability insurance policy or equivalent self-insurance.

2. Title XVIII of the Social Security Act, e.g., Medicare.

3. The Medicaid/Medi-Cal program pursuant to Title XIX of the Social Security Act.

4. Any other publicly sponsored or funded program of medical care.

Custodial or Maintenance Care — care furnished in the home primarily for supervisory care or supportive services, or in a facility primarily to provide room and board (which may or may not include nursing care, training in personal hygiene and other forms of self care or supervisory care by a Doctor of Medicine); or care furnished to an Insured who is mentally or physically disabled, and:

1. Who is not under specific medical, surgical or psychiatric treatment to reduce the disability to the extent necessary to enable the individual to live outside an institution providing such care; or

2. When, despite such treatment, there is no reasonable likelihood that the disability will be so reduced.

Deductible – the Calendar Year amount you must pay for specific Covered Services that are a benefit of the Plan before you become entitled to receive certain Benefit payments from the Plan for those Services.

Domiciliary Care — care provided in a Hospital or other licensed facility because care in the individual's home is not available or is unsuitable.

Durable Medical Equipment — equipment designed for repeated use which is Medically Necessary to treat an illness or injury, to improve the functioning of a malformed body member, or to prevent further deterioration of the individual's medical condition. Durable Medical Equipment includes wheelchairs, hospital beds, respirators, and other items that the Plan determines are Durable Medical Equipment.

Effective Date — the date an applicant meets all enrollment and prepayment requirements and is accepted by Blue Shield Life.

Emergency Services — Services for a medical condition, including a psychiatric emergency medical condition, manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate

medical attention could reasonably be expected to result in any of the following:

1. Placing the patient's health in serious jeopardy;
2. Serious impairment to bodily functions;
3. Serious dysfunction of any bodily organ or part.

Experimental or Investigational in Nature — Any treatment, therapy, procedure, drug or drug usage, facility or facility usage, equipment or equipment usage, device or device usage, or supplies which are not recognized in accordance with generally accepted professional medical standards as being safe and effective for use in the treatment of the illness, injury, or condition at issue. Services which require approval by the Federal government or any agency thereof, or by any State government agency, prior to use and where such approval has not been granted at the time the services or supplies were rendered, shall be considered Experimental or Investigational in Nature

Services or supplies which themselves are not approved or recognized in accordance with accepted professional medical standards, but nevertheless are authorized by law or by a government agency for use in testing, trials, or other studies on human patients, shall be considered Experimental or Investigational in Nature.

Hospital Services — Services provided under the direction of a Physician, in a licensed Hospital to treat illness or injury and which require the facilities of a Hospital.

Incurred — a charge shall be deemed to be "Incurred" on the date the particular Service, which gives rise to it, is provided or obtained.

Inpatient — an individual who has been admitted to a Hospital as a registered bed patient and is receiving Services under the direction of a Doctor of Medicine.

Insured — a Subscriber.

Intensive Outpatient Care Program — an Outpatient Mental Health (or substance abuse) treatment program utilized when a patient's condition requires structure, monitoring, and medical/psychological intervention at least three (3) hours per day, three (3) times per week.

Medical Necessity

Benefits are provided only for Services that are Medically Necessary.

1. Services which are Medically Necessary include only those which have been established as safe and effective, are furnished in accordance with generally accepted professional standards to treat an illness, injury, or medical condition, and which, as determined by the Plan, are:
   a. Consistent with the Plan's medical policy; and
   b. Consistent with the symptoms or diagnosis; and
   c. Not furnished primarily for the convenience of the Insured, the attending Physician or Other Provider; and
   d. Furnished at the most appropriate level which can be provided safely and effectively to the Insured.
2. If there are two (2) or more Medically Necessary services that may be provided for the illness, injury, or medical condition, Blue Shield Life will provide benefits based on the most cost-effective service.
3. Hospital Inpatient Services which are Medically Necessary include only those Services which satisfy the above requirements, require the acute bed-patient (overnight) setting, and which could not have been provided in a Physician's office, the Outpatient department of a Hospital, or in a lesser facility without adversely affecting the Insured's condition or the quality of medical care rendered. Inpatient Services that are not Medically Necessary and are not covered, include hospitalization:
   a. For diagnostic studies that could have been provided on an Outpatient basis;
   b. For medical observation or evaluation;
   c. For personal comfort;
   d. In a pain management center to treat or cure chronic pain; and
   e. For Inpatient Rehabilitation that can be provided on an Outpatient basis.
4. The Plan reserves the right to review all claims to determine whether services are Medically Necessary, and may use the services of Physician consultants, peer review committees of professional societies or Hospitals, and other consultants.

Mental Health Services — see definition of Psychiatric Care.

Mental Health Services Administrator (MHSA) —The MHSA is a specialized health care service plan that will underwrite and deliver the Plan's Mental Health and substance abuse Services through a separate network of MHSA Participating Providers.

Negotiated Rate — the amount a Preferred Hospital has agreed to accept as payment-in-full for covered Services, except for Copayments, Coinsurance or amounts in excess of specified benefit maximums, and except as provided under the section entitled COVERED SERVICES.

Occupational Therapy - treatment under the direction of a Doctor of Medicine and provided by a certified occupational therapist utilizing arts, crafts, or specific training in daily living skills, to improve and maintain a patient's ability to function.

Orthosis — an orthopedic appliance or apparatus used to support, align, prevent, or correct deformities or to improve the function of movable body parts.

Out-of-Country Services — Medical services received outside the United States of America.

Outpatient — an Insured receiving Services, but not as an Inpatient.

Partial Hospitalization / Day Treatment Program — a treatment program that may be freestanding or Hospital-based and provides Services at least five (5) hours per day and at least four (4) days per week. Patients may be admitted directly to this level of care, or transferred from acute Inpatient care following acute stabilization.

Physical Therapy - treatment provided by a Doctor of Medicine or under the direction of a Doctor of Medicine when provided by a registered physical therapist, certified occupational therapist, or licensed Doctor of Podiatric Medicine. Treatment utilizes physical agents and therapeutic procedures such as ultrasound, heat, range of motion testing, and massage, to improve a patient's musculoskeletal, neuromuscular, and respiratory systems.

Plan — the Blue Shield of California Life & Health Insurance Company and/or the Blue Shield Life Vital Shield 2900.

Policy— this Policy, the appendices, all endorsements to it, and all applications for coverage and health statements.

Pre-Existing Condition — an illness, injury, or condition (including disability) which existed during the six (6) months prior to the Effective Date with Blue Shield Life if, during that time, any medical advice, diagnosis, care, or treatment was recommended or received from a licensed health practitioner.

Prosthesis — an artificial part, appliance, or device used to replace a missing part of the body.

Psychiatric Care (Mental Health Services) — psychoanalysis, psychotherapy, counseling, medical management, or other services provided by a psychiatrist, psychologist, licensed clinical social worker, or licensed marriage and family therapist for diagnosis or treatment of a mental or emotional disorder, or the mental or emotional problems associated with an illness, injury or other condition.

Reasonable and Customary Charge – In California: The lower of (1) the provider's billed charge, or (2) the amount determined by Blue Shield Life to be the reasonable and customary value for the services rendered by a non-Plan Provider based on statistical information that is updated at least annually and considers many factors including, but not limited to, the provider's training and experience, and the geographical area where the services are rendered: Outside of California: The lower of (1) the provider's billed charge, or, (2) the amount, if any established by the laws of the state to be paid for Emergency Services.

Reconstructive Surgery — surgery to correct or repair abnormal structures of the body caused by congenital defects, developmental abnormalities, trauma, infection, tumors or disease to do either of the following: 1) to improve functions, or 2) to create a normal appearance to the extent possible.

Rehabilitation — Inpatient care furnished primarily to restore an individual's ability to function as normally as possible after a disabling illness or injury. Rehabilitation services may consist of Physical Therapy, Occupational Therapy, and/or Respiratory Therapy and are provided with the expectation that the patient has restorative potential. Rehabilitation services will be provided for as long as continued treatment is Medically Necessary pursuant to the treatment plan.

Resident of California — an individual who spends in the aggregate more than 180 days each year within the State of California and has not established a permanent residence in another state or country.

Residential Care – services provided in a facility or a free-standing residential treatment center that provides overnight/extended-stay services for Members who do not qualify for Acute Care or Skilled Nursing Services

Respiratory Therapy - treatment under the direction of a Doctor of Medicine and provided by a certified respiratory therapist, to preserve or improve a patient's pulmonary function.

Serious Emotional Disturbances of a Child — refers to individuals who are minors under the age of 18 years who:

1. Have one or more mental disorders in the most recent edition of the Diagnostic and Statistical manual of Mental Disorders (other than a primary substance use disor-

der or developmental disorder), that results in behavior inappropriate for the child's age according to expected developmental norms, and

2. Meet the criteria in paragraph (2) of subdivision (a) of Section 5600.3 of the Welfare and Institutions Code. This section states that members of this population shall meet one or more of the following criteria:

   a. As a result of the mental disorder the child has substantial impairment in at least two of the following areas: self-care, school functioning, family relationships, or ability to function in the community: and either of the following has occurred: the child is at risk of removal from home or has already been removed from the home or the mental disorder and impairments have been present for more than six (6) months or are likely to continue for more than one (1) year without treatment;

   b. The child displays one of the following: psychotic features, risk of suicide or risk of violence due to a mental disorder.

Services — Medically Necessary health care Services and Medically Necessary supplies furnished incident to those Services.

Severe Mental Illnesses — conditions with the following diagnoses: schizophrenia, schizo-affective disorder, bipolar disorder (manic depressive illness), major depressive disorders, panic disorder, obsessive-compulsive disorder, pervasive developmental disorder or autism, anorexia nervosa, bulimia nervosa.

Special Food Products — a food product which is both of the following:

1. Prescribed by a Physician or Nurse Practitioner for the treatment of phenylketonuria (PKU) and is consistent with the recommendations and best practices of qualified health professionals with expertise germane to, and experience in the treatment and care of, phenylketonuria (PKU). It does not include a food that is naturally low in protein, but may include a food product that is specially formulated to have less than one gram of protein per serving;
2. Used in place of normal food products, such as grocery store foods, used by the general population.

Speech Therapy — treatment, under the direction of a Doctor of Medicine and provided by a licensed speech pathologist or speech therapist, to improve or retrain a patient's vocal skills which have been impaired by a diagnosed illness or injury.

Subacute Care — skilled nursing or skilled rehabilitation provided in a Hospital or Skilled Nursing Facility to patients who require skilled care such as nursing Services, physical, occupational or speech therapy, a coordinated program of multiple therapies or who have medical needs that require daily Registered Nurse monitoring. A facility, which is primarily a rest home, convalescent facility, or home for the aged is not included.

Subscriber — an individual who is a Resident of California and has made application individually, has been enrolled by Blue Shield Life, and has maintained Blue Shield Life membership in accord with this Policy.

IN WITNESS WHEREOF, Blue Shield of California Life & Health Insurance Company, through its duly authorized Officers, execute this Policy, to take effect on the Subscriber's Effective Date.

Seth A. Jacobs, Secretary
Blue Shield of California Life & Health Insurance Company

Paul Markovich, President
Blue Shield of California Life & Health Insurance Company

For claims submission and information
contact:
BLUE SHIELD OF CALIFORNIA LIFE & HEALTH INSURANCE COMPANY
P. O. Box 272610
Chico, CA95927-2610

You may call Customer Service toll free:
1-888-852-5345

The hearing impaired may call Blue Shield Life's
Customer Service Department through Blue Shield Life's toll-free TTY number at
1-800-241-1823.

Benefits Management Program Telephone Numbers
for Pre-admission and/or Prior Authorization :
1-800-343-1691

For Prior Authorization of Benefits Management Program Radiological Services:
1-888-642-2583

For Prior Authorization for Inpatient Mental Health and substance abuse services, contact the Mental Health Services Administrator at:
1-877-214-2928

Please refer to the Benefits Management Program section of this Policy booklet for information.

Exhibit B

Vital Shield℠ Plus 400 Generic Rx

Blue Shield of California
Life & Health Insurance Company

Policy

Individual and Family Plans

Vital Shield Plus 400 Generic Rx

Policy for Individuals and Families

This Policy is issued by Blue Shield of California Life & Health Insurance Company ("Blue Shield Life"), to the Insured whose identification cards are issued with this Policy. In consideration of statements made in the application and timely payment of Premiums, Blue Shield Life agrees to provide the benefits of this Policy.

NOTICE TO NEW SUBSCRIBERS

Please read this Policy carefully. If you have questions, contact Blue Shield Life. You may surrender this Policy by delivering or mailing it with the Identification Cards, within ten (10) days from the date it is received by you, to BLUE SHIELD LIFE, 50 BEALE STREET, SAN FRANCISCO, CA 94105. Immediately upon such delivery or mailing, the Policy shall be deemed void from the beginning, and Premiums paid will be refunded.

PLEASE NOTE

Some hospitals and other providers do not provide one or more of the following services that may be covered under your policy and that you or your family member might need: family planning; contraceptive services, including emergency contraception; sterilization, including tubal ligation at the time of labor and delivery; infertility treatments; or abortion. You should obtain more information before you become a policyholder or select a network provider. Call your prospective doctor or clinic, or call the health plan at Blue Shield Life's Customer Service telephone number provided on the last pages of this booklet to ensure that you can obtain the health care services that you need.

IMPORTANT!

No Insured has the right to receive the benefits of this Plan for Services or supplies furnished following termination of coverage. Benefits of this Plan are available only for Services and supplies furnished during the term it is in effect and while the individual claiming benefits is actually covered by this Policy. Benefits may be modified during the term of this Plan as specifically provided under the terms of this Policy or upon renewal. If benefits are modified, the revised benefits (including any reduction in benefits or the elimination of benefits) apply for Services or supplies furnished on or after the effective date of the modification. There is no vested right to receive the benefits of this Plan.

The Vital Shield Plus 400 Generic Rx

Subscriber Bill of Rights

As a Vital Shield Plus 400 Generic Rx Subscriber, you have the right to:

1. Receive considerate and courteous care, with respect for your right to personal privacy and dignity.
2. Receive information about all health Services available to you, including a clear explanation of how to obtain them.
3. Receive information about your rights and responsibilities.
4. Receive information about your Vital Shield Plus 400 Generic Rx, the Services we offer you, the Physicians, and other practitioners available to care for you.
5. Have reasonable access to appropriate medical services.
6. Participate actively with your Physician in decisions regarding your medical care. To the extent permitted by law, you also have the right to refuse treatment.
7. A candid discussion of appropriate or Medically Necessary treatment options for your condition, regardless of cost or benefit coverage.
8. Receive from your Physician an understanding of your medical condition and any proposed appropriate or Medically Necessary treatment alternatives, including available success/outcomes information, regardless of cost or benefit coverage, so you can make an informed decision before you receive treatment.
9. Receive preventive health Services.
10. Know and understand your medical condition, treatment plan, expected outcome, and the effects these have on your daily living.
11. Have confidential health records, except when disclosure is required by law or permitted in writing by you. With adequate notice, you have the right to review your medical record with your Physician.
12. Communicate with and receive information from Customer Service in a language that you can understand.
13. Know about any transfer to another Hospital, including information as to why the transfer is necessary and any alternatives available.
14. Be fully informed about the Blue Shield Life grievance procedure and understand how to use it without fear of interruption of health care.
15. Voice complaints or grievances about the Vital Shield Plus 400 Generic Rx, or the care provided to you.

The Vital Shield Plus 400 Generic Rx

Subscriber Responsibilities

As a Vital Shield Plus 400 Generic Rx Subscriber, you have the responsibility to:

1. Carefully read all Vital Shield Plus 400 Generic Rx materials immediately after you are enrolled so you understand how to use your Benefits and how to minimize your out of pocket costs. Ask questions when necessary. You have the responsibility to follow the provisions of your Vital Shield Plus 400 Generic Rx membership as explained in the Policy.

2. Maintain your good health and prevent illness by making positive health choices and seeking appropriate care when it is needed.

3. Provide, to the extent possible, information that your Physician, and/or the Plan need to provide appropriate care for you.

4. Follow the treatment plans and instructions you and your Physician have agreed to and consider the potential consequences if you refuse to comply with treatment plans or recommendations.

5. Ask questions about your medical condition and make certain that you understand the explanations and instructions you are given.

6. Make and keep medical appointments and inform your Physician ahead of time when you must cancel.

7. Communicate openly with the Physician you choose so you can develop a strong partnership based on trust and cooperation.

8. Offer suggestions to improve the Vital Shield Plus 400 Generic Rx.

9. Help Blue Shield Life to maintain accurate and current medical records by providing timely information regarding changes in address, family status and other health plan coverage.

10. Notify Blue Shield Life as soon as possible if you are billed inappropriately or if you have any complaints.

11. Treat all Plan personnel respectfully and courteously as partners in good health care.

12. Pay your Premiums, Copayment, Coinsurance, and charges for non-covered Services on time.

13. For all Mental Health and substance abuse Services, follow the treatment plans and instructions agreed to by you and the Mental Health Service Administrator (MHSA) and obtain prior authorization for all Non-Emergency Inpatient Mental Health and substance abuse Services.

14. Follow the provisions of the Blue Shield Life Benefits Management Program.

TABLE OF CONTENTS

Summary of Benefits

Preferred Provider Plan

Note: The SUMMARY OF BENEFITS represents only a brief description of the Benefits. Please read this Policy carefully for a complete description of provisions, benefits, exclusions, and other important information pertaining to this Plan.

For Benefits that have a visit maximum, all visits count toward the visit maximum, regardless of whether the Calendar Year Deductible has been satisfied, or you have reached the Maximum Calendar Year Copayment/Coinsurance Responsibility.

Note that certain services are covered only if rendered by a Preferred Provider. Using a Non-Preferred Provider could result in no payment by Blue Shield Life for services. Please read this Summary of Benefits and the section entitled Covered Services so you will know from which providers, health care may be obtained. The Preferred Provider Directory can be located online at www.blueshielca.com or by calling Customer Service at the telephone number provided on the last page of this Policy.

Calendar Year Deductible per Insured and Family Deductible [1] (Medical Plan Deductible)	Deductible Responsibility
The Calendar Year deductible for applicable covered Services rendered by any combination of Preferred Providers, Participating Providers, MHSA Participating Providers, and/or Other Providers, is as indicated.	**$400 per Insured $800 per Family**
The Calendar Year deductible for applicable covered Services rendered by any combination of Non-Preferred Providers and MHSA Non-Participating Providers is as indicated.	**$5,000 per Insured $10,000 per Family**

The Calendar Year deductible applies to all Covered Services Incurred during a Calendar Year except for the following:

- The first five office visits per Calendar Year by a Preferred Physician as described in the Additional Details on Certain Services for Certain Medical Conditions section;
- The first five visits per Calendar Year by a MHSA Participating Provider as described in the Additional Details on Certain Services for Mental Illness or Serious Emotional Disturbances of a Child section;
- Gynecological, colorectal, and osteoporosis screenings as describe in the Preventive Care Services section; and
- Outpatient prescription drugs and mail service prescription drugs including covered diabetes-related medications and diabetic testing supplies;

Claims for these Services do not count toward the Calendar Year Deductible:

- Outpatient Diabetes self-management training;
- Family Planning visits including counseling, consultations, and diaphragm fitting;
- Home Health Care Services;
- Home Infusion/Home Injectable Therapy Benefits;
- Outpatient or Out-of-Hospital X-Ray, Pathology, and Laboratory Services;
- Office visit to an MHSA Participating Provider [2] for Severe Mental Illnesses or Serious Emotional Disturbances of a Child even if such visit is used to determine the condition and diagnosis of the Insured [3];
- PKU Related Formulas and Special Food Products;
- Psychological Testing;
- Covered travel expenses for bariatric surgery Services;
- Any injectable contraceptive when administered by a Physician as specified in the Family Planning Services section; and
- Outpatient physician office visits in the Insured's home or physician's office [4].

[1] The Calendar Year deductible applies to all applicable Services and may include Services on both a Copayment and/or Co-insurance basis.

[2] A Mental Health Service Administrator (MHSA) Participating Provider is a Provider who participates in the MHSA Mental Health Provider Network. See the Definitions section for additional information.

[3] See the Additional Details on Certain Services for Mental Illness or Serious Emotional Disturbances of a Child section for additional information.

[4] See the Additional Details on Certain Services for Certain Medical Conditions section for additional information.

Fourth Quarter Deductible Credit

Any charges that accumulate towards the Insured's Medical Plan Deductible in the last three months of a Calendar Year are eligible to be credited towards the Insured's Medical Plan Deductible for the following Calendar Year.

The benefit as described above only applies if:

1. An Insured is covered under the Vital Shield Plus 400 Generic Rx plan in consecutive Calendar Years; and
2. An Insured has not satisfied their per Insured Calendar Year Medical Plan Deductible as described in the Summary of Benefits; and
3. An Insured is not eligible to receive Benefits due to the Family Calendar Year Medical Plan Deductible, as described in the Summary of Benefits, having been satisfied.

Additional Payments

Additional payments for failure to utilize the Benefit Management Program.

Please refer to the Benefits Management Programs section for additional information.

Maximum Aggregate Payment	Maximum Blue Shield Life Payment
The maximum aggregate payment amount is determined by totaling all covered Benefits provided to you whether covered under the Plan as a Subscriber or Dependent while covered under this Plan or while covered under any prior or subsequent health plan with Blue Shield of California or any of its affiliated companies, including Blue Shield Life. Benefits in excess of this amount are not covered under this Plan.	**$3,000,000 per Insured**

Maximum per Insured Calendar Year Copayment/Coinsurance Responsibility [1] [2]	Copayment/Coinsurance Responsibility [1]
The maximum Calendar Year Copayment/Coinsurance responsibility for applicable covered Services rendered by any combinations of Preferred Providers, Participating Providers, MHSA Participating Providers, and/or Other Providers.	**$2,900 per Insured** **$5,800 per Family,**
The maximum Calendar Year Copayment/Coinsurance responsibility for applicable covered Services rendered by Non-Preferred Providers and MHSA Non-Participating Providers.	**$15,000 per Insured** **$30,000 per Family**

[1] No benefit payment is made by the Plan for the following Services until the Maximum per Insured Calendar Year Copayment/Coinsurance responsibility is met. Until that responsibility is met, the Insured pays 100% of the Allowable Amount for the following Services. Additionally, claims for these Services do not count toward the Maximum per Insured Calendar Year Copayment/Coinsurance responsibility. Once the Maximum per Insured Calendar Year Copayment/Coinsurance responsibility is met, the Plan pays 100% of the Allowable Amount for the remainder of the Calendar Year.

Outpatient Diabetes self-management training;
Family Planning visits including counseling, consultations, and diaphragm fitting;
Home Health Care Services;
Outpatient or Out-of-Hospital X-Ray, Pathology, and Laboratory Services;
Office visits to an MHSA Participating or MHSA Non-Participating Provider for Severe Mental Illnesses or Serious Emotional Disturbances of a Child even if such visit is used to determine the condition and diagnosis of the Insured ✦;
Psychological Testing; and
Outpatient physician office visits in the Insured's home or physician's office.✧

[2] Charges for the following Services are not included in the calculation of the Maximum per Insured Calendar Year Copayment/Coinsurance responsibility and may cause the Insured's payment responsibility to exceed the maximums listed in this section.

Outpatient prescription drugs including mail service prescription drugs including covered diabetes related medications, home self-administered injectables, and diabetic testing supplies;
Charges in excess of specified benefit maximums;
Services received from MHSA Non-Participating hospitals;
Charges for Services which are not covered and charges by non-Preferred and MHSA Non-Participating Providers in excess of amounts covered by the Plan;
Services provided by a Non-Preferred Hospital-based Skilled Nursing Facility;
Non-Emergency Services from a Non-Participating Hospital;
Outpatient Surgery from a Non-Participating Ambulatory Surgery Center;
Any additional payment Incurred under the Benefits Management Program section;
Family Planning injectable contraceptives administered by a Physician;
Services received from a non-participating Dialysis Center;
Services as described in the Preventive Care Benefits section;
Copayments for covered MHSA Participating Provider Outpatient or office visits ✦; and
Outpatient physician office visits in the Insured's home or physician's office

✦ See the Additional Details on Certain Services for Mental Illness or Serious Emotional Disturbances of a Child section for additional information.
✧ See the Additional Details on Certain Services for Certain Medical Conditions section for additional information.

Note that Copayments, Coinsurance, and charges for Services not accruing to the Maximum per Insured Calendar Year Copayment/Coinsurance responsibility continue to be the Insured's payment responsibility after the Maximum per Insured Calendar Year Copayment/Coinsurance responsibility is reached.

Additional Details on Certain Services for Certain Medical Conditions

The Plan provides a benefit for the first five visits per Calendar Year by a Preferred Physician, excluding a MHSA Participating Provider, for any of the following Services, prior to the satisfaction of the Calendar Year deductible and the Maximum per Insured Calendar Year Copayment/Coinsurance responsibility:

Outpatient Diabetes self-management training; or
Physician/Professional office visits, except as specifically listed elsewhere in this Summary of Benefits; or
An annual physical examination, or annual gynecological examination, or well baby care examinations as specified in the Preventive Care Services section.

Note: The benefits as described above cannot be applied to certain Services rendered by a MHSA Participating Provider. See the Additional Details on Certain Services for Mental Illness or Serious Emotional Disturbances of a Child for additional information on certain Services from a MHSA Participating Provider.

Additional Details on Certain Services for Mental Illness or Serious Emotional Disturbances of a Child

The Plan provides a benefit for the first five visits per Calendar Year by a MHSA Participating Provider for office or outpatient visits related to Severe Mental Illness or Serious Emotional Disturbances of a Child, including the initial visit to determine the condition and diagnosis of the Insured. This benefit is provided prior to the satisfaction of the Calendar Year deductible or the Maximum per Insured Calendar Year Copayment/Coinsurance responsibility.

Benefit	Copayment/Coinsurance Responsibility *	
	Services by Preferred, Participating, and Other Providers **	**Services by Non-Preferred and Non-Participating Providers *****
Ambulance Benefits Covered Services by ambulance companies	40% of billed charges	40% of billed charges
Ambulatory Surgical Benefits Covered Services by Ambulatory Surgery Centers Note: Participating Ambulatory Surgery Centers may not be available in all areas. Outpatient ambulatory surgery Services may also be obtained from a Hospital or an ambulatory surgery center that is affiliated with a Hospital. Ambulatory surgery Services obtained from a Hospital or a Hospital affiliated ambulatory surgery center will be paid at the Preferred or Non-Preferred level as specified in the Hospital section of this Summary of Benefits.	40%	50% of up to $300 per visit Allowable Amount

* Unless otherwise specified, Copayments/Coinsurance are calculated on the Allowable Amount.

** Other Providers are not preferred Providers and so for Services from Other Providers you are responsible for all charges above the Allowable Amount. Other Providers include acupuncturists, ambulance companies, nursing homes, and certain labs (for a complete list of Other Providers see the Definitions section).

*** For Services by Non-Preferred and Non-Participating Providers you are responsible for all charges above the Allowable Amount.

Benefit	Copayment/Coinsurance Responsibility *	
	Services by Preferred Bariatric Surgery Service Providers [1]	**Services by Non-Preferred and Non-Participating Providers [1]**
Bariatric Surgery Benefits for Residents of Designated Counties in California [2]		
Facility Bariatric Surgery Services		
Hospital Inpatient Services	40%	Not covered [1]
Hospital Outpatient Services	40%	Not covered [1]
Physician Bariatric Surgery Services	40%	Not covered [1]
Note: Bariatric surgery Services for residents of non-designated counties [1] will be paid as any other covered surgery as described elsewhere in this Summary of Benefits.		
All bariatric surgery Services must be prior authorized in writing, from the Plan's Medical Director. Prior authorization is required for all Insureds, whether residents of designated or a non-designated county.		

* Unless otherwise specified, Copayments/Coinsurance are calculated on the Allowable Amount.

[1] Bariatric Surgery Services for residents of designated counties must be provided by a Preferred Bariatric Surgery Services Provider. See the Bariatric Surgery Services Benefits and Definitions sections for additional information.

[2] See the Bariatric Surgery Services Benefits section for a list of designated counties.

Benefit	Copayment/Coinsurance Responsibility *	
	Services by Preferred, Participating, and Other Providers **	**Services by Non-Preferred and Non-Participating Providers *****
Clinical Trials for Cancer Benefits Covered Services for the Insured who has been accepted into an approved clinical trial for cancer when prior authorized by the Plan. Services for routine patient care will be paid on the same basis and at the same Benefit levels as other covered Services shown in the Summary of Benefits.	No charge	No charge

* Unless otherwise specified, Copayments/Coinsurance are calculated on the Allowable Amount.

** Other Providers are not preferred Providers and so for Services from Other Providers you are responsible for all charges above the Allowable Amount. Other Providers include acupuncturists, ambulance companies, nursing homes, and certain labs (for a complete list of Other Providers see the Definitions section).

*** For Services by Non-Preferred and Non-Participating Providers you are responsible for all charges above the Allowable Amount.

[1] No benefits are provided for Chiropractic Services by Non-Preferred or Non-participating Providers.

Benefit	Copayment/Coinsurance Responsibility *	
	Services by Preferred, Participating, and Other Providers **	**Services by Non-Preferred and Non-Participating Providers *****
Diabetes Care Benefits		
Covered Services and supplies	40%	50%
Outpatient self-management training		
If one of the five Calendar Year office visits is used for Outpatient self-management training	$30 per visit [1]	$30 per visit [1]
Otherwise	No Copayment ★	$30 per visit [1]
Dialysis Center Benefits [2]	40%	50% of up to $300 per day

* Unless otherwise specified, Copayments/Coinsurance are calculated on the Allowable Amount.

** Other Providers are not preferred Providers and so for Services from Other Providers you are responsible for all charges above the Allowable Amount. Other Providers include acupuncturists, ambulance companies, nursing homes, and certain labs (for a complete list of Other Providers see the Definitions section).

*** For Services by Non-Preferred and Non-Participating Providers you are responsible for all charges above the Allowable Amount.

[1] If billed by your provider, you will also be responsible for an office visit Copayment.

[2] Prior authorization by Blue Shield Life is required for all dialysis Services.

★ No benefit payment is made by the Plan for this Service until the Maximum per Insured Calendar Year Copayment/Coinsurance responsibility is met. Once the Maximum per Insured Calendar Year Copayment/Coinsurance responsibility is met, the Plan pays 100% of the Allowable Amount for this Service. See the Maximum per Insured Calendar Year Copayment/Coinsurance Responsibility section for more information.

Benefit	Copayment/Coinsurance Responsibility *	
	Services by Preferred, Participating, and Other Providers **	**Services by Non-Preferred and Non-Participating Providers *****
Emergency Room Benefits		
Emergency room Physician Services	No Copayment ★	No Copayment ★
Emergency room Services not resulting in an admission	$100 per visit plus 40%	$100 per visit plus 40%
Emergency room Services resulting in an admission (billed as part of Inpatient Hospital Services)	40%	40% [1]
Family Planning Benefits [2]		
Counseling and Consultation Services	No Copayment ★	Not covered
Injectable Contraceptives when administered by a Physician during an Office Visit	$25 [3]	Not covered
Tubal ligation, vasectomy, and elective abortion	No Copayment ★	Not covered

* Unless otherwise specified, Copayments/Coinsurance are calculated on the Allowable Amount.

** Other Providers are not preferred Providers and so for Services from Other Providers you are responsible for all charges above the Allowable Amount. Other Providers include acupuncturists, ambulance companies, nursing homes, and certain labs (for a complete list of Other Providers see the Definitions section).

*** For Services by Non-Preferred and Non-Participating Providers you are responsible for all charges above the Allowable Amount.

[1] For emergency room Services directly resulting in an admission as an Inpatient to a Non-Preferred Hospital which Blue Shield Life determines are not an emergency, your Copayment/Coinsurance will be the Non-Preferred Hospital Inpatient Services Copayment/Coinsurance.

[2] No benefits are provided for Family Planning Services by Non-Preferred or Non-Participating Providers.

[3] Copayment for injectable contraceptives is in addition to any Copayment for the Office Visit.

★ No benefit payment is made by the Plan for this Service until the Maximum per Insured Calendar Year Copayment/Coinsurance responsibility is met. Once the Maximum per Insured Calendar Year Copayment/Coinsurance responsibility is met, the Plan pays 100% of the Allowable Amount for this Service. See the Maximum per Insured Calendar Year Copayment/Coinsurance Responsibility section for more information.

Benefit	Copayment/Coinsurance Responsibility *	
	Services by Preferred, Participating, and Other Providers **	**Services by Non-Preferred and Non-Participating Providers *****
Home Health Care Benefits Home health agency Services including home visits by a nurse, home health aide, medical social worker, physical therapist, speech therapist, or occupational therapist.	No copayment ★	Not covered [1]
Medical supplies and related laboratory Services to the extent the Benefits would have been provided had the Insured remained in the Hospital or Skilled Nursing Facility. Note: There is a combined Benefit maximum of 90 visits per Insured, per Calendar Year for all Home Health and Home Infusion/Home Injectable Services.	No copayment ★	Not covered [1]
Home Infusion/Home Injectable Therapy Benefits Home infusion/home injectable therapy and infusion nursing visits provided by a Home Infusion Agency. Note: There is a combined Benefit maximum of 90 visits per Insured, per Calendar Year for all Home Health and Home Infusion/Home Injectable Services.	No copayment ★	Not covered [1]

* Unless otherwise specified, Copayments/Coinsurance are calculated on the Allowable Amount.

** Other Providers are not preferred Providers and so for Services from Other Providers you are responsible for all charges above the Allowable Amount. Other Providers include acupuncturists, ambulance companies, nursing homes, and certain labs (for a complete list of Other Providers see the Definitions section).

*** For Services by Non-Preferred and Non-Participating Providers you are responsible for all charges above the Allowable Amount.

[1] Services by Non-Participating Home Health Care/Home Infusion Agencies are not covered unless prior authorized by the Plan. When authorized by the Plan, these Non-Participating Agencies will be reimbursed at a rate determined by the Plan and the agency and your Copayment/Coinsurance will be at the Participating Agency Copayment/Coinsurance.

★ No benefit payment is made by the Plan for this Service until the Maximum per Insured Calendar Year Copayment/Coinsurance responsibility is met. Once the Maximum per Insured Calendar Year Copayment/Coinsurance responsibility is met, the Plan pays 100% of the Allowable Amount for this Service. See the Maximum per Insured Calendar Year Copayment/Coinsurance Responsibility section for more information.

Benefit	Copayment/Coinsurance Responsibility *	
	Services by Preferred, Participating, and Other Providers **	**Services by Non-Preferred and Non-Participating Providers *****
Hospice Program Benefits Covered Services for Insureds who have been accepted into an approved Hospice Program.		
Continuous home care during a period of crisis	40%	Not covered [1]
General Inpatient care	40%	Not covered [1]
Inpatient respite care	No charge	Not covered [1]
Routine home care	No charge	Not covered [1]
Pre-hospice consultative visit	No charge	Not covered [1]

* Unless otherwise specified, Copayments/Coinsurance are calculated on the Allowable Amount.

** Other Providers are not preferred Providers and so for Services from Other Providers you are responsible for all charges above the Allowable Amount. Other Providers include acupuncturists, ambulance companies, nursing homes, and certain labs (for a complete list of Other Providers see the Definitions section).

*** For Services by Non-Preferred and Non-Participating Providers you are responsible for all charges above the Allowable Amount.

[1] Services by Non-Participating Hospice Agencies are not covered unless prior authorized by the Plan. When authorized by the Plan, these Non-Participating Agencies will be reimbursed at a rate determined by the Plan and the agency and your Co-insurance will be at the Participating Provider level.

Benefit	Copayment/Coinsurance Responsibility *	
	Services by Preferred, Participating, and Other Providers **	**Services by Non-Preferred and Non-Participating Providers *****
Hospital Care Benefits (Facility Services)		
Inpatient Services		
Emergency Facility Services	40%	40% [1]
Non-Emergency Facility Services	40%	50% of up to $500 per day

* Unless otherwise specified, Copayments/Coinsurance are calculated on the Allowable Amount.

** Other Providers are not preferred Providers and so for Services from Other Providers you are responsible for all charges above the Allowable Amount. Other Providers include acupuncturists, ambulance companies, nursing homes, and certain labs (for a complete list of Other Providers see the Definitions section).

*** For Services by Non-Preferred and Non-Participating Providers you are responsible for all charges above the Allowable Amount.

[1] For Emergency Services by Non-Preferred Hospitals, your Copayment/Coinsurance will be at the Preferred Hospital Co-payment/Coinsurance.

Benefit	Copayment/Coinsurance Responsibility *	
	Services by Preferred, Participating, and Other Providers **	**Services by Non-Preferred and Non-Participating Providers *****
Hospital Care Benefits (Facility Services) *continued*		
Outpatient Services		
Services for Illness or Injury	40%	50% of up to $500 per day [1]
Surgery Services	40%	50% of up to $500 per day [1]
Dialysis Services [2]	40%	50% of up to $300 per day

* Unless otherwise specified, Copayments/Coinsurance are calculated on the Allowable Amount.

** Other Providers are not preferred Providers and so for Services from Other Providers you are responsible for all charges above the Allowable Amount. Other Providers include acupuncturists, ambulance companies, nursing homes, and certain labs (for a complete list of Other Providers see the Definitions section).

*** For Services by Non-Preferred and Non-Participating Providers you are responsible for all charges above the Allowable Amount.

[1] For Emergency Services by Non-Preferred Hospitals, your Copayment/Coinsurance will be at the Preferred Hospital Co-payment/Coinsurance.

[2] Prior authorization by Blue Shield Life is required for all dialysis Services.

Benefit	Copayment/Coinsurance Responsibility *	
	Services by Preferred, Participating, and Other Providers **	**Services by Non-Preferred and Non-Participating Providers *****
Medical Treatment for the Teeth, Gums, Jaw Joints, or Jaw Bones Benefits		
Office Visit		
If one of the first five office visits is used for medical treatment of teeth, gums, jaw joints, or jaw bones.	$30	No Copayment ★
Otherwise	No Copayment ★	No Copayment ★
Services with the office visit	No Copayment ★	No Copayment ★

* Unless otherwise specified, Copayments/Coinsurance are calculated on the Allowable Amount.

** Other Providers are not preferred Providers and so for Services from Other Providers you are responsible for all charges above the Allowable Amount. Other Providers include acupuncturists, ambulance companies, nursing homes, and certain labs (for a complete list of Other Providers see the Definitions section).

*** For Services by Non-Preferred and Non-Participating Providers you are responsible for all charges above the Allowable Amount.

★ No benefit payment is made by the Plan for this Service until the Maximum per Insured Calendar Year Copayment/Coinsurance responsibility is met. Once the Maximum per Insured Calendar Year Copayment/Coinsurance responsibility is met, the Plan pays 100% of the Allowable Amount for this Service. See the Maximum per Insured Calendar Year Copayment/Coinsurance Responsibility section for more information.

Benefit	Copayment/Coinsurance Responsibility *	
Mental Health and Substance Abuse Benefits **(All Services provided through the Plan's Mental Health Service Administrator [MHSA])**	**Services by MHSA Participating Providers ***	**Services by MHSA Non-Participating Providers ****
Inpatient Mental Health Services [1]		
Hospital Services	40%	50% of up to $500 per day [2]
Partial Hospitalization [3]	40% per episode of care [3]	50% of up to $500 per day
Professional (Physician Services)		
If one of the five office visits is used for Severe Mental Illnesses or Serious Emotional Disturbances of a Child.	$30	No Copayment ★
Otherwise	No Copayment ★	No Copayment ★
Outpatient Facility & Office Mental Health Services for Severe Mental Illnesses or Serious Emotional Disturbances of a Child [4]		
Hospital Outpatient department Services (including intensive Outpatient care and electroconvulsive therapy [ECT])	40%	50% of up to $500 per day [2]
Office Services	No Copayment ★	No Copayment ★

* Unless otherwise specified, Copayments are calculated based on the Allowable Amount.

** For Services by MHSA Non-Participating Providers you are responsible for all charges above the Allowable Amount.

[1] All Inpatient Mental Health Services and Outpatient Partial Hospitalization and Outpatient electroconvulsive therapy Services (except for Emergency and urgent Services) must be prior authorized by the MHSA.

[2] For Emergency Services by MHSA Non-Participating Hospitals your Copayment/Coinsurance will be the MHSA Participating Hospital Copayment/Coinsurance based on billed charges.

[3] For Partial Hospitalization Services, an episode of care is the date from which the patient is admitted to the Partial Hospitalization Program to the date the patient is discharged or leaves the Partial Hospitalization Program. Any Services received between these two dates would constitute the episode of care. If the patient needs to be readmitted at a later date, this would constitute another episode of care.

[4] This Copayment/Coinsurance includes both Outpatient facility and Professional (Physician) Services.

★ No benefit payment is made by the Plan for this Service until the Maximum per Insured Calendar Year Copayment/Coinsurance responsibility is met. Once the Maximum per Insured Calendar Year Copayment/Coinsurance responsibility is met, the Plan pays 100% of the Allowable Amount for this Service. See the Maximum per Insured Calendar Year Copayment/Coinsurance Responsibility section for more information.

Benefit	Copayment/Coinsurance Responsibility *	
Mental Health and Substance Abuse Benefits *(continued)* **(All Services provided through the Plan's Mental Health Service Administrator [MHSA])**	**Services by MHSA Participating Providers ***	**Services by MHSA Non-Participating Providers ****
Outpatient Facility & Office Mental Health Services for other than Severe Mental Illnesses or Serious Emotional Disturbances of a Child Note: No Benefits are provided for Outpatient or out-of-Hospital Mental Health Services & substance abuse care from MHSA Non-Participating Providers, except for the initial visit. [1]	Not Covered [1]	Not covered [1]
Psychological Testing	No Copayment ★	No Copayment ★
Psychosocial support through LifeReferrals 24/7	No charge	N/A

* Unless otherwise specified, Copayments are calculated based on the Allowable Amount.

** For Services by MHSA Non-Participating Providers you are responsible for all charges above the Allowable Amount.

[1] For the initial Mental Health Service or substance abuse care visit to determine the condition and diagnosis of the Insured, Benefits will be provided and paid as if the condition was a Severe Mental Illness or a Serious Emotional Disturbances of a Child as shown above.

★ No benefit payment is made by the Plan for this Service until the Maximum per Insured Calendar Year Copayment/Coinsurance responsibility is met. Once the Maximum per Insured Calendar Year Copayment/Coinsurance responsibility is met, the Plan pays 100% of the Allowable Amount for this Service. See the Maximum per Insured Calendar Year Copayment/Coinsurance Responsibility section for more information.

Benefit	Copayment/Coinsurance Responsibility *	
	Services by Preferred, Participating, and Other Providers **	**Services by Non-Preferred and Non-Participating Providers *****
Outpatient or Out-of-Hospital X-Ray, Pathology, and Laboratory Benefits	No Copayment ★ [1]	No Copayment ★ [1]
PKU Related Formulas & Special Food Products Benefits PKU related formulas & special food products The above Services must be prior authorized by the Plan.	No Copayment ★	Not covered [4]
Podiatric Benefits If one of the five office visits is used for Podiatric Services Otherwise	 $30 per visit No Copayment ★	 No Copayment ★ No Copayment ★

* Unless otherwise specified, Copayments/Coinsurance are calculated on the Allowable Amount.

** Other Providers are not preferred Providers and so for Services from Other Providers you are responsible for all charges above the Allowable Amount. Other Providers include acupuncturists, ambulance companies, nursing homes, and certain labs (for a complete list of Other Providers see the Definitions section).

*** For Services by Non-Preferred and Non-Participating Providers you are responsible for all charges above the Allowable Amount.

[1] Coinsurance will be assessed per provider and per date of Service.

[2] If billed by your provider, you will also be responsible for an office visit Copayment.

[3] For Services by certified occupational therapists and certified respiratory therapists, which are Other Providers, you are responsible for all charges above the Allowable Amount.

[4] Services by Non-Participating Home Health Care/Home Infusion Agencies are not covered unless prior authorized by the Plan. When authorized by the Plan, these Non-Participating Agencies will be reimbursed at a rate determined by the Plan and the agency and your Copayment/Coinsurance will be at the Participating Agency Copayment/Coinsurance.

★ No benefit payment is made by the Plan for this Service until the Maximum per Insured Calendar Year Copayment/Coinsurance responsibility is met. Once the Maximum per Insured Calendar Year Copayment/Coinsurance responsibility is met, the Plan pays 100% of the Allowable Amount for this Service. See the Maximum per Insured Calendar Year Copayment/Coinsurance Responsibility section for more information.

Benefit	Copayment/Coinsurance Responsibility *	
	Prescriptions filled by a Participating Retail or Mail Order Pharmacy	**Prescriptions filled by a Non-Participating Pharmacy [3]**
Outpatient Prescription Drug Benefits [1, 2, 3, 4, 5 & 6]		
Retail prescriptions Formulary Generic Drugs	$10	Not covered
Mail service prescriptions Formulary Generic Drugs	$20	Not covered
Home Self-Administered Injectables	40%	Not covered

* Copayment / Coinsurance is calculated based on the contracted rate for covered prescriptions between Blue Shield Life and the Participating Pharmacy, including Specialty Pharmacies, or the Participating Mail Order Pharmacy.

[1] The Insured's Calendar Year deductible does not apply to the Outpatient Prescription Drug benefit.

[2] The Insured's Maximum Calendar Year Copayment/Coinsurance responsibility does not apply to the Outpatient Prescription Drug benefit.

[3] Except for covered emergencies and Drugs for emergency contraception, no benefits are provided for Drugs received from Non-Participating Pharmacies.

[4] Copayment / Coinsurance apply per prescription or refill.

[5]There are no Benefits for Brand Name Drugs under the Vital Shield Plus 400 Generic Rx plan.

[6]The Outpatient Prescription Drug benefit is separate from the Vital Shield Plus 400 Generic Rx plan.

Benefit	Copayment/Coinsurance Responsibility *	
	Services by Preferred, Participating, and Other Providers **	**Services by Non-Preferred and Non-Participating Providers *****
Pregnancy Benefits	No Coverage	No Coverage
Preventive Care Benefits [1]		
Annual Physical Examination including only the annual routine physical examination office visit; urinalysis; eye and ear screening; and pediatric and adult immunizations and the immunizing agent		
If one of the five office visits is used for the Annual Physical Examination	$30	Not covered
Otherwise	No Copayment ★	Not covered
Annual Gynecological Examination including only the annual gynecological examination office visit		
If one of the five office visits is used for the Annual Physical Examination	$30	Not covered
Otherwise	No Copayment ★	Not covered
Well Baby Examinations including only the well baby examination office visit; tuberculin test; and pediatric immunizations and the immunizing agent		
If one of the five office visits is used for the Well Baby Examination	$30	Not covered
Otherwise	No Copayment ★	Not covered

* Unless otherwise specified, Copayments/Coinsurance are calculated on the Allowable Amount.

** Other Providers are not preferred Providers and so for Services from Other Providers you are responsible for all charges above the Allowable Amount. Other Providers include acupuncturists, ambulance companies, nursing homes, and certain labs (for a complete list of Other Providers see the Definitions section).

*** For Services by Non-Preferred and Non-Participating Providers you are responsible for all charges above the Allowable Amount.

[1] No benefits are provided for Preventive Care Services when rendered by Non-Preferred or Non-Participating Providers.

★ No benefit payment is made by the Plan for this Service until the Maximum per Insured Calendar Year Copayment/Coinsurance responsibility is met. Once the Maximum per Insured Calendar Year Copayment/Coinsurance responsibility is met, the Plan pays 100% of the Allowable Amount for this Service. See the Maximum per Insured Calendar Year Copayment/Coinsurance Responsibility section for more information.

Benefit	Copayment/Coinsurance Responsibility *	
	Services by Preferred, Participating, and Other Providers **	**Services by Non-Preferred and Non-Participating Providers *****
Preventive Care Benefits *continued*		
Colorectal Cancer Screening Services	40%	Not Covered
Mammography; routine Papanicolaou (Pap) test or other Food and Drug Administration (FDA) approved cervical cancer screening test; and the human papillomavirus (HPV) screening test only	40%	Not Covered
Certain Osteoporosis Screening Services	40%	Not Covered
NurseHelp 24/7	No Charge	Not Covered

* Unless otherwise specified, Copayments/Coinsurance are calculated on the Allowable Amount.

** Other Providers are not preferred Providers and so for Services from Other Providers you are responsible for all charges above the Allowable Amount. Other Providers include acupuncturists, ambulance companies, nursing homes, and certain labs (for a complete list of Other Providers see the Definitions section).

*** For Services by Non-Preferred and Non-Participating Providers you are responsible for all charges above the Allowable Amount.

Benefit	Copayment/Coinsurance Responsibility *	
	Services by Preferred, Participating, and Other Providers **	**Services by Non-Preferred and Non-Participating Providers *****
Professional (Physician) Benefits		
Office visit		
If one of the five office visits is used for Professional (Physician) Services	$30	No Copayment ★
Otherwise	No Copayment ★	No Copayment ★
Services with the office visit	No Copayment ★	No Copayment ★
Visits to the home, Hospital except for those rendered in the Emergency Room, skilled nursing facility, and Ambulatory Surgery Center, including surgery, chemotherapy, and kidney dialysis	No Copayment ★	No Copayment ★
Prosthetic Appliance Benefits		
For Surgically implanted and other prosthetic devices, including prosthetic bras, provided to restore and achieve symmetry incident to a mastectomy.	40%	50%
For Blom-Singer and artificial larynx prostheses for speech therapy following a laryngectomy are covered as a surgical professional benefit.	40%	50%
Radiological Procedures Requiring Prior Authorization		
Outpatient, non-Emergency radiological procedures including CT scans, MRIs, MRAs. PET scans, and cardiac diagnostic procedures utilizing nuclear medicine	No copayment ★	No Copayment ★
Note: Blue Shield Life requires prior authorization for all these Services.		

* Unless otherwise specified, Copayments/Coinsurance are calculated on the Allowable Amount.

** Other Providers are not preferred Providers and so for Services from Other Providers you are responsible for all charges above the Allowable Amount. Other Providers include acupuncturists, ambulance companies, nursing homes, and certain labs (for a complete list of Other Providers see the Definitions section).

*** For Services by Non-Preferred and Non-Participating Providers you are responsible for all charges above the Allowable Amount.

★ No benefit payment is made by the Plan for this Service until the Maximum per Insured Calendar Year Copayment/Coinsurance responsibility is met. Once the Maximum per Insured Calendar Year Copayment/Coinsurance responsibility is met, the Plan pays 100% of the Allowable Amount for this Service. See the Maximum per Insured Calendar Year Copayment/Coinsurance Responsibility section for more information.

Benefit	Copayment/Coinsurance Responsibility *	
	Services by Preferred, Participating, and Other Providers **	**Services by Non-Preferred and Non-Participating Providers *****
Skilled Nursing Facility Benefits		
Services by a Skilled Nursing Facility Unit of a Hospital	40%	50%
Services by a free–standing Skilled Nursing Facility	40% [1]	40% [1]
Note: There is a combined Benefit maximum of 100 days per Insured, per Calendar Year for all skilled nursing Services.		

* Unless otherwise specified, Copayments/Coinsurance are calculated on the Allowable Amount.

** Other Providers are not preferred Providers and so for Services from Other Providers you are responsible for all charges above the Allowable Amount. Other Providers include acupuncturists, ambulance companies, nursing homes, and certain labs (for a complete list of Other Providers see the Definitions section).

*** For Services by Non-Preferred and Non-Participating Providers you are responsible for all charges above the Allowable Amount.

[1] For Services by free-standing skilled nursing facilities (nursing homes), which are Other Providers, you are responsible for all charges above the Allowable Amount.

Benefit	Copayment/Coinsurance Responsibility *	
	Services by Preferred, Participating, & Other Providers **	**Services by Non-Preferred & Non-Participating Providers *****
Transplant Benefits		
Organ Transplants		
Hospital Services	40%	50% of up to $500 per day
Professional (Physician) Services	40%	50%
Special Transplant Benefits [1]		
Facilities Services in a Special Transplant Facility	40%	Not covered
Professional (Physician) Services	40%	Not covered
Note: The Plan requires prior authorization for all Special Transplant Services. Also, all Services must be provided at a Special Transplant Facility designated by Blue Shield Life.		

* Unless otherwise specified, Copayments/Coinsurance are calculated on the Allowable Amount.

** Other Providers are not preferred Providers and so for Services from Other Providers you are responsible for all charges above the Allowable Amount. Other Providers include acupuncturists, ambulance companies, nursing homes, and certain labs (for a complete list of Other Providers see the Definitions section).

*** For Services by Non-Preferred and Non-Participating Providers you are responsible for all charges above the Allowable Amount.

[1] Special Transplant Benefits are limited to the procedures listed in the Covered Services section. See the Special Transplant Benefits Covered Services section for information on Services and requirements.

Your Vital Shield Plan 400 Generic Rx and How to Use It -

PLEASE READ THE FOLLOWING SO YOU WILL KNOW FROM WHOM OR WHAT GROUP OF PROVIDERS, HEALTH CARE MAY BE PROVIDED.

The Vital Shield Plus 400 Generic Rx has a common goal with you and with health care professionals - quality health care coverage at a reasonable cost. You can control your out-of-pocket costs by carefully choosing the providers from whom you receive covered Services.

This Plan has two different payment levels depending on the Physician or Hospital from which you receive covered Services. Blue Shield Life has a statewide network of nearly 50,000 Physician Members and contracted Hospitals known as Preferred Providers. Many other health care professionals, including optometrists and podiatrists are also Preferred Providers.

The highest benefits of the Vital Shield Plus 400 Generic Rx are provided when you receive covered Services from a Preferred Provider. You will Incur higher out-of-pocket costs when you receive covered Services from a Non-Preferred Provider.

Note: choosing a Preferred Provider will assure the lowest level of Insured's payments available under this Plan. See the "Definitions" section for more information.

Preferred Providers have agreed to accept the Plan's payment, plus payment for any applicable deductibles, the Insured's Copayments and Coinsurances, or amounts in excess of specified benefit maximums as payment-in-full for covered Services, except as provided under the section entitled ACTS OF THIRD PARTIES. This is not true of Non-Preferred Providers. If you receive Services from a Non-Preferred Provider, the Plan's payment may be substantially less than the amount the provider bills. You are responsible for the difference between the amount the Non-Preferred Provider bills and the amount the Plan pays.

In addition, certain services are not covered when received from Non-Preferred Providers. It is therefore to your advantage to obtain medical and Hospital Services from Preferred Providers.

Failure to meet these responsibilities may result in your Incurring a substantial financial liability. Some services may not be covered unless prior review and other requirements are met.

Blue Shield Life, or the MHSA, will render a decision on all requests for prior authorization, and pre-admission review within five (5) business days from receipt of the request. The treating provider will be notified of the decision within 24 hours followed by written notice to the provider and Subscriber within two (2) business days of the decision. For urgent Services in situations in which the routine decision making process might seriously jeopardize the life or health of an Insured, or when the Insured is experiencing severe pain, Blue Shield Life, or the MHSA, will respond as soon as possible to accommodate the Insured's condition not to exceed 72 hours from receipt of the request.

Preferred Providers submit claims for payment after their Services have been received. You or your Non-Preferred Providers also submit claims for payment after Services have been received.

Providers do not receive financial incentives or bonuses from the Plan.

When you need health care, present your Blue Shield Life Identification Card to your Physician, Hospital or other licensed health care provider. Your Identification Card has your Subscriber and group number on it. Be sure to include your Insured and group numbers on all claims you submit to Blue Shield Life. Preferred Providers usually bill the Plan directly. See section on Notice and Proof of Claim in this Policy for information on filing a claim if a provider has not billed the Plan directly. Blue Shield Life will notify you of its determination within thirty (30) days after receipt of the claim.

The Vital Shield Plus 400 Generic Rx is specifically designed for you to use the Blue Shield Life Provider Network of Preferred Providers. Refer to the "Covered Services" section of this Policy for Copayment and Coinsurance information. Preferred Providers are listed in the Preferred Provider Directories.

If you wish to obtain a copy of the Preferred Provider Directory, you may request a copy by contacting the Plan's Customer Service Department at 1-800-431-2809. You may also verify this information by accessing Blue Shield Life's Internet site located at http://www.blueshieldca.com.

Note: A Preferred Provider's status may change. It is your obligation to verify whether the Physician, Hospital, or Alternate Care Services provider you choose is a Preferred Provider in case there have been any changes since your Preferred Provider Directory has been published.

Insureds who reasonably believe that they have an emergency medical condition which requires an emergency

response are encouraged to appropriately use the "911" emergency response system where available.

For all Mental Health and substance abuse Services: The MHSA is a specialized health care service plan that will underwrite and deliver the Plan's Mental Health and substance abuse Services through a separate network of Mental Health Service Administrator (MHSA) Participating Providers.

Note that MHSA Participating Providers are only those Providers who participate in the MHSA network and have contracted with the MHSA to provide Mental Health and substance abuse Services to Insureds. A Blue Shield Life Provider Network Preferred/Participating Provider may not be an MHSA Participating Provider. MHSA Participating Providers agree to accept the MHSA's payment, plus your payment of any applicable deductible, Copayment, Coinsurance or amounts in excess of benefit maximums specified, as payment-in-full for covered Mental Health and substance abuse Services. This is not true of MHSA Non-Participating Providers; therefore, it is to your advantage to obtain Mental Health and substance abuse Services from MHSA Participating Providers.

It is your responsibility to ensure that the Provider you select for Mental Health and substance abuse Services is an MHSA Participating Provider. MHSA Participating Providers are indicated in the Behavioral Health Provider Directory. Additionally, Insureds may contact the MHSA directly for information on, and to select an MHSA Participating Provider by calling 1-877-214-2928. You may also search for an MHSA Participating Provider by accessing Blue Shield Life's Internet site located at http://www.blueshieldca.com.

Blue Shield Life Network of Preferred Providers
PLEASE READ THE FOLLOWING SO YOU WILL KNOW FROM WHOM OR WHAT GROUP OF PROVIDERS, HEALTH CARE MAY BE OBTAINED.

The California Department of Insurance has regulations that establish access standards for a plan's provider network in California. For purposes of these provide network access standards, the service area for this Plan is the State of California.

This Plan is most effective and advantageous when covered Services are received from Preferred Providers. You receive the maximum benefits of the Plan when you receive Services from these providers.

Insureds are paid directly by Blue Shield Life if Services are received from a Non-Preferred Provider. Payments to Insureds for Services are in amounts identical to those made directly to providers. See the section entitled Notice and Proof of Claim in this Policy for information on filing a claim if a provider has not billed the Plan directly. Blue Shield Life will notify you of its determination within thirty (30) days after receipt of the claim.

Insureds are not responsible to Preferred Providers for payment for covered Services, except for payment of any applicable deductibles, Copayments, Coinsurances, or amounts in excess of specified benefit maximums, once the Insured's Calendar Year deductible has been satisfied, except as provided under the section entitled Acts of Third Parties.

Payment for Emergency Services rendered by a physician or hospital who is not a Preferred Provider will be based on the Allowable Amount but will be paid at the Preferred level of benefits. You are responsible for notifying the Plan within 24 hours, or by the end of the first business day, following an emergency admission at a Non-Preferred Hospital, or as soon as is reasonably possible to do so.

Continuity of Care by a Terminated Provider
Insureds who are being treated for acute conditions, serious chronic conditions, pregnancies (including immediate postpartum care), or terminal illness; or who are children from birth to 36 months of age; or who have received authorization from a now-terminated provider for surgery or another procedure as part of a documented course of treatment can request completion of care in certain situations with a provider who is leaving the Blue Shield Life provider network. Contact Customer Service to receive information regarding eligibility criteria and the policy and procedure for requesting continuity of care from a terminated provider.

Financial Responsibility for Continuity of Care Services
If an Insured is entitled to receive Services from a terminated provider under the preceding Continuity of Care provision, the responsibility of the Insured to that provider for Services rendered under the Continuity of Care provision shall be no greater than for the same Services rendered by a Preferred Provider in the same geographic area.

Premiums
Monthly Premiums are as stated in the Appendix. Blue Shield Life offers a variety of options and methods by which you may pay your Premiums. Please call Customer Service at 1-800-431-2809 to discuss these options or visit the Blue Shield Life internet site at http://www.blueshieldca.com.

Payments by mail are to be sent to:

Blue Shield Life
P.O. Box 51827
Los Angeles, CA 0051-6127.

Additional Premiums may be charged in the event that a state or any other taxing authority imposes upon Blue Shield Life a tax or license fee, which is calculated upon, base Premiums or Blue Shield Life's gross receipts or any portion of either. Premiums increase according to the Subscriber's age, as stated in the Appendix. Premiums may also increase from time to time as determined by Blue Shield Life. You will receive thirty (30) days written notice of any changes in the monthly Premiums for this Plan.

Plan Changes

The benefits of this Plan, including but not limited to Covered Services, deductible, Copayment, Coinsurance, and annual copayment/coinsurance maximum amounts, are subject to change at any time. Blue Shield will provide at least 30 days written notice of any such change.

Benefits for Services or supplies furnished after the Effective Date of any change in benefits will be based on the change. There is no vested right to obtain benefits.

Conditions of Coverage

Enrollment

1. Enrollment of Subscribers or Dependents is not effective until Blue Shield Life approves an application and accepts the applicable Premiums. Only Blue Shield Life's Underwriting Department can approve applications.

2. An applicant, upon completion and approval by Blue Shield Life of the application, is entitled to the benefits of this Policy upon the Effective Date.

   By completing an application, the Subscriber and/or Dependent(s) agrees to cooperate with Blue Shield Life by providing, or providing access to, documents and other information that the Plan may request to corroborate the information for coverage. If the Subscriber and/or Dependent(s) fail or refuse to provide these documents or information to Blue Shield Life, coverage under this plan may be cancelled.

3. The Effective Date of the benefits of a newborn child will be the date of birth if the Subscriber contacts Blue Shield Life at the Customer Service telephone number listed at the back of this booklet, to have the newborn child added to this Policy as a Dependent. Such request must be made within 31 days of the newborn child's date of birth. If a request to add the child as a Dependent is not made within 31 days of birth, the coverage for that child shall terminate on the 32nd day.

   If the Subscriber wishes to add a newborn child as a Dependent 32 or more days after birth, Blue Shield Life will require the submission of a completed application and the child will be subject to medical underwriting. This may result in the child being declined coverage by Blue Shield Life.

4. The Effective Date of benefits for an adopted child will be the date the Subscriber, spouse, or Domestic Partner has the right to control the child's health care, if the Subscriber requests the child be added to this Policy as a Dependent. Such request must be made within 31 days of the date the Subscriber, spouse, or Domestic Partner has the right to control the child's health care. If a request to add the child as a Dependent is not made within 31 days of the date the Subscriber, spouse, or Domestic Partner has the right to control the child's health care, the coverage for that child shall terminate on the 32nd day.

   To add a child placed for adoption to this Policy as a Dependent, the Subscriber must contact Blue Shield Life at the Customer Service telephone number listed at the back of this booklet. The Customer Service Department will advise the Subscriber of the exact process for adding a child place for adoption as a Dependent, including, but not limited to, the necessary documentation and the documentation shall be submitted to Blue Shield Life. Enrollment requests for an adopted child must be accompanied by evidence of the Subscriber's, spouse's, or Domestic Partner's right to control the child's health care, which includes a facility minor release report, a medical authorization form, or a relinquishment form.

   If the Subscriber wishes to add a child placed for adoption as a Dependent 32 or more days after the date the Subscriber, spouse or Domestic Partner has the right to control the child's health care, Blue Shield Life will require the submission of a completed application, and the child will be subject to medical underwriting. This may result in the child being declined coverage by Blue Shield Life.

5. If a court has ordered that you provide coverage for your spouse or Domestic Partner, or Dependent child, under your health benefit Plan, their coverage will become effective within 31 days of presentation of a court order by the district attorney, or upon presentation of a court order or request by a custodial party, as described in subdivision (j) of Section 14124.93 of the Welfare and Institutions Code or Medi-Cal program.

Limitation on Enrollment

1. Subscribers must be Residents of California. Upon change of residence to another jurisdiction, this Policy will terminate. Coverage may be transferred to a Blue Cross or Blue Shield Plan for that jurisdiction, if any. See the section entitled Transfer of Coverage.

2. Dependent benefits shall be discontinued as of the following, except as specifically set forth in the definition of Dependent in the section entitled Definitions:

   a. The date the Dependent child attains age 19, if not a full-time student;

   b. The date the Dependent child attains the age of 23, if a full-time student;

   c. The date the Dependent spouse or Domestic Partner enters a final decree of divorce, annulment or dissolution of marriage, or domestic partnership from the Subscriber.

Duration of the Policy

This Policy shall be renewed upon receipt of prepaid Premiums unless otherwise terminated as described herein. Renewal is subject to Blue Shield Life's right to amend this Policy. Any change in Premiums or benefits, are effective after 30 days notice from date of mailing to the Subscriber's address of record with Blue Shield Life.

Termination / Cancellation / Reinstatement of the Policy

1. Blue Shield Life may terminate this Policy together with all like Policies by giving 90 days written notice. No Insured shall be terminated individually by Blue Shield Life for any cause other than as provided under this Section. A Subscriber desiring to terminate this Policy shall give Blue Shield Life 30 days written notice.

This Policy may be cancelled by Blue Shield Life for false representations to, or concealment of material facts from, Blue Shield Life in any health statement, application, or any written instruction furnished to Blue Shield Life by the Insured at any time before or after issuance of this Policy, or fraud or deception in enrollment. The Policy may also be cancelled if the Subscriber and/or Dependent(s) fail or refuse to provide access to documents and other information that was provided in the application for coverage. Cancellation in such instances shall be effective as of the original Effective Date of coverage, without prior notice to the Subscriber.

Blue Shield Life may terminate this Policy for cause immediately upon written notice for the following:

a. Material information that is false or misrepresented information provided on the enrollment application or given to the Plan;

b. Permitting use of your Insured identification card by someone other than yourself or your Dependents to obtain Services;

c. Obtaining or attempting to obtain Services under this Policy by means of false, materially misleading, or fraudulent information, acts or omissions; or

d. Abusive or disruptive behavior which: (1) threatens the life or well being of Plan personnel and providers of Services; or (2) substantially impairs the ability of Blue Shield Life to arrange for Services to the Insured; or (3) substantially impairs the ability of providers of Service to furnish Services to the Insured or to other patients.

e. Blue Shield Life may terminate this Policy for cause upon thirty (30) days written notice if the Subscriber moves out of California. See the section entitled Transfer of Coverage for additional information.

Blue Shield Life shall, within 31 days of the notice of termination or cancellation, return to the Subscriber the amount of prepaid Premiums, if any, minus any monies paid by Blue Shield Life for Incurred claims that Blue Shield Life determines will not have been earned as of such terminating date. However, Blue Shield Life reserves the right to recoup all payments from the Subscriber for Incurred charges, which exceed the Premiums, paid by the Subscriber, if this Policy is cancelled for fraud or deception.

2. Cancellation of the Policy for Nonpayment of Premiums:
If the Policy is being cancelled because you failed to pay the required Premiums when due, then coverage will end retroactively back to the last day of the month for which Premiums were paid. This retroactive period will not exceed 60 days from the date of mailing of the Notice Confirming Termination of Coverage. The Plan will notify you in a Prospective Notice of Cancellation if your Premiums have not been received. This notice will provide you with the following information:

a. That Premiums due have not been paid and that the Policy will be cancelled if you do not pay the required Premiums within 15 days from the date the Prospective Notice of Cancellation is mailed;

b. The specific date and time when coverage for you and all of your Dependants will end if Premiums are not paid; and

c. Information regarding the consequences of any failure to pay the Premiums within 15 days.

Within five (5) business days of canceling or not renewing the Policy, the Plan will mail you a Notice Confirming Termination of Coverage, which will inform you of the following:

d. That the Policy has been cancelled, and the reasons for cancellation; and

e. The specific date and time when coverage for you and all your Dependents ended; and

f. Information regarding the availability of reinstatement of coverage under the Policy.

3. Reinstatement of the Policy after Cancellation:
If the Policy is cancelled for nonpayment of Premiums, the Plan will permit reinstatement of the Policy or coverage twice during any twelve month period, without a change in Premiums and without consideration of the medical condition of your or any Dependent, if the amounts owed are paid within 15 days of the date the Notice Confirming Termination of Coverages is mailed to you. If your request for reinstatement and payment of all outstanding amounts is not received within the required 15 days, or if the Policy is cancelled more than twice during the preceding twelve month period, then the Plan is not required to reinstate you, and you will need to re-apply for coverage. In this case, the Plan may impose different Premiums and consider the medical condition of you and your Dependent(s).

Transfer of Coverage

1. If a Subscriber moves out of California, coverage under this Policy will terminate. If a Subscriber moves to an area served by another Blue Cross and/or

Blue Shield Plan and notifies Blue Shield Life of his new address, the Subscriber's coverage may be transferred to the plan serving his new address.

2. The new plan must offer the Subscriber at least its group conversion policy. This is a type of policy normally provided to subscribers who leave a group and apply for new coverage as individuals.

3. Conversion policies provide coverage without a medical examination or health statement.

4. If the Subscriber accepts the conversion policy, the new plan will credit the Subscriber for the length of his enrollment in this Plan toward any of the new plan's waiting periods. Any physical or mental conditions covered by this Plan will be covered by the new plan without a new waiting period if the new plan offers this feature to others carrying the same type of coverage.

5. The required dues or Premium amount and benefits available from the new plan may vary significantly from this Plan.

6. In addition, the new plan may offer other types of coverage outside the transfer program, which may:
   a. Require a medical examination or health statement to exclude coverage for pre-existing conditions, and
   b. Not credit the time enrolled in this Plan.

Renewal of the Policy

Blue Shield Life shall renew this Policy, except under the following conditions:

1. Non-payment of Premiums;

2. Fraud, misrepresentation, or omission;

3. Termination of plan type by Blue Shield Life;

4. Subscriber moves out of the service area or the Subscriber is no longer a Resident of California;

5. If a bona fide association arranged for the Subscriber's coverage under this Policy, when that Subscriber's membership in the association ceases.

Maximum Aggregate Payment

The maximum aggregate of benefits payable is as shown in the Summary of Benefits. The maximum aggregate payment amount is determined by totaling all covered benefits provided to you whether you are a Subscriber or a Dependent while covered under this plan or while covered under any prior or subsequent health plan with Blue Shield of California or any of its affiliated companies, including Blue Shield Life. Benefits in excess of this amount are not covered under this plan.

Medical Necessity

Benefits are provided only for Services that are Medically Necessary.

1. Services which are Medically Necessary include only those which have been established as safe and effective, are furnished in accordance with generally accepted professional standards to treat an illness, injury, or medical condition, and which, as determined by the Plan, are:
   a. Consistent with the Plan's medical policy; and
   b. Consistent with the symptoms or diagnosis; and
   c. Not furnished primarily for the convenience of the Insured, the attending Physician or Other Provider; and
   d. Furnished at the most appropriate level which can be provided safely and effectively to the Insured.

2. If there are two (2) or more Medically Necessary services that may be provided for the illness, injury, or medical condition, Blue Shield Life will provide benefits based on the most cost-effective service.

3. Hospital Inpatient Services which are Medically Necessary include only those Services which satisfy the above requirements, require the acute bed-patient (overnight) setting, and which could not have been provided in a Physician's office, the Outpatient department of a Hospital, or in a lesser facility without adversely affecting the Insured's condition or the quality of medical care rendered. Inpatient Services that are not Medically Necessary and are not covered, include hospitalization:

a. For diagnostic studies that could have been provided on an Outpatient basis;

b. For medical observation or evaluation;

c. For personal comfort;

d. In a pain management center to treat or cure chronic pain; and

e. For Inpatient Rehabilitation that can be provided on an Outpatient basis.

4. The Plan reserves the right to review all claims to determine whether services are Medically Necessary, and may use the services of Physician consultants, peer review committees of professional societies or Hospitals, and other consultants.

Second Medical Opinion Policy
If you have a question about your diagnosis, or believe that additional information concerning your condition would be helpful in determining the most appropriate plan of treatment, you may make an appointment with another Physician for a second medical opinion. Your attending Physician may also offer to refer you to another Physician for a second opinion.

Remember that the second opinion visit is subject to all Plan Policy benefit limitations and exclusions. Additionally, please see the section on "Your Vital Shield Plus 400 Generic Rx and How to Use It" regarding advantages from selecting a Preferred Physician for these services.

Utilization Review
State law requires that insurers disclose to Insureds and providers the process used to authorize or deny health care services under the Plan. The Plan has completed documentation of this process ("Utilization Review"), as required under Section 10123.135 of the California Insurance Code. To request a copy of the document describing this Utilization Review process, call the Plan's Customer Service Department at 1-800-431-2809.

Health Education and Health Promotion
Health education and health promotion services provided by Blue Shield Life include the Member Newsletter. Additionally, Blue Shield Life's Internet site is located at http://www.blueshieldca.com. Insureds using a personal computer and modem with World Wide Web access may view and download healthcare information.

Retail-Based Health Clinics
Retail-based health clinics are Outpatient facilities, usually attached or adjacent to retail stores, pharmacies, etc..., which provide limited, basic medical treatment for minor health issues. They are staffed by nurse practitioners under the direction of a Physician and offer services on a walk-in basis. Covered Services received from retail-based health clinics will be paid on the same basis and at the same Benefit levels as other covered Services shown in the Summary of Benefits. Retail-based health clinics may be found in the Preferred Provider Directory or the Online Physician Directory located at http://www.blueshieldca.com. See the Blue Shield Life Preferred Providers section for information on the advantages of choosing a Preferred Provider

NurseHelp 24/7 and LifeReferrals 24/7
NurseHelp 24/7 and LifeReferrals 24/7 programs provide Insured with no charge, confidential, unlimited telephone support for information, consultations, and referrals for health and psychosocial issues. Insured may obtain these services by calling a 24-hour, toll-free telephone number. There is no charge for these services.
These programs include:

NurseHelp 24/7 – Insured may call a registered nurse toll free via 1-877-304-0504, a 24-hours a day, to receive confidential advice and information about minor illnesses and injuries, chronic conditions, fitness, nutrition, and other health related topics.

Psychosocial support through LifeReferrals 24/7 – Insured may call 1-800-985-2405 on an unlimited, 24-hour basis for confidential psychosocial support services. Professional counselors will provide support through assessment, referrals, and counseling. Note: see the sections entitled Preventive Care Services and Mental Health and Substance Abuse Services for important information concerning this feature.

Benefits Management Program

The Plan has established the Benefits Management Program to assist you, your Dependents, or provider in identifying the most appropriate and cost-effective course of treatment for which certain benefits will be provided under this Plan and for determining whether the services are Medically Necessary. However, you, your Dependents, and provider make the final decision concerning treatment. The Benefits Management Program includes: prior authorization for certain Services; emergency admission notification; Hospital Inpatient review; discharge planning; and case management if determined to be applicable and appropriate by the Plan.

Certain portions of the Benefits Management Program also contain Additional and Reduced Payment requirements for either not contacting the Plan or not following the Plan's recommendations. Failure to contact the Plan

for authorization of services listed in the sections below or failure to follow the Plan's recommendations may result in reduced payment or non-payment if the Plan determines the service was not a covered Service. Please read the following sections thoroughly so you understand your responsibilities in reference to the Benefits Management Program. Remember that all provisions of the Benefit Management Program also apply to your Dependents.

The Plan requires prior authorization for selected Inpatient and Outpatient Services, supplies and Durable Medical Equipment; PKU related formulas and Special Food Products; admission into an approved Hospice Program; and for certain radiology procedures. Pre-admission is required review for all Inpatient Hospital and Skilled Nursing Facility Services (except for Emergency Services) and notification for Inpatient Emergency Services [1]. In these situations, you or your provider need to call the Plan as described in the following sections.

[1] See the paragraph entitled Emergency Admission Notification later in this section for notification requirements.

By obtaining prior authorization for certain Services or pre-admission review prior to receiving Services, you and your provider can verify if: (1) the Plan considers the proposed treatment Medically Necessary, (2) if Plan benefits will be provided for the proposed treatment, and (3) if the proposed setting is the most appropriate as determined by the Plan. You and your provider may be informed about Services that could be performed on an Outpatient basis in a Hospital or Outpatient Facility.

Prior Authorization

For services listed in the section below, you or your provider can determine before the service is provided whether a procedure or treatment program is a Covered Service and may also receive a recommendation for an alternative Service. Failure to contact Blue Shield Life as described below or failure to follow the recommendations of Blue Shield Life for Covered Services will result in a reduced payment per procedure as described in the section entitled Additional and Reduced Payments for Failure to Use the Benefits Management Program.

For Services other than those listed in the sections below, you, your Dependents or provider should consult the Principal Benefits and Coverages (Covered Services) section of this booklet to determine whether a service is covered.

You or your Physician must call the Customer Service telephone number as indicated on the back of the Insured's identification card for prior authorization for the Services listed in the section except for the Outpatient radiological procedures.

For prior authorization for these radiological procedures, you or your Physician must call 1-888-642-2583.

The Plan requires prior authorization for the following Services:

1. Admission into an approved Hospice Program as specified under Hospice Program Benefits in the Covered Services section.

2. Clinical Trial for Cancer Benefits.
   Insureds who have been accepted into an approved clinical trial for cancer as described under the Covered Services section must obtain prior authorization from Blue Shield Life in order for the routine patient care delivered in a clinical trial to be covered.

Failure to obtain prior authorization or to follow the recommendations of Blue Shield Life for Hospice Program Benefits or Clinical Trial for Cancer Benefits as above will result in non-payment of Services by Blue Shield Life.

3. Select injectable drugs administered in the physician office setting.*

   * Prior authorization is based on Medical Necessity, appropriateness of therapy, or when effective alternatives are available.

   Note: Your Preferred or Non-Preferred Physician must obtain prior authorization for select injectable drugs administered in the physician's office. Failure to obtain prior authorization or to follow the recommendations of Blue Shield Life for select injectable drugs may result in non-payment by Blue Shield Life if the service is determined not to be a covered Service; in that event you may be financially responsible for services rendered by a Non-Preferred Physician.

4. Home Health Care Benefits from Non-Preferred Providers.

5. Home Infusion/Injectable Therapy Benefits from Non-Preferred Providers.

6. Surgery Services which may be considered to be Cosmetic in nature rather than Reconstructive (e. g. eyelid surgery, rhinoplasty, abdominoplasty, or breast reduction) and those Reconstructive Surgeries which may result in only minimal improvement in function or appearance. The Reconstructive Surgery Benefit

is limited to Medically Necessary surgeries and procedures as described in the section entitled Covered Services.

7. Arthroscopic surgery of the temporomandibular joint (TMJ) Services.

8. Dialysis Services as specified under the Dialysis Center Benefits and Hospital Benefits (Facility Services) in the Covered Services section.

Failure to obtain prior authorization or to follow the recommendations of Blue Shield Life for:

Home Infusion/Home Injectable Therapy Benefits from Non-Preferred Providers;
Cosmetic surgery Services;
Arthroscopic surgery of the TMJ services; and
Dialysis Services

as described above may result in non-payment of Services by Blue Shield Life.

9. PKU Related Formulas and Special Food Products Benefits;

10. The following radiological procedures when performed in an Outpatient setting on a non-emergency basis:

CT (Computerized Tomography) scans;
MRIs (Magnetic Resonance Imaging);
MRAs (Magnetic Resonance Angiography);
PET (Positron Emission Tomography); and
Any cardiac diagnostic procedure utilizing Nuclear Medicine

Prior authorization is not required for these radiological Services when obtained outside of California. See the "Out-of-Area Program: The BlueCard Program" section in this booklet for an explanation of how payment is made for out-of-state Services.

11. Special Transplant Benefits (as specified under Special Transplant Benefits in the Covered Services section).

12. All Bariatric Surgery.

13. Hospital and Skilled Nursing Facility admissions (see the subsequent Hospital and Skilled Nursing Facility section for more information).

14. Outpatient psychiatric Partial Hospitalization and Outpatient electroconvulsive therapy (ECT) Services for the treatment of mental illness.

Failure to obtain prior authorization or to follow the recommendations of Blue Shield Life for:

PKU Related Formulas and Special Food Products;
Outpatient radiological procedures as specified above;
Special Transplant Benefits;
All Bariatric Surgery;
Hospital and Skilled Nursing Facility admissions; and
Outpatient psychiatric Partial Hospitalization and Outpatient ECT Services

as described above will result in reduced payment as described in the Additional and Reduced Payments for Failure to use the Benefits Management Program section or may result in non-payment of services if Blue Shield Life determines that the service is not a covered Service.

Other specific Services and procedures may require prior authorization as determined by Blue Shield Life. A list of Services and procedures requiring prior authorization can be obtained by your provider by going to www.blueshieldca.com or by calling the Customer Service telephone number as indicated on the back of the Insured's identification card.

Pre-admission Review

Hospital and Skilled Nursing Facility Admissions
Prior Authorization must be obtained from Blue Shield Life for all Hospital and Skilled Nursing Facility admissions (except for Admissions required for Emergency Services). Included are Hospitalizations for continuing Inpatient Rehabilitation and skilled nursing care, transplants, bariatric surgery, and Inpatient Mental Health or substance abuse Services described later in this section.

Prior Authorization for Other than Mental Health or Substance Abuse Admissions
Whenever your Physician recommends a Hospital or Skilled Nursing Facility admission, you or your Physician must contact the Plan's Medical Management Unit at 1-800-343-1691 at least five (5) business days prior to the admission. However, in case of an admission for Emergency Services, the Plan must receive Emergency Admission Notification within 24 hours or by the end of the first business day following the admission, or as soon as it is reasonably possible to do so.

Medical Management will discuss the benefits available, review the medical information provided and may rec-

ommend that to obtain the full benefits of this Plan that the Services be performed on an Outpatient basis.

Examples of procedures that may be recommended to be performed on an Outpatient basis if medical conditions do not indicate Inpatient care include:

1. Biopsy of lymph node, deep axillary;
2. Hernia repair, inguinal;
3. Esophagogastroduodenoscopy with biopsy;
4. Excision of ganglion;
5. Repair of tendon;
6. Heart catheterization;
7. Diagnostic bronchoscopy;
8. Creation of arterial venous shunts (for hemodialysis).

Failure to contact Blue Shield Life as described or failure to follow the recommendations of Blue Shield Life will result in an Additional Payment per admission as described in the section entitled Additional and Reduced Payments for Failure to Use the Benefits Management Program or may result in reduction or non-payment if Blue Shield Life determines the admission is not a covered Service [1].

[1] For admission for Special Transplant Benefits and for Bariatric Services for Residents of Designated Counties, failure to receive prior authorization in writing and/or failure to have the procedure performed at a Blue Shield Life designated facility will result in non-payment of services by Blue Shield Life. See the sections entitled Transplant Benefits and Bariatric Surgery Benefits for details.

Prior Authorization for Inpatient Mental Health or Substance Abuse Services, and Outpatient Partial Hospitalization and Outpatient ECT Services

All Inpatient Mental Health and substance abuse Services and Outpatient psychiatric Partial Hospitalization Services, except for Emergency Services, must be prior authorized by the Mental Health Service Administrator (MHSA).

For an admission for Emergency Mental Health or substance abuse Services, the MHSA should receive Emergency Admission Notification within 24 hours or by the end of the first business day following the admission, or as soon as it is reasonably possible to do so, or the Subscriber may be responsible for the Additional Payment as described below.

For prior authorization of Inpatient Mental Health and substance abuse Services and Outpatient psychiatric Partial Hospitalization and Outpatient ECT Services, call the MHSA at 1-877-214-2898.

Failure to contact Blue Shield Life or the MHSA as described above or failure to follow the recommendations of Blue Shield Life will result in an Additional Payment per admission as described in the section entitled Additional and Reduced Payments for Failure to Use the Benefits Management Program and may result in reduction or non-payment if Blue Shield Life or the MHSA determines that the admission is not a covered Service. For Outpatient psychiatric Partial Hospitalization and Outpatient ECT Services, failure to contact Blue Shield or the MHSA as described above or failure to follow the recommendations of Blue Shield will result in non-payment of services by Blue Shield.

Note: Blue Shield Life or the MHSA will render a decision of all requests for prior authorization within five (5) business days from receipt of the request. The treating provider will be notified of the decision within 24 hours followed by written notice to the provider and Subscriber within two (2) business days of the decision. For urgent services in situations in which the routine decision making process might seriously jeopardize the life or health of the Insured or when the Insured is experiencing severe pain, Blue Shield Life will respond as soon as possible to accommodate the Insured's condition not to exceed 72 hours from the receipt of the request.

Emergency Admission Notification

If an Insured is admitted for Emergency Services, the Insured or the attending Physician must notify Blue Shield Life within 24 hours or by the end of the first business day following the admission, or as soon as it is reasonably possible to do so or the first $500 of the Allowable Amount for the Emergency Services will not be covered.

Hospital Inpatient Review

The Plan monitors Inpatient stays. The stay may be extended or reduced as warranted by your condition, except in situations of maternity admissions for which the length of stay is 48 hours or less for a normal, vaginal delivery or 96 hours or less for a Cesarean section unless the attending Physician, in consultation with the mother, determines a shorter Hospital length of stay is adequate. Also, for mastectomies or mastectomies with lymph node dissections, solely your Physician in consultation with you will determine the length of Hospital stays. When a determination is made that the Insured no longer requires

the level of care available only in an Acute Care Hospital, written notification is given to you and your Doctor of Medicine. You will be responsible for any Hospital charges Incurred beyond 24 hours of receipt of notification.

Discharge Planning
If further care at home or in another facility is appropriate following discharge from the Hospital, the Plan will work with the Physician and Hospital discharge planners to determine whether benefits are available under this Plan to cover such care.

Case Management
The Benefits Management Program may also include case management, which provides assistance in making the most efficient use of Plan benefits. Individual case management may also arrange for alternative care benefits in place of prolonged or repeated hospitalizations, when it is determined to be appropriate through a Blue Shield Life review. Such alternative care benefits will be available only by mutual consent of all parties and, if approved, will not exceed the benefit to which you would otherwise have been entitled under this Plan. The Plan is not obligated to provide the same or similar alternative care benefits to any other person in any other instance. The approval of alternative care benefits will be for a specific period of time and will not be construed as a waiver of the Plan's right to thereafter administer this health Plan in strict accordance with its express terms.

Additional and Reduced Payments for Failure to use the Benefits Management Program

For non-emergency services, Additional Payments may be required, or payments may be reduced, as described below, when an Insured fails to follow the procedures described under the sections entitled Prior Authorization and Hospital and Skilled Nursing Facility Admissions of the Benefit Management Program. These Additional Payments will be required in addition to any applicable Calendar Year deductible, Copayment / Coinsurance, and amounts in excess of Benefit dollar maximums specified and will not be included in the calculation of the Insured's Maximum Calendar Year Copayment / Coinsurance responsibility.

1. Failure to contact Blue Shield Life as described in the section entitled Prior Authorization for Other than Mental Health or Substance Abuse Admissions of the Benefits Management Program or failure to follow the recommendations of Medical Management will result in an Additional Payment per Hospital or Skilled Nursing Facility admission as described below or may result in reduction or non-payment if Blue Shield Life determines that the admission is not a covered Service.

   a. The first $500 of the Allowable Amount per admission will not be covered.

2. Failure to contact the MHSA as described in the section entitled Prior Authorization for Mental Health or Substance Abuse, and Outpatient Partial Hospitalization and Outpatient ECT Services of the Benefits Management Program or failure to follow the recommendations of the MHSA will result in an Additional Payment per admission as described below and may also result in reduction or non-payment if the MHSA determines that the admission is not a covered Service.

   a. The first $500 of the Allowable Amount per admission will not be covered.

3. Failure to obtain prior authorization or to follow the recommendations of Blue Shield Life for covered Medically Necessary enteral formulas and Special Food Products for the treatment of phenylketonuria (PKU) will result in a 50% reduction in the amount payable by Blue Shield Life after the calculation of the Calendar Year deductible and any applicable Copayment / Coinsurance required by this Plan. You will be responsible for the applicable Calendar Year deductible, any Copayments / Coinsurance, and the additional 50% of the charges that are payable under this Plan.

4. Failure to obtain prior authorization for the radiological procedures listed in the Benefits Management program section under Prior Authorization or to follow the recommendations of Blue Shield Life will result in Reduced Payment amounts describe below per procedure and may result in non-payment for procedures which are determined not to be covered Services.

   a. For covered Services that are not authorized in advance, the amount payable will be reduced by 50% after the calculation of the deductible and any applicable Copayment / Coinsurance required by this Plan. You will be responsible for the remaining 50% and applicable Calendar Year deductible and any Copayments / Coinsurance.

   b. For Services provided by a Non-Preferred Provider, the Subscriber will also be responsible for all charges in excess of the Allowable Amount.

Deductible

Calendar Year Medical Plan Deductible

This Plan has separate Deductibles for Services rendered by Preferred Providers and for those rendered by Non-Preferred Providers.

The Calendar Year per Insured medical plan deductible amounts are shown in the Summary of Benefits. After the Calendar Year per Insured medical plan deductible is satisfied for those Services to which the appropriate deductible applies, Benefits will be provided for covered Services. The Calendar Year per Insured medical plan deductible amount must be made up of charges covered by the Plan. Charges in excess of the Allowable Amount do not apply toward the deductibles. The medical plan deductible must be satisfied once during each Calendar Year by or on behalf of each Insured separately, except that the medical plan deductible shall be deemed satisfied with respect to the Subscriber and all of his covered Dependents collectively after the Family deductible amount has been satisfied. Note: The Deductible also applies to a newborn child or a child placed for adoption, who is covered for the first 31 days, even if application is not made to add the child as a Dependent on the Plan. The Calendar Year medical plan deductible amount does count toward the Maximum Calendar Year Copayment/Coinsurance responsibility.

Calendar Year Formulary Brand Name Drug Deductible

The Calendar Year per Insured Formulary Brand Name Drug deductible is shown in the Summary of Benefits. After the Calendar Year per Insured Formulary Brand Name Drug deductible is satisfied for those Drugs to which the deductible applies, Benefits will be provided for covered Drugs. The Calendar Year Formulary Brand Name Drug deductible amount is made up of charges covered by the Plan. Charges in excess of the contracted rate do not apply toward the deductible and the deductible must be satisfied once during each Calendar Year by or on behalf of each Insured separately.

The Calendar Year medical deductible applies to all covered Services Incurred during a Calendar Year except for those Services shown in the Summary of Benefits.

Note: The Calendar Year Deductible is separate from the Formulary Brand Name Drug Deductible included in the Outpatient Prescription Drug Benefit.

The Formulary Brand Name Drug Deductible does not count toward the Medical Plan Deductible nor toward the Insured's Maximum Calendar Year Copayment / Coinsurance responsibility.

Payment

The Insured's Copayment and Coinsurance amounts, applicable deductibles, and copayment maximum amounts for covered Services are shown in the Summary of Benefits. The Summary of Benefits also contains information on benefit and Copayment/Coinsurance maximums and restrictions.

Complete benefit descriptions may be found in the Principal Benefits and Coverages (Covered Services) section. Plan exclusions and limitations may be found in the Principal Limitations, Exceptions, Exclusions, and Reductions section.

Out-of-Area Program: The BlueCard® Program

Benefits will be provided, according to paragraphs a., b., and c. below for covered Services received by Subscribers and their eligible Dependent(s) who are temporarily traveling outside of California within the United States. (Temporary traveling is defined as a Subscriber or Dependent(s) who spends in the aggregate not more than 180 days each Calendar Year outside the State of California.) The Plan calculates the Insured's Coinsurance as a percentage of the Allowable Amount, as defined in this Policy. When covered Services are received in another state, the Insured's Copayment and Coinsurance will be based on the local Blue Cross Blue and/or Shield plan's arrangement with its providers.

a. Covered Services received from a Provider who has contracted with the local Blue Cross and/or Blue Shield plan are paid at the Preferred Provider level. Insureds are responsible for the remaining Copayment and Coinsurance.

b. Non-emergency covered Services received from providers who have not contracted with the local Blue Cross and/or Blue Shield plan are paid at the Non-Preferred level of the local Blue Cross and/or Blue Shield plan's Allowable Amount. Insureds are responsible for the remaining Copayment and Coinsurance as well as any charges in excess of the local Blue Cross and/or Blue Shield plan's Allowable Amount.

c. Emergency Services received from providers who have not contracted with the local Blue Cross and/or Blue Shield plan are paid at the Preferred Provider level of billed charges, except that services of physicians and hospitals are paid based on the Allowable Amount. Insureds are responsible for the remaining Copayment and Coinsurance.

If you do not see a Participating Provider through the BlueCard Program, you will have to pay for the entire bill for your medical care and submit a claim to the local Blue Cross and/or Blue Shield plan or to Blue Shield Life for payment. Blue Shield Life will notify you of its determination within thirty (30) days after the receipt of the claim. Blue Shield Life will pay you at the Non-Preferred Provider benefit level. Remember that your Copayment is higher when you see a Non-Preferred Provider. You will be responsible for paying the entire difference between the amount paid by Blue Shield Life and the amount billed.

Charges for Services which are not covered, and charges by Non-Preferred Providers in excess of the amount covered by the plan, are the Insured's responsibility and are not included in Copayment and Coinsurance calculations.

To receive the maximum benefits of your plan, please follow the procedure below.

When you require covered Services while temporarily traveling outside of California:

1. call *BlueCard Access*® at 1-800-810-BLUE (2583) to locate physicians and hospitals that participate with the local Blue Cross and/or Blue Shield plan, or go on-line at www.bcbs.com and select the "Find a Doctor or Hospital" tab; and,

2. visit the participating physician or hospital and present your membership card.

The participating physician or hospital will verify your eligibility and coverage information by calling *BlueCard Eligibility* at 1-800-676-BLUE. Once verified and after Services are provided, a claim is submitted electronically and the participating physician or hospital is paid directly. You may be asked to pay for your applicable Copayment, Coinsurance, and plan deductible at the time you receive the service.

You will receive an Explanation of Benefits, which will show your payment responsibility. You are responsible for the Copayment, Coinsurance, and plan deductible amounts shown in the Explanation of Benefits.

Pre-admission review is required for all inpatient hospital services and notification is required for inpatient emergency services. Prior Authorization is required for selected inpatient and outpatient services, supplies, and durable medical equipment. To receive pre-admission review from Blue Shield Life, the out-of-area provider should call the Customer Service telephone number as indicated on the back of the Insured's identification card.

If you need Emergency Services, you should seek immediate care from the nearest medical facility. The benefits of this plan will be provided for covered Services received anywhere in the world for the emergency care of an illness or injury.

Care for Covered Urgent Care and Emergency Services outside the United States

Benefits will also be provided for covered Services received while temporarily traveling outside of the United States through the BlueCard Worldwide® Network. If you need urgent care while out of the country, call either the toll-free *BlueCard Access* number at 1-800-810-2583 or call collect at 1-804-673-1177, 24 hours a day, seven days a week. In an emergency, go directly to the nearest hospital. If your coverage requires pre-certification or prior authorization, you should call Blue Shield Life at the Customer Service telephone number as indicated on the back of the Insured's identification card. For inpatient hospital care at participating hospitals, show your I.D. card to the hospital staff upon arrival. You are responsible for the usual out-of-pocket expenses (non-covered charges, deductibles, Coinsurance, and Copayments).

When you receive services from a physician, you will have to pay the doctor and then submit a claim. Also for inpatient hospitalization, if you do not use the BlueCard Worldwide Network, you will have to pay the entire bill for your medical care and submit a claim form (with a copy of the bill) to Blue Shield Life.

Before traveling abroad, call your local Customer Service office for the most current listing of participating hospitals world-wide or you can go on-line at www.bcbs.com and select "Find a Doctor or Hospital".

Calculation of your deductibles, Coinsurance, Copayments, and Copayment maximum responsibilities under the BlueCard Program:

When you obtain health care services through the BlueCard Program outside of California, the amount you pay for covered services is calculated on the lower of:

1. the Allowable Amount for your covered services, or

2. the negotiated price that the local Blue Cross and/or Blue Shield plan passes on to us.

Often, this "negotiated price" will consist of a simple discount, which reflects the actual price paid by the local Blue Cross and/or Blue Shield plan. But sometimes it is

an estimated price that factors into the actual price expected settlements, withholds, any other contingent payment arrangements and non-claims transactions with your health care provider or with a specified group of providers. The negotiated price may also be billed charges reduced to reflect an average expected saving with your health care provider or with a specified group of providers. The price that reflects average savings may result in greater variation (more or less) from the actual price paid than will the estimated price. The negotiated price will also be adjusted in the future to correct for over- or underestimation of past prices. However, the amount you pay is considered a final price.

Statutes in a small number of states may require the local Blue Cross and/or Blue Shield plan to use a basis for calculating Insured liability for covered Services that does not reflect the entire savings realized or expected to be realized on a particular claim or to add a surcharge. Should any state statutes mandate Insured liability calculation methods that differ from the usual BlueCard Program method noted above or require a surcharge, Blue Shield Life would then calculate your liability for any covered health care services in accordance with the applicable state statute in effect at the time you received your care.

For any other providers, the amount pay, if not subject to a flat dollar copayment, is calculated on the Allowable Amount for your covered services.

Maximum per Insured Calendar Year Copayment/Coinsurance Responsibility

1. The per Insured and Family maximum Copayment/Coinsurance responsibility each Calendar Year for covered Services rendered by Preferred Providers, MHSA Participating Providers, and Other Providers is show in the Summary of Benefits.

2. The per Insured and Family maximum Copayment/Coinsurance responsibility each Calendar Year for covered Services rendered by any combination of Preferred Providers, Non-Preferred Providers, MHSA Participating and Non-Participating Providers, and Other Providers is shown in the Summary of Benefits.

Once an Insured's maximum responsibility has been met *, the Plan will pay 100% of the Allowable Amount fro that Insured's covered Services for the remainder of the Calendar Year, except as described below. Once the Family maximum responsibility has been met *, the Plan will pay 100% of the Allowable Amount for the Subscriber's and all covered Dependents' covered Services for the remainder of that Calendar Year, except as noted below.

* Note: Certain Services and amounts are not included in the calculation of the Maximum Calendar Year Copayment/Coinsurance. These are items shown in the Summary of Benefits.

Charges for these items may cause an Insured's payment responsibility to exceed the maximums.

Copayments, Coinsurance, and charges for Services not accruing to the Insured's maximum Calendar Year Copayment/Coinsurance Responsibility continue to be the Insured's responsibility after the Calendar Year Copayment/Coinsurance Maximum is reached.

Principal Benefits and Coverages (Covered Services)

Benefits are provided for the following Medically Necessary covered Services, subject to the applicable deductibles, Copayments and Coinsurance, and charges in excess of the Benefit maximums, Preferred Provider provisions, and Benefits Management Program provisions. Coverage for these Services is subject to all terms, conditions, limitations and exclusions of the Policy, to any conditions or limitations set forth in the benefit descriptions below, and to the Principal Limitations, Exceptions, Exclusions, and Reductions listed in this Policy.

The Copayments and Coinsurance, if applicable, are shown in the Summary of Benefits.

Note: Except as may be specifically indicated, for Services received from Non- Preferred and Non-Participating Providers, Insureds will be responsible for all charges above the Allowable Amount in addition to the indicated dollar or percentage Insured Copayment.

Except as specifically provided herein, services are covered only when rendered by an individual or entity that is licensed or certified by the state to provide health care services and is operating within the scope of that license or certification.

Ambulance Benefits

Benefits are provided for (1) Medically Necessary ambulance Services (surface and air) when used to transport an Insured from place of illness or injury to the closest medical facility where appropriate treatment can be received, or (2) Medically Necessary ambulance transportation from one medical facility to another.

Ambulatory Surgery Center Benefits

Ambulatory surgery Services means surgery which does not require admission to a Hospital (or similar facility) as a registered bed patient.

Outpatient Services including general anesthesia and associated facility charges in connection with dental procedures are covered when performed in an Ambulatory Surgery Center because of an underlying medical condition or clinical status and the Insured is under the age of seven or developmentally disabled regardless of age or when the Insured's health is compromised and for whom general anesthesia is Medically Necessary regardless of age. This Benefit excludes dental procedures and Services of a dentist or oral surgeon.

Note: Reconstructive Surgery and associated covered Services are only covered when determined by the Plan to be Medically Necessary and only to correct or repair abnormal structures of the body which result in more than a minima improvement in function or appearance. In accordance with the Woman's Health & Cancer Rights Act, Reconstructive Surgery on either breast provided to restore and achieve symmetry incident to a mastectomy including treatment of physical complications of a mastectomy and lymphedemas is covered. For coverage of prosthetic devices incident to a mastectomy, see Reconstructive Surgery under Professional (Physician) Benefits. Any such Services must be received while the Policy is in force with respect to the Insured. Benefits will be provided in accordance with guidelines established by the Plan and developed in conjunction with plastic and reconstructive surgeons.

No benefits will be provided for the following surgeries or procedures unless determined by the Plan to be Medically Necessary to correct or repair abnormal structures of the body caused by congenital defects, developmental abnormalities, trauma, infection, tumors, or disease, and which will result in more than minimal improvement in function or appearance:

- Surgery to excise, enlarge, reduce, or change the appearance of any part of the body;
- Surgery to reform or reshape skin or bone;
- Surgery to excise or reduce skin or connective tissue that is loose , wrinkled, sagging, or excessive on any part of the body;
- Hair transplantation; and
- Upper eyelid blepharoplasty without documented significant visual impairment or symptomatology.

This limitation shall not apply when breast reconstruction is performed subsequent to a Medically Necessary Mastectomy, including surgery on either breast to achieve or restore symmetry.

Bariatric Surgery Benefits
Benefits are provided for Hospital and professional Services in connection with Medically Necessary bariatric surgery to treat morbid or clinically severe obesity as described below.

All bariatric surgery services must be prior authorized, in writing, by Blue Shield Life's Medical Director. Prior authorization is required for all Persons, whether residents of a designated or non-designated county.

Services for Residents of Designated Counties in California
For Insureds who reside in a California county designated * as having facilities contracting with Blue Shield Life to provide bariatric Services, Blue Shield Life will provide Benefits for certain Medically Necessary bariatric surgery procedures only if:

1. Services are performed at a Preferred Bariatric Surgery Services Hospital and by a Preferred Bariatric Surgery Services Physician that have contracted with Blue Shield Life to provide the procedure; and
2. Services are consistent with Blue Shield Life's medical policy; and
3. Prior authorization is obtained, in writing, from Blue Shield Life's Medical Director.

* See the list of designated counties below.

The Plan reserves the right to review all requests for prior authorization for these bariatric benefits and to make a decision regarding benefits and to make a decision regarding benefits based on a) the medical circumstances of each patient, and b) consistency between the treatment proposed and the Plan's medical policy.

For Insureds who reside in a designated county, failure to obtain prior written authorization as described above and/or failure to have the procedure performed at a Preferred Bariatric Surgery Services Hospital by a Preferred Bariatric Surgery Services Physician will result in denial of claims for this benefit.

The following are designated counties in which the Plan has contracted with facilities to provide bariatric Services:

Imperial	San Bernardino
Kern	San Diego

Los Angeles	Santa Barbara
Orange	Ventura
Riverside	

Bariatric Travel Expenses Reimbursement for Residents of Designated Counties in California
Insureds who reside in designated counties and who have obtained written authorization from Blue Shield Life to receive bariatric Services at a Preferred Bariatric Surgery Services Hospital may be eligible to receive reimbursement for associated travel expenses.

To be eligible to receive travel expense reimbursement, the Insured's home must be 50 or more miles from the nearest Preferred Bariatric Surgery Services Hospital. All requests for travel expense reimbursement must be prior approved by Blue Shield Life. Approved travel-related expenses will be reimbursed as follows:

1. Transportation to and from the facility up to a maximum of $130 per trip:
   a. For the Person for a maximum of three (3) trips;
      i. One (1) trip for a pre-surgical visit,
      ii. One (1) trip for the surgery, and
      iii. One (1) trip for a follow-up visit.
   b. For one (1) companion for a maximum of two (2) trips;
      i. One (1) trip for the surgery, and
      ii. One (1) trip for a follow-up visit.

2. Hotel accommodations not to exceed $100 per day:
   a. For the Person and one (1) companion for a maximum of two (2) days per trip,
      i. One (1) trip for a pre-surgical visit, and
      ii. One (1) trip for a follow-up visit.

   b. For one (1) companion for a maximum of four (4) days for the duration of the surgery admission.

   All hotel accommodation is limited to one (1), double-occupancy room. Expenses for in-room and other hotel services are specifically excluded.

3. Related expenses judged reasonable by Blue Shield Life not to exceed $25 per day per Person up to a maximum of four (4) days per trip. Expenses for tobacco, alcohol, drugs, telephone, television, delivery, and recreation are specifically excluded.

Submission of adequate documentation including receipts is required before reimbursement will be made.

Covered bariatric travel expenses are not subject to the Calendar Year deductible and do not accrue to the maximum Calendar Year Copayment responsibility.

Note: bariatric surgery Services for residents of non-designated counties will be paid as any other surgery as described elsewhere in this section when:

1. Services are consistent with the Plan's medical policy; and,
2. Prior authorization is obtained, in writing, from the Plan's Medical Director.

For Insureds who reside in non-designated counties, travel expenses associated with bariatric surgery Services are not covered.

Benefits are limited to a per Insured, per Calendar Year maximum as shown in the Summary of Benefits.

Clinical Trial for Cancer Benefits
Benefits are provided for routine patient care for Persons who have been accepted into an approved clinical trial for cancer when prior authorized by Blue Shield Life, and:

1. The clinical trial has a therapeutic intent and the Insured's treating Physician determines that Participation in the clinical trial has a meaningful potential to benefit the Person with a therapeutic intent; and

2. The Insured's treating Physician recommends participation in the clinical trial; and

3. The Hospital and/or Physician conducting the clinical trial is a Participating Provider, unless the protocol for the trial is not available through a Participating Provider.

Services for routine patient care will be paid on the same basis and at the same benefit levels as other covered Services shown in the Covered Services section.

Routine patient care consists of those Services that would otherwise be covered by the Plan if those Services were not provided in connection with an approved clinical trial, but does not include:

1. Drugs or devices that have not been approved by the federal Food and Drug Administration (FDA);

2. Services other than health care services, such as travel, housing, companion expenses and other non-clinical expenses;

3. Any item or service that is provided solely to satisfy data collection and analysis needs and that is not used in the clinical management of the Insured;

4. Services that, except for the fact that they are being provided in a clinical trial, are specifically excluded under the Plan; or

5. Services customarily provided by the research sponsor free of charge for any enrollee in the trial.

An approved clinical trial is limited to a trial that is approved by one of the following:

1. One of the National Institutes of Health;

2. The federal Food and Drug Administration (FDA), in the form of an investigational new drug application;

3. The United States Department of Defense;

4. The United States Department of Veterans Affairs; or

5. Involves a drug that is exempt under federal regulations from a new drug application.

Diabetes Care Benefits
Diabetes Equipment
Benefits are provided for the following devices, equipment, and supplies, including replacement after the expected life of the item and when Medically Necessary, for the management and treatment of diabetes when Medically Necessary:

a. Blood glucose monitors, including those designed to assist the visually impaired;

b. Insulin pumps and all related necessary supplies;

c. Podiatric devices to prevent or treat diabetes-related complications, including extra-depth orthopedic shoes;

d. Visual aids, excluding eyewear, and/or video-assisted devices, designed to assist the visually impaired with proper dosing of Insulin.

For coverage of diabetic testing supplies including blood and/or urine testing strips or tablets, lancets and lancet puncture devices and pen delivery systems for the administration of Insulin, refer to the section entitled Outpatient Prescription Drugs.

Diabetes Outpatient Self-Management Training

Benefits are provided for diabetes Outpatient self-management training, education and medical nutrition therapy that is Medically Necessary to enable an Insured to properly use the devices, equipment and supplies, and any additional Outpatient self-management training, education and medical nutrition therapy when directed or prescribed by the Person's Physician. Services will be covered when provided by Physicians, registered dieticians, or registered nurses that are certified diabetes educators.

Dialysis Benefits
Benefits are provided for Medically Necessary dialysis Services, including renal dialysis, hemodialysis, peritoneal dialysis, and related procedures.
Included in this Benefit are Medically Necessary dialysis related laboratory tests, equipment, medications, supplies, and dialysis self-management training for home dialysis.

Note: Prior Authorization by Blue Shield Life is required for all dialysis services. See the section entitled Benefit Management Program for additional information.

Emergency Room Benefits
Benefits are provided for Medically Necessary Services provided in the Emergency Room of a Hospital.

Note: Emergency Room Services resulting in an admission to a Non-Preferred Hospital which the Plan determines are not emergencies will be paid as part of the Inpatient Hospital Services. The Insured Copayment/Coinsurance for non-emergency Inpatient Hospital Services from a Non-Preferred Hospital is shown in the Summary of Benefits.

For Emergency Room Services directly resulting in an admission to a different Hospital, the Insured is responsible for the emergency room Insured Copayment/Coinsurance plus the appropriate admitting Hospital Services Insured Copayment/Coinsurance as shown in the Summary of Benefits.

Family Planning Benefits
Benefits are provided for the following Family Planning Services without illness or injury being present.

Note: No benefits are provided for Family Planning Services from Non-Participating Providers.

1. Family planning counseling and consultation Services, including Physician office visits for diaphragm fittings;

2. Injectable contraceptives when administered by a Physician;

3. Voluntary sterilization (tubal ligation and vasectomy) and elective abortions. No benefits are provided for contraceptives, except as may be provided under the Outpatient Prescription Drug Benefit section.

Home Health Care Benefits
Benefits are provided for home health care Services when the Services are Medically Necessary, ordered by an attending Physician, and included in a written treatment plan.

Services by a Non-Participating Home Health Care Agency, shift care, private duty nursing, and stand-alone health aide services must by prior authorized by Blue Shield Life.

Covered Services are subject to any applicable Deductible, Copayments, and Coinsurance. Visits by home health care agency providers will be payable up to a combined per Insured, per Calendar Year visit maximum as shown in the Summary of Benefits.

Intermittent and part-time visits by a home health agency to provide Skilled Nursing and other skilled Services are covered up to 4 visits per day, 2 hours per visit not to exceed 8 hours per day by any of the following professional providers:

1. Registered nurse;

2. Licensed vocational nurse;

3. Physical therapist, Occupational therapist, or Speech therapist;

4. Certified home health aide in conjunction with the services of 1, 2 or 3 above;
5. Medical social worker.

For the purposes of this Benefit, visits from home health aides of 4 hours or less shall be considered 1 visit.

In conjunction with professional Services by a home health agency, medical supplies used during covered visits by home health agency necessary for the home health care treatment plan and related laboratory Services are covered to the extent the Benefits would have been provided had the Insured remained in the Hospital or Skilled Nursing Facility.

This Benefit does not include medications, drugs, or injectables covered under the Home Infusion/Home Injectable Therapy Benefits or under the supplemental Benefit for Outpatient Prescription Drugs.

Skilled Nursing Services are defined as a level of care that includes services that can only be preformed safely and correctly by a licensed nurse (either a registered nurse or a licensed vocational nurse).

(Note: See the Hospice Program Services Benefits section for information about when an Insured is admitted into a Hospice Program and a specialized description of Skilled Nursing Services for hospice care.)

Note: For information concerning diabetes self-management training, see the Diabetes Care Benefits section.

Home Infusion / Home Injectable Therapy Benefits
Benefits are provided for home infusion and IV injectable therapy, including home infusion agency Skilled Nursing visits, parenteral nutrition Services, enteral nutrition Services and associated supplements, medical supplies used during a covered visit, pharmaceuticals administered intravenously, related laboratory Services and for Medically Necessary FDA approved injectable medications when prescribed by a Doctor of Medicine and provided by a home infusion agency.

Covered Services are subject to any applicable Deductible, Copayments, and Coinsurance. Visits by home infusion/injectable agency providers will be payable up to a combined per Insured, per Calendar Year visit maximum as shown in the Summary of Benefits.

This Benefit does not include medications, drugs, Insulin, disposable Insulin syringes, and certain Home Self-Administered Injectables covered under the Outpatient Prescription Drug Benefit section.

Skilled Nursing Services are defined as a level of care that includes services that can only be performed safely and correctly by a licensed nurse (either a registered nurse or a licensed vocational nurse).

Note: Benefits are also provided for infusion therapy provided in infusion suites associated with a Participating Home Infusion Agency.

Note: Services rendered by Non-Participating Home Health Care and Home Infusion agencies must be prior authorized by Blue Shield Life.

Hospice Program Benefits
Benefits are provided for the following Services through a Participating Hospice Agency when an eligible Insured requests admission to and is formally admitted to an approved Hospice Program. The Insured must have a Ter-

minal Illness as determined by their Physician's certification and the admission must receive prior approval from the Plan. (Note: Insured with a Terminal Illness who have not elected to enroll in a Hospice Program can receive a pre-hospice consultative visit from a Participating Hospice Agency.) Covered Services are available on a 24-hour basis to the extent necessary to meet the needs of individuals for care that is reasonable and necessary for the palliation and management of Terminal Illness and related conditions. Insureds can continue to receive covered Services that are not related to the palliation and management of the Terminal Illness from the appropriate provider. Note: hospice services provided by a Non-Participating hospice agency are not covered except in certain circumstances in counties in California in which there are no Participating Hospice Agencies and only when authorized by Blue Shield Life.

All of the Services listed below must be received through a Participating Hospice Agency.

1. Pre-hospice consultative visit regarding pain and symptom management, hospice, and other care options including care planning (Persons do not have to be enrolled in the Hospice Program to receive this Benefit).
2. Interdisciplinary Team care with development and maintenance of an appropriate Plan of Care and management of Terminal Illness and related conditions.
3. Skilled Nursing Services, certified health aide Services, and homemaker Services under the supervision of a qualified registered nurse.
4. Bereavement Services.
5. Social Services / Counseling Services with medical social services provided by a qualified social worker. Dietary counseling, by a qualified provider, shall also be provided when needed.
6. Medical Direction with the medical director being also responsible for meeting the general medical needs for the Terminal Illness of the Insured to the extent that these needs are not met by the Insured's other providers.
7. Volunteer Services.
8. Short-term Inpatient care arrangements.
9. Pharmaceuticals, medical equipment, and supplies that are reasonable and necessary for the palliation and management of Terminal Illness and related conditions.
10. Physical therapy, occupational therapy, and speech-language pathology Services for purposes of symptom control, or to enable the enrollee to maintain activities of daily living and basic functional skills.
11. Nursing care Services that are covered on a continuous basis for as much as 24-hours a day during Periods of Crisis as necessary to maintain a Insured at home. Hospitalization is covered when the Interdisciplinary Team makes the determination that skilled nursing care is required at a level that cannot be provided in the home. Either Homemaker Services or Home Health Aide Services or both, may be covered on a 24-hour continuous basis during Periods of Crisis but the care provided during these periods must be predominantly nursing care.
12. Respite Care Services are limited to an occasional basis and to no more than five consecutive days at a time.

Insureds are allowed to change their Participating Hospice Agency only once during each Period of Care. Persons can receive care for two 90-day periods followed by an unlimited number of 60-day periods. The care continues through another Period of Care if the Participating Provider recertifies that the Insured is Terminally Ill.

Definitions:

Bereavement Services – services available to the immediate surviving family members for a period of at least one (1) year after the death of the Insured These services shall include an assessment of the needs of the bereaved family and the development of a care plan that meets these needs, both prior to, and following the death of the Insured.

Continuous Home Care – home care provided during a Period of Crisis. A minimum of eight (8) hours of continuous care, during the 24-hour day, beginning and ending at midnight is required. This care could be four (4) hours in the morning and another four (4) hours in the evening. Nursing care must be provided for more than half of the period of care and must be provided by either a registered nurse or licensed practical nurse. Homemaker Services or Home Health Aide Services may be provided to supplement the nursing care. When fewer than eight (8) hours of nursing care are required, the services are covered as routine home care rather than Continuous Home Care.

Home Health Aide Services - services providing for the personal care of the Terminally Ill Insured and the performance of related tasks in the Insured's home in accordance with the Plan of Care in order to increase the level

of comfort and to maintain personal hygiene and a safe, healthy environment for the patient. Home Health Aide Services shall be provided by a person who is certified by the state Department of Health Services as a home health aide pursuant to Chapter 8 of Division 2 of the Health and Safety Code.

Homemaker Services – services that assist in the maintenance of a safe and healthy environment and services to enable the Insured to carry out the treatment plan.

Hospice Service or Hospice Program – a specialized form of interdisciplinary health care that is designed to provide palliative care, alleviate the physician, emotional, social, and spiritual discomforts of a Insured who is experiencing the last phases of life due to the existence of a Terminal Disease, to provide supportive care to the primary caregiver and the family of the hospice patient, and which meets all of the following criteria:

a. Considers the Insured and the Insured's family in addition of the Insured, as the unit of care.

b. Utilizes and Interdisciplinary Team to assess the physical, medical, psychological, and social and spiritual needs of the Insured and their family.

c. Requires the Interdisciplinary Team to develop an overall Plan of Care and to provide coordinated care which emphasizes supportive Services, including, but not limited to, home care, pain control, and short-term Inpatient Services. Short-term Inpatient Services are intended to ensure both continuity of care and appropriateness of services for those Persons who cannot be managed at home because of acute complications or the temporary absence of a capable primary caregiver.

d. Provides for the palliative medical treatment of pain and other symptoms associated with a Terminal Disease, but does not provide for efforts to cure the disease.

e. Provides for Bereavement Services following the Insured's death to assist the family to cope with social and emotional needs associated with the death.

f. Actively utilizes volunteers in the delivery of Hospice Services

g. Provides Services in the Insured's home or primary place of residence to the extent appropriate based on the medical needs of the Insured.

h. Is provided through a Participating Hospice.

Interdisciplinary Team – the hospice care team that includes, but is not limited to, the Insured and their family, a physician and surgeon, a registered nurse, a social worker, a volunteer, and a spiritual caregiver.

Medical Direction – Services provided by a licensed physician and surgeon who is charged with the responsibility of acting as a consultant to the Interdisciplinary Team, a consultant to the Insured's Participating Provider, as requested, with regard to pain and symptom management, and liaison with physicians and surgeons in the community. For purposes of this section, the person providing these Services shall be referred to as the "medical director".

Period of Care – the time when the Participating Provider recertifies that the Insured still needs and remains eligible for hospice care even if the Insured lives longer than one (1) year. A Period of Care starts the day the Insured begins to receive hospice care and ends when the 90 or 60-day period has ended.

Period of Crisis – a period in which the Insured requires continuous care to achieve palliation or management of acute medical symptoms.

Plan of Care – a written plan developed by the attending physician and surgeon, the "medical director" (as defined under "Medical Direction") or physician and surgeon designee, and the Interdisciplinary Team that addresses the needs of an Insured and family admitted to the Hospice Program. The Hospice shall retain overall responsibility for the development and maintenance of the Plan of Care and quality of Services delivered.

Respite Care Services – short-term Inpatient care provided to the Insured only when necessary to relieve the family members or other persons caring for the Insured.

Skilled Nursing Services – nursing Services provided by or under the supervision of a registered nurse under a Plan of Care developed by the Interdisciplinary Team and the Insured's provider to the Insured and his family that pertain to the palliative, supportive services required by the Insured with a Terminal Illness. Skilled Nursing Services include, but are not limited to, Subscriber or Dependent assessment, evaluation, and case management of the medical nursing needs of the Insured, the performance of prescribed medical treatment for pain and symptom control, the provision of emotional support to both the Insured and his family, and the instruction of caregivers in providing personal care to the enrollee. Skilled Nursing Services provide for the continuity of Services for the Insured and his family and are available on a 24-hour on-call basis.

Social Service / Counseling Services – those counseling and spiritual Services that assist the Insured and his family to minimize stresses and problems that arise from social, economic, psychological, or spiritual needs by utilization appropriate community resources, and maximize positive aspects and opportunity for growth.

Terminal Disease or Terminal Illness – a medical condition resulting in a prognosis of life of one (1) year or less, if the disease follows its natural course.

Volunteer Services – services provided by trained hospice volunteers who have agreed to provide service under the direction of a hospice staff member who has been designated by the Hospice to provide direction to hospice volunteers. Hospice volunteers may provide support and companionship to the Insured and his family during the remaining days of the Insured's life and to the surviving family following the Insured's death.

Hospital Care Benefits (Facility Services)
Other than Mental Health Services & substance abuse care, Skilled Nursing Facility Services, and Hospice Program Services which are described n subsequent sections.

Inpatient Services for Treatment of Illness or Injury

1. Any accommodation up to the Hospital's established semi-private room rate, or, if Medically Necessary as certified by a Doctor of Medicine, the intensive care unit.

2. Benefits are provided for Services required to treat involuntary Complications of Pregnancy on the Insured's Effective Date of coverage. Complications of Pregnancy include, but are not limited to, Medically Necessary Cesarean Section, miscarriage, toxemia of pregnancy (preeclampsia and eclampsia), hyperemesis gravidarum, ectopic (tubal or extra-uterine) pregnancy, nephritis or pyelitis of pregnancy, placenta abruptio or puerperal infection.

   Emergency Services and Complications of Pregnancy are paid just as any other illness.

   No benefits are provided for services subsequent to termination of coverage under this Policy.

3. Use of operating room and specialized treatment rooms.

4. Reconstructive Surgery and associated covered Services when determined by the Plan to be Medically Necessary and only to correct or repair abnormal structures of the body and which result in more than a minimal improvement in function or appearance. In accordance with the Women's Health & Cancer Rights Act, Reconstructive Surgery on either breast provided to repair and achieve symmetry incident to a mastectomy including treatment of physical complications of a mastectomy and lymphedemas is covered. For coverage of prosthetic devices incident to a mastectomy, see Reconstructive Surgery under Professional (Physician) Benefits. Any such Services must be received while the Policy is in force with respect to the Insured. Benefits will be provided in accordance with guidelines established by the Plan and developed in conjunction with plastic and reconstructive surgeons.

   No benefits will be provided for the following surgeries or procedures unless determined by the Plan to be Medically Necessary to correct or repair abnormal structures of the body caused by congenital defects, developmental abnormalities, trauma, infection, tumors, or disease, and which will result in more than minimal improvement in function or appearance:

   - Surgery to excise, enlarge, reduce or change the appearance of any part of the body;
   - Surgery to reform or reshape skin or bone;
   - Surgery to excise or reduce skin or connective tissue that is loose, wrinkled, sagging, or excessive on any part of the body;
   - Hair transplantation; and
   - Upper eyelid blepharoplasty without documented significant visual impairment of symptomatology.

   This limitation shall not apply when breast reconstruction is performed subsequent to a Medically Necessary mastectomy, including surgery on either breast to achieve or restore symmetry.

5. Surgical supplies, dressings and cast materials, and anesthetic supplies furnished by the Hospital

6. Rehabilitation when furnished by the Hospital, and Rehabilitative Care when furnished by the Hospital and approved in advance by the Plan under its Benefits Management Program.

7. Drugs and oxygen.

8. Administration of blood and blood plasma, including the cost of blood, blood plasma, and blood processing.

9. X-Ray examination and laboratory tests.

10. Radiation therapy and chemotherapy for cancer including catheterization, infusion devices, and associated drugs and supplies.

11. Use of medical appliances and equipment.

12. Subacute Care.

13. Inpatient Services including general anesthesia and associated facility charges in connection with dental procedures when hospitalization is required because of an underlying medical condition or clinical status and the Insured in under the age of seven or developmentally disables regardless of age or when the Insured's health is compromised ad for whom general anesthesia is Medically Necessary regardless of age. Excludes dental procedures and Services of a dentist or oral surgeon.

14. Medically Necessary Inpatient substance abuse detoxification Services required to treat potentially life-threatening symptoms of acute toxicity or acute withdrawal are covered when an Insured is admitted through the emergency room, or when Medically Necessary Inpatient substance abuse detoxification is prior authorized by the Plan.

Outpatient Services for Treatment of Illness or Injury or for Surgery

1. Medically Necessary Services provided in the Outpatient Facility of a Hospital.

2. Outpatient care provided by the admitting Hospital within 24 hours before admission, when care is related to the condition for which Inpatient admission was made.

3. Radiation therapy and chemotherapy for cancer, including catheterization, infusion devices, and associated drugs and supplies.

4. Reconstructive Surgery and associated covered Services when determined by the Plan to be Medically Necessary and only to correct or repair abnormal structures of the body and which result in more than a minimal improvement in function or appearance. In accordance with the Women's Health & Cancer Rights Act, Reconstructive Surgery on either breast provided to repair and achieve symmetry incident to a mastectomy including treatment of physical complications of a mastectomy and lymphedemas is covered. For coverage of prosthetic devices incident to a mastectomy, see Reconstructive Surgery under Professional (Physician) Benefits. Any such Services must be received while the Policy is in force with respect to the Insured. Benefits will be provided in accordance with guidelines established by the Plan and developed in conjunction with plastic and reconstructive surgeons.

   No benefits will be provided for the following surgeries or procedures unless determined by the Plan to be Medically Necessary to correct or repair abnormal structures of the body caused by congenital defects, developmental abnormalities, trauma, infection, tumors, or disease, and which will result in more than minimal improvement in function or appearance:

   - Surgery to excise, enlarge, reduce or change the appearance of any part of the body;
   - Surgery to reform or reshape skin or bone;
   - Surgery to excise or reduce skin or connective tissue that is loose, wrinkled, sagging, or excessive on any part of the body;
   - Hair transplantation; and
   - Upper eyelid blepharoplasty without documented significant visual impairment of symptomatology.

   This limitation shall not apply when breast reconstruction is performed subsequent to a Medically Necessary mastectomy, including surgery on either breast to achieve or restore symmetry.

5. Outpatient Services including general anesthesia and associated facility charges in connection with dental procedures when performed in the Outpatient Facility of a Hospital because of an underlying medical condition or clinical status and the Insured is under age of seven or developmentally disabled regardless of age or when the Insured's health is compromised and for whom general anesthesia is Medically Necessary regardless of age. Excludes dental procedures and Services of a dentist or oral surgeon.

Covered lab and X-Ray Services provided in an Outpatient Hospital setting are paid as descried under the Outpatient/Out-of-Hospital X-Ray, Pathology, and Laboratory Benefits, Outpatient Rehabilitation Benefits, and Speech Therapy Benefits sections.

Medical Treatment of the Teeth, Gums, Jaw Joints, or Jaw Bones Benefits

Benefits are provided for Hospital and professional Services for conditions of the teeth, gums, or jaw joints and jaw bones including adjacent tissues only to the extent that they are provided for:

1. The treatment of tumors of the gums;

2. The treatment of damage to the natural teeth caused solely by an Accidental Injury is limited to Medically Necessary services until the services result in initial, palliative stabilization of the Insured as determined by the Plan;

   Note: Dental services provided after initial medical stabilization, prosthodontics, orthodontia, and/or cosmetic services are not covered. This benefit does not include damage to the natural teeth that is not accidental, e.g. resulting from chewing or biting;

3. Medically Necessary non-surgical treatment (e.g., splint and physical therapy) of Temporomandibular Joint Syndrome (TMJ);

4. Surgical and arthroscopic treatment of TMJ if prior history shows conservative medical treatment has failed;

5. Medically Necessary treatment of maxilla and mandible (Jaw Joints and Jaw Bones); or

6. Orthognathic Surgery (surgery to reposition the upper and/or lower jaw) which is Medically Necessary to correct a skeletal deformity.

No benefits are provided for:

1. Services performed on the teeth, gums (other than tumors) and associated periodontal structures, routine care of teeth and gums, diagnostic Services, preventive or periodontic Services, dental orthoses and prostheses, including hospitalization incident thereto;

2. Orthodontia (dental services to correct irregularities or malocclusion of the teeth) for any reason, including treatment to alleviate TMJ;

3. Dental implants (endosteal, subperiosteal or transosteal);

4. Any procedure (e.g. vestibuloplasty) intended to prepare the mouth for dentures or for the more comfortable use of dentures;

5. Alveolar ridge surgery of the jaws if performed primarily to treat diseases related to the teeth, gums or periodontal structures, or to support natural or prosthetic teeth;

6. Fluoride treatments except when used with radiation therapy to the oral cavity.

See Principal Limitations, Exceptions, Exclusions, and Reductions, General Exclusions for additional Services that are not covered.

Mental Health and Substance Abuse Benefits

The Plan's Mental Health Service Administrator (MHSA) administers and delivers the Plan's Mental Health and substance abuse Services. Prior authorization is not required for Inpatient mental Health and substance abuse Services when obtained outside of California. See the "Out-of-Area Program: The BlueCard Program" section of this Policy for an explanation of how payment is made for out of state Services.

All Non-Emergency Inpatient Mental Health Services and Outpatient Partial Hospitalization and Outpatient electroconvulsive therapy (ECT) Services must be prior authorized by the MHSA. For prior authorization, Insureds should contact the MHSA at 1-877-214-2928. (See the Benefits Management Program section for complete information.)

Benefits are provided for the following Medically Necessary covered Mental Health and substance abuse Services, subject to applicable deductibles, Copayments, Coinsurance and charges in excess of any benefit maximums, MHSA Participating Provider provisions and Benefits Management Program provision.

Benefits are provided, as described below, for the diagnosis and treatment of Mental Health and substance abuse conditions. All Non-Emergency Inpatient Mental Health Services and all Outpatient Partial Hospitalization Services must be prior authorized by the MHSA.

The Copayments and Coinsurance for covered Mental Health and substance abuse Services, if applicable, are shown in the Summary of Benefits.

Benefits are limited to a per Insured, per Calendar Year maximum as shown in the Summary of Benefits.

Note: For all Inpatient Hospital care except for Emergency Services, failure to contact eh MHSA prior to obtaining Services will result in the Insured being responsible for and additional payment as outlined in the "Hospital and Skilled Nursing Facility Admissions" para-

graphs of the Benefits Management Program section. For Outpatient psychiatric Partial Hospitalization and Outpatient ECT Services, failure to contact Blue Shield or the MHSA as described above or failure to follow the recommendations of Blue Shield will result in non-payment of services by Blue Shield.

1. Inpatient Mental Health Services
Benefits are provided for psychiatric Inpatient Services in connection with hospitalization for the treatment of mental illness (including treatment of Severe Mental Illnesses of an Insured of any age and of Serious Emotional Disturbances of a Child). Residential care is not covered.

Note: See Hospital Benefits, Inpatient Services for Treatment of Illness or Injury for information on Medically Necessary Inpatient substance abuse detoxification.

2. Outpatient Facility and Office Care
Benefits are provided for Outpatient facility and office care for Severe Mental Illnesses or Serious Emotional Disturbances of a Child and for other than Severe Mental Illnesses of Serious Emotional Disturbances of a Child are for substance abuse care.

Outpatient or office Mental Health Services and substance abuse care for other than Severe Mental Illnesses or Serious Emotional Disturbances of a Child are limited to a combined per Insured per Calendar Year visit maximum as shown in the Summary of Benefits. Note: this does not apply to Outpatient Partial Hospitalization Services.
The initial Mental Health Services of substance abuse care visit to determine the condition and diagnosis of the Insured will be paid as if the condition was a Severe Mental Illness or a Serious Emotional Disturbance of a Child.

If the outcome of the initial visit determines that the condition is other than a Severe Mental Illness or a Serious Emotional Disturbance of a Child, the visit will count towards the Calendar Year maximum.

No benefits are provided for Outpatient or office care from MHSA Non-Participating Providers for Mental Health Services for other than Severe Mental Illnesses or Serious Emotional Disturbances of a Child or for treatment of substance abuse, except for the initial visit. Note: this does not apply to Outpatient Partial Hospitalization Services.

3. Outpatient Hospital Partial Hospitalization and Outpatient ECT Services
Benefits are provided for Hospital and professional Services in connection with psychiatric Partial Hospitalization and ECT for the treatment of mental illness (including treatment of Severe Mental Illnesses of a Insured of any age and of Serious Emotional Disturbances of a Child.

4. Psychological testing
Psychological testing is a covered Benefit when provided to diagnose a mental illness.

No benefits are provided for:

1. telephone psychiatric consultations;
2. testing for intelligence or learning disabilities

5. Psychosocial Support
Notwithstanding the Benefits provided elsewhere in this section, the Insured may also call 1-800-985-2405 or an unlimited, 24 hour basis for confidential psychosocial support Services available through LifeReferrals 24/7. Professional counselors will provide support through assessment, referrals, and counseling.

In California, support may include, as appropriate, a referral to a counselor for a maximum of three no charge, face-to-face visits within a six month period. These visits will not accrue to the Benefit maximums that are applicable to Mental Health and Substance Abuse Services.

In the event that the Services required of an Insured are most appropriately provided by a psychiatrist or the condition is not likely to be resolved in a brief treatment regimen, the Insured will be referred to the MHSA intake line to access their Mental Health and Substance Abuse Services which are described elsewhere in this section.

Outpatient or Out-of-Hospital X-Ray, Pathology, and/or Laboratory Benefits
Benefits are provided for diagnostic X-Ray Services, diagnostic examinations, clinical pathology, and laboratory Services, when provided to diagnose illness or injury. Certain routine laboratory Services performed as part of a preventative health screening are covered under the Preventive Care Benefits section.

Benefits are also provided for genetic testing for certain conditions when the Insured has risk factors such as family history or specific symptoms. The testing must be expected to lead to increased or altered monitoring for early detection of disease, a treatment plan or other therapeutic intervention, and determined to be Medically Necessary and appropriate in accordance with Blue Shield Life medical policy. See the section on Pregnancy Benefits for information on genetic testing disorders of the fetus.

See the section on Radiological Procedures Requiring Prior Authorizations and Benefit Management Program

section for information on procedures that require prior authorization by the Plan.

Outpatient Prescription Generic Drug Benefits
This plan's prescription drug coverage provides less coverage on average than the standard benefit set by the federal government for Medicare Part D (also called creditable coverage). It is important to know that generally you may only enroll in a Part D plan from November 15th through December 31st of each year, and if you do not enroll when first eligible you may be subject to payment of higher Part D premiums when you enroll at a later date. For more information about drug coverage, call Customer Service at 1-800-431-2809, Monday through Thursday, 8:00 a.m. to 5:00 p.m., or Friday 9:00 a.m. to 5:00 p.m. The TTY telephone number is 1-866-346-7197.

This benefit includes access to Blue Shield's Participating Pharmacy Network. By presenting your Blue Shield Identification Card to a Participating Pharmacy you will pay Blue Shield's contracted rate for covered medication. This will significantly reduce your out of pocket costs for covered medications. Please see the section entitled "Obtaining Outpatient Prescription Drugs at a Participating Pharmacy" for more details.

The following prescription drug benefit is separate from the Blue Shield Life Vital Shield Plus 400 Generic Rx coverage.

The Calendar year Maximum Copayment and Coinsurance does not apply to the Outpatient Prescription Generic Drug benefit; however, the general provisions and exclusions of the Blue Shield Life Vital Shield Plus 400 Generic Rx shall apply.

Note: Except for covered emergencies and Drugs for emergency contraception, no benefits are provided for drugs received from Non-Participating Pharmacies.

There are no benefits for Brand Name Drugs under the Outpatient Prescription Generic Drug benefit.

1. Outpatient Prescription Generic Drug Benefit
   Subject to the terms and conditions of this Section, benefits are provided for Outpatient prescription Generic Drugs, which are prescribed by a licensed Physician and are obtained from a Participating Pharmacy. Benefits are provided for Formulary Drugs, which are Generic Drugs listed on Blue Shield's Prescription Drug Formulary. Blue Shield's Pharmacy and Therapeutics Committee update this Formulary on a periodic basis. Select Generic Drugs and Generic Drug dosages and most Generic Home Self-Administered Injectables require prior authorization by Blue Shield for Medical Necessity, appropriateness of therapy or when effective, lower cost alternatives are available. Your Physician may request prior authorization from Blue Shield. Coverage for selected Generic Drugs may be limited to a specific quantity as described in the section entitled Limitation on Quantity of Generic Drugs that May be Obtained per Prescription or Refill.

2. Outpatient Drug Formulary
   Medications are selected for inclusion in Blue Shield's Outpatient Drug Formulary based on safety, efficacy, FDA bioequivalence data and then cost. New drugs and clinical data are reviewed regularly to update the Formulary. However, only Generic Drugs listed on the Blue Shield Life Formulary are covered under this Outpatient Prescription Generic Drug benefit. Blue Shield's Pharmacy and Therapeutics Committee during scheduled meetings four times a year reviews drugs considered for inclusion or exclusion from the Formulary.

   Insureds may call Blue Shield's Customer Service Department at the number listed on their Blue Shield Life Identification Card to inquire if a specific Generic Drug is included in the Formulary. The Customer Service Department can also provide Insureds with a printed copy of the Formulary. Insureds may also access the Formulary through the Blue Shield Life web site at http://www.blueshieldca.com.

3. Definitions
   Brand Name Drugs — FDA approved Drugs under patent to the original manufacturer and only available under the original manufacturer's branded name. Note: Brand Name Drugs are not covered under the Blue Shield Life Vital Shield Plus 400 Generic Rx.

   Drugs — (1) Drugs which are approved by the Food and Drug Administration (FDA), requiring a prescription either by Federal or California law, (2) Insulin and disposable Insulin needles and syringes; (3) pen delivery systems for the administration of Insulin as Medically Necessary; (4) diabetic testing supplies (including lancets, lancet puncture devices, and blood and urine testing strips and test tablets); (5) oral contraceptives and diaphragms; (6) inhalers and inhaler spacers for the management and treatment of asthma.; and (7) smoking cessation Drugs which require a prescription – coverage limited to one 12-week course of treatment per lifetime of the Insured. Note: The Blue Shield Life Vital Shield Plus 400 Generic Rx only provides coverage for Generic Drugs and the items listed in (2), (3), (4), and diaphragms.

Note: No Prescription is necessary to purchase the items shown in (3) and (4) above; however, in order to be covered these items must be ordered by your Physician.

Formulary — A comprehensive list of Drugs maintained by Blue Shield's Pharmacy and Therapeutics Committee for use under the Prescription Drug Program, which is designed to assist Physicians in prescribing Drugs that are Medically Necessary and cost effective. The Formulary is updated periodically. If not otherwise excluded, the Formulary includes all Generic Drugs.

Generic Drugs — Drugs that (1) are approved by the Food and Drug Administration (FDA) as a therapeutic equivalent to the Brand Name Drug, (2) contain the same active ingredient as the Brand Name Drug, and (3) cost less than the Formulary Brand Name Drug equivalent.

Home Self-Administered Injectables - Home Self-Administered Injectable medications are defined as those Drugs that are Medically Necessary; administered more often than once a month by the patient or family member; administered subcutaneously or intramuscularly; deemed safe for self-administration as determined by Blue Shield Life's Pharmacy and Therapeutics Committee; prior authorized by Blue Shield: and obtained from a Blue Shield Life Specialty Pharmacy. Intravenous (IV) medications (i.e. those medications administered directly into a vein) are not considered Home Self-Administered Injectable drugs. Home Self-Administered Injectables are listed in the Plan's Prescription Drug Formulary. Note: Brand Name Home Self-Administered Injectables are not covered under the Blue Shield Life Vital Shield Plus 400 Generic Rx.

Non-Formulary Drugs — Drugs determined by Blue Shield's Pharmacy and Therapeutics Committee as being duplicative or as having preferred Formulary Drug alternatives available. Benefits may be provided for Non-Formulary Drugs and are always subject to the Non-Formulary Copayment.

Non-Participating Pharmacy — a pharmacy that does not participate in the Blue Shield Life Pharmacy Network.

Participating Pharmacy — a pharmacy that participates in the Blue Shield Life Pharmacy Network. These Participating Pharmacies have agreed to a contracted rate for covered prescriptions for Blue Shield Life Subscribers.

To select a Participating Pharmacy, Insureds may access this information at http://www.blueshieldca.com or call the toll-free Customer Service telephone number on their Blue Shield Life Identification Card.

Specialty Pharmacy Network – select Participating Pharmacies contracted by Blue Shield Life to provide covered Home Self-Administered Injectables. These pharmacies offer 24-hour clinical services and provide prompt home delivery of Home Self-Administered Injectables.

To select a Specialty Pharmacy, the Insured may access this information at http://www.blueshieldca.com or call the toll-free Customer Services telephone number on their Blue Shield Life Identification Card.

4. Obtaining Outpatient Prescription Generic Drugs from Participating Pharmacies

   a. To obtain prescription Generic Drugs, the Insured must present his Blue Shield Life Identification Card. Note: Except for covered emergencies and Generic Drugs for emergency contraception, claims for drugs obtained without using the Blue Shield Life Identification Card will be denied.

   b. Benefits are provided for Generic Home Self-Administered Injectables only when obtained from a Blue Shield Life Specialty Pharmacy, except in the case of an emergency. In the event of an emergency, covered Generic Drug Home Self-Administered Injectables that are needed immediately may be obtained from any Participating Pharmacy, or, if necessary, from a Non-Participating Pharmacy.

   c. Formulary Generic Drugs -
   The Insured is responsible for paying the Formulary Generic Drug Copayment/Coinsurance for each new and refill Formulary Generic Drug prescription. The pharmacist will collect from the Insured the Copayment/Coinsurance at the time the Drugs are obtained. If the Plan's contracted rate for the prescription is less than the Insured's Copayment/Coinsurance amount, the Insured is responsible for payment of the contracted rate only. The Copayment/Coinsurance for Formulary Generic Drugs is shown in the Summary of Benefits.

d. Prescription Generic drugs obtained at a non-participating pharmacy are not covered unless Medically Necessary for a covered emergency. If the Insured must obtain Generic Drugs from a non-participating pharmacy due to a covered emergency, the submission of a Prescription Drug Claim form noting "Emergency Request" on the form is required. Claim forms are provided upon request from the Blue Shield Life Service Center. Claims must be submitted to:

Blue Shield Life
Pharmacy Services
P.O. Box 7168
San Francisco, CA 94120

Claims must be received within 1 year from the date of service to be considered for payment. Reimbursement for covered emergency claims will be made for the purchase price of covered prescription Drug(s) less any applicable Copayments(s)/Coinsurance.

When the Plan receives Notice of Claim, the Plan will send you an Insured's Statement of Claim form for filing proof of a claim. For consideration of a claim due to a covered emergency, you must note "Emergency Request" on the Insured's Statement of Claim form and it should be submitted to:

Blue Shield Life
Pharmacy Services
P.O. Box 7168
San Francisco, CA 94120

The Plan must receive written proof of claim within 90 days after the date of service for which claim is being made. Send a copy of your itemized bill or pharmacy statement along with your completed Insured's Statement of Claim form.

A claim will not be reduced or denied for failure to provide proof within this time if it is shown that it was not reasonably possible to furnish proof, and that proof was provided as soon as it was reasonably possible. However, no claim will be paid if proof is received more than one (1) year after the date of loss, unless the Insured was legally unable to notify the Plan. Reimbursement for covered emergency claims will be made for the purchase price of covered prescription Drug(s) less any applicable Copayments(s) and Coinsurance.

e. The Insured is responsible for paying Copayment/Coinsurance as shown in the Summary of Benefits for Generic Home Self-Administered Injectables, including any combination kit or package containing both oral and Home Self-Administered Injectable Drugs.

5. Obtaining Outpatient Prescription Drugs through the Mail Service Prescription Drug Program

a. For the Insured's convenience, when Generic Drugs have been prescribed for a chronic condition and the Insured's medication dosage has been stabilized, he may obtain the Generic Drugs through Mail Service Prescription Generic Drug Program. The Insured should submit the applicable mail service Copayment/Coinsurance as indicated in the Summary of Benefits, an order form, and his Blue Shield Life Identification number to the address indicated on the Mail Service envelope. Insureds should allow 14 days to receive the Generic Drugs. The Insured's Physician must indicate a prescription quantity, which is equal to the amount to be dispensed. Generic Home Self-Administered Injectables, except for Insulin, are not covered through the Mail Service Prescription Generic Drug Program.

b. Mail Service Generic Drugs –
The Insured is responsible for the Mail Service Formulary Generic Drug Copayment for each covered prescription. If the Plan's contracted rate for the prescription is less than the Insured's Copayment/Coinsurance amount, the Insured is responsible for payment of the contracted rate only. To obtain the Participating Pharmacy contracted rate, please contact the mail service pharmacy at 1-866-346-7200. The Copayment/Coinsurance for Mail Service Drugs is shown in the Summary of Benefits.

c. If the Insured, or Physician (regardless of any "Dispense as Written" instructions) requests a Formulary Brand Name Drug when a Formulary Generic Drug is available and the Brand Name Drug Deductible has been satisfied, the Insured is responsible for paying the difference between the cost to Blue Shield of the Formulary Brand Name Drug and its Formulary Generic Drug equivalent, as well as the applicable Mail Service Formulary Generic Name Drug Copayment.

6. Prior Authorization Process for Select Formulary and Non-Formulary Drugs and Most Home Self-Administered Injectables

   Select Formulary Drugs, as well as most Home Self-Administered Injectables may require prior authorization for Medical Necessity. Select Non-Formulary Drugs may require prior authorization for Medical Necessity, and to determine if lower cost alternatives are available and just as effective. Your Physician may request prior authorization by submitting supporting information to Blue Shield. Once all required supporting information is received, prior authorization approval or denial, based upon Medical Necessity, is provided within five business days or within 72 hours for an expedited review.

7. Limitation on Quantity of Generic Drugs That May Be Obtained Per Prescription or Refill

   a. Outpatient Prescription Generic Drugs are limited to a quantity not to exceed a 30-day supply. Some prescriptions are limited to a maximum allowable quantity based on Medical Necessity and appropriateness of therapy as determined by Blue Shield Life's Pharmacy and Therapeutics Committee.

   b. Mail Service Prescription Generic Drugs are limited to a quantity not to exceed a 60 day supply. If the Insured's Physician indicates a prescription quantity of less than a 60-day supply that amount will be dispensed and refill authorizations cannot be combined to reach a 60 day supply.

   c. Prescriptions may be refilled at a frequency that is considered to be Medically Necessary.

8. Exclusions for Outpatient Prescription Generic Drug Benefit

   a. No benefits are provided under the Outpatient Prescription Generic Drug Benefit for the following (please note, certain Services excluded below may be covered under other benefits/portions of your Policy - you should refer to the applicable section to determine if Drugs are covered under that Benefit):

   b. Any Drugs provided or administered while the Insured is an Inpatient, or in a Physician's office (see the Professional (Physician) Benefit and Hospital Benefits sections of your Policy);

   c. Take home Drugs received from a Hospital, convalescent home, Skilled Nursing Facility, or similar facility (see the Hospital Benefits and skilled Nursing Facilities Benefits sections of your Policy);

   d. Drugs, (except as specifically listed as covered under this Outpatient Prescription Generic Drug section), which can be obtained without a prescription or for which there is a non-prescription Drug that is an identical chemical equivalent (i.e. same active ingredient and dosage) to a prescription Drug;

   e. Drugs for which the Insured is not legally obligated to pay, or for which no charge is made;

   f. Drugs that are considered to be experimental or investigational;

   g. Medical devices or supplies except as specifically listed as covered herein; see the sections entitled Durable Medical Equipment Benefit and Prosthetic Appliance Benefits for complete information;

   h. Blood or blood products (see the Hospital Benefits section of your Policy);

   i. Drugs when prescribed for cosmetic purposes, including but not limited to Drugs

used to retard or reverse the effects of skin aging or to treat hair loss;

j. Dietary or Nutritional Products see the PKU Related Formulas and Special Food Products section of your Policy;

k. Injectable Drugs which are not self-administered, and all injectable Drugs for the treatment of infertility. Other Injectable Medications may be covered under the Home Health Care Benefits, Family Planning Service, Hospice Program Services, and Home Infusion/Home Injectables Therapy Benefits sections of the Plan. No benefits are provided for Brand Name Home Self-Administered Injectables;

l. Appetite suppressants, or Drugs for weight reduction except when Medically Necessary for the treatment of morbid obesity. In such cases the Drug will be subject to prior authorization from Blue Shield Life;

m. Contraceptive devices (except diaphragms), injections and implants;

n. Compounded medications if: (1) there is a Formulary alternative, or, (2) there are no FDA-approved indications. Compounded medications that do not include at least one (1) Drug, as defined, are not covered;

o. Replacement of lost, stolen, or destroyed Prescription Drugs;

p. Drugs obtained from a Non-Participating Pharmacy, except Generic Drugs for Emergency coverage;

q. Drugs prescribed for treatment of dental conditions. This exclusion shall not apply to antibiotics prescribed to treat infection nor to medications prescribed to treat pain;

r. Pharmaceuticals that are reasonable and necessary for the palliation and management of Terminal Illness and related conditions if they are provided to an Insured enrolled in a Hospice Program through a Participating Hospice Agency;

s. Brand Name Drugs except for Insulin and disposable Insulin needles and syringes, pen delivery systems for the administration of Insulin as determined by Blue Shield Life to be Medically Necessary diabetic testing supplies (including lancets, lancet puncture devices, and blood and urine testing strips and test tablets); and diaphragms; or

t. Immunizations and vaccinations by any mode of administration (oral, injection, or otherwise) solely for the purpose of travel.

u. Drugs packaged in convenience kits that include non-prescription convenience items, unless the Drug is not otherwise available without the non-prescription components. This exclusion shall not apply to items used for the administration of diabetes or asthma Drugs.

PKU Related Formulas and Special Food Product Benefits

Benefits are provided for enteral formulas, related medical supplies, and Special Food Products that are Medically Necessary for the treatment of phenylketonuria (PKU) to avert the development of serious physical or mental disabilities or to promote normal development or function as a consequence of PKU. All benefits must be prior authorized by the Plan and must be prescribed and/or ordered by the appropriate health care professional.

Podiatric Benefits

Podiatric Services include office visits and other covered Services customarily provided by a licensed doctor of podiatric medicine. Covered surgical procedures pro-

vided in conjunction with this Benefit, are described under the Professional (Physician) Benefits section. Covered lab, pathology, and X-Ray Services provided in conjunction with this Benefit, are described under the Outpatient or Out-of-Hospital X-Ray, Pathology, and Laboratory Benefits section.

Pregnancy Benefits
No benefits are provided for pregnancy and maternity care, routine circumcisions, and prenatal diagnosis of genetic disorders of the fetus by means of diagnostic testing.

Preventive Health Benefits
Preventive Care Services are those primary preventive medical Services provided by a Physician for the early detection of disease when no symptoms are present and for those items specifically listed below.
The specific benefits listed below for Preventive Care are not subject to the Calendar Year deductible.

Note: No benefits for Preventive Care Services are provided from Non-Preferred Providers.

1. Annual Physical Examination;
   For the Subscriber and Dependents age three (3) and over, benefits are provided for one (1) health appraisal examination in each Calendar Year.

   Benefits for the Annual Physical Examination include only the following Services:

   a. Annual routine physical examination office visit;

   b. Urinalysis;

   c. Eye and ear screenings, provided by a family practitioner or general practitioner, for Subscribers and dependent children through age 16 to determine the need for referral to a specialist for eye refraction or audiogram. No benefits are provided for routine examinations by Optometrists or Audiologists, or for routine eye refraction.; and

   d. Pediatric and adult immunizations and the immunizing agent, as recommended by the American Academy of Pediatrics and the United States Public Health Service through its U.S. Preventive Services Task Force and/or the Advisory Committee on Immunization Practices (ACIP) of the Centers for Disease Control and Prevention (CDC) except for immunizations and vaccinations by any mode of administration (oral, injection, or otherwise) solely for the purpose of travel.

   If the Insured's Physician provides or orders any covered Outpatient or out-of-Hospital X-Ray, laboratory, or pathology Services beyond those listed in this Annual Physical Examination benefit, those Services will be subject to the per Insured Calendar Year deductible and the Insured will be responsible for additional Copayment(s) or Coinsurance as outlined in the section titled Outpatient or Out-of-Hospital X-ray, Pathology, and/or Laboratory Benefits.

2. Annual Gynecological Examination:
   Benefits for the annual gynecological exam include only the following Services:

   a. Annual gynecological examination office visit;

   b. Mammography, and

   c. Routine Papanicolaou (Pap) test of other Food and Drug Administration (FDA) approved cervical cancer and human papillomavirus virus (HPV) screening tests.

   If the Insured's Physician provides or orders any covered Outpatient or out-of-Hospital X-Ray, pathology, or laboratory Services beyond those listed in this Annual Gynecological Examination benefit, those Services will be subject to the per Insured Calendar Year deductible and the Insured will be responsible for additional Copayment(s) or Coinsurance as outlined in section entitled Outpatient or Out-of-Hospital X-ray, Pathology, and/or Laboratory Benefits.

3. Colorectal Cancer Screening:
   For Subscribers or Dependents age 50 and older, benefits are provided based on Blue Shield Life's Preventive Health Guidelines. These guidelines regarding examinations and tests are derived from the most recent version with all updates of the Guide to Preventive Services of the U. S. Preventive Services Task Force as convened by the U. S. Public Health Service and those of the American Cancer Society, including frequency and patient age recommendations.

   Colorectal cancer screening examinations and test for diagnostic rather than preventive purposes, or any covered Outpatient or our-of-Hospital X-ray, laboratory, or pathology Services will be subject to the per Insured, per Calendar Year Deductible and the Insured will be responsible for additional Copayment(s)/Coinsurance as outlined in the Outpatient or Out-of-Hospital X-ray, Pathology, and Laboratory

Benefits or Ambulatory Surgery Center Benefits sections.

The facility Copayment/Coinsurance for Colorectal Cancer Screening Service(s) is applied in addition to the Copayment/Coinsurance for any associated office visit(s), Copayment/Coinsurance amounts for Colorectal Cancer Screening Services performed in an Outpatient facility or Ambulatory Surgery Center are described in the Outpatient or Out-of-Hospital X-ray, Pathology, and Laboratory Benefits or Ambulatory Surgery Center Benefits sections.

4. Osteoporosis Screening:
Benefits are provided for osteoporosis screening for Subscribers and Dependents age 65 and older, or age 60 and older if the Insured is at increased risk.

5. Well-Baby Examination:
Benefits are provided when a Physician provides routine pediatric care to a Subscriber less than three (3) years of age.

Benefits are provided when a Physician provides routine pediatric care to a newborn or Dependent child that is less than three (3) years of age, of the Subscriber or covered spouse or Domestic Partner.

Well-baby examination benefits include only the following Services:

a. Well baby examination office visits;

b. Tuberculin test; and

c. Pediatric immunizations and the immunizing agent, as recommended by the American Academy of Pediatrics and the United States Public Health Service through its U.S. Preventive Services Task Force and/or the Advisory Committee on Immunization Practices (ACIP) of the Centers for Disease Control and Prevention (CDC).

If the Insured's Physician provides or orders any covered Outpatient or out-of-Hospital X-Ray, pathology, or laboratory Services beyond those listed in this Well-Baby Examination, those Services will be subject to the per Insured Calendar Year Deductible and the Insured will be responsible for additional Copayment(s) and/or Coinsurance as outlined in the section entitled Outpatient or Out-of-Hospital X-ray, Pathology, and/or Laboratory Benefits.

Prosthetic Appliances

Medically Necessary Prostheses for surgically implanted and other prosthetic devices (including prosthetic bras) provided to restore and achieve symmetry incident to a mastectomy, are covered. See Reconstructive Surgery under Professional (Physician) Benefits.

Additionally, Blom-Singer and artificial larynx prostheses for speech therapy following a laryngectomy are covered as a surgical professional benefit.

Benefits are provided at the most cost effective level of care that is consistent with professionally recognized standards of practice. If there are two (2) or more professionally recognized appliances equally appropriate for a condition, Benefits will be based upon the most cost-effective appliance.

Benefits for any other Prosthetic Appliances are specifically excluded. See the section entitled General Exclusions for additional information.

Professional (Physician) Benefits
Other than Preventive Care, Mental Health and substance abuse care, Hospice Program Services, Dialysis Benefits, and Bariatric Surgery which are described in other sections.

Professional Services by providers other than Physicians are described elsewhere under Covered Services.

Covered lab, pathology, and X-Ray Services provided in conjunction with these Professional Services listed below, are described under the Outpatient or Out-of-Hospital X-Ray, Pathology, and Laboratory Benefits section.

Note: A Preferred Physician may offer extended hour and urgent care Services on a walk-in basis in a non-hospital setting such as the Physician's office or an urgent care center. Services received from a Preferred Physician at an extended hours facility will be reimbursed as Physician Office Visits. A list of urgent care providers may be found in the Blue Shield Life Preferred Provider Directory. This information may also be viewed by accessing the Plan's Internet site located at http://www.blueshieldca.com.

Benefits are provided for Services of Physicians for treatment of illness or injury, and for treatment of physical complications of a mastectomy, including lymphedemas, as indicated below.

1. Visits to the office, beginning with the first visit;

2. Services or consultants, including those for second medical opinion consultations;

3. Mammography and Papanicolaou test or other FDA (Food and Drug Administration) approved cervical cancer screening tests;

4. Asthma self-management training and education to enable an Insured to properly use asthma-related medication and equipment such as inhalers, spacers, nebulizers, and peak flow monitors;

5. Visits to the home, Hospital, Skilled Nursing Facility, and Emergency Room;

6. Surgical procedures. When multiple surgical procedures are performed during the same operation, Benefits for the secondary procedure(s) will be determined based on the Plan's Medical Policy. No benefits are provided for secondary procedures which are incidental to, or an integral part of, the primary procedure;

7. Reconstructive Surgery and associated covered Services when determined by the Plan to be Medically Necessary and only to correct or repair abnormal structures of the body and which result in more than a minimal improvement in function or appearance. In accordance with the Women's Health & Cancer Rights Act, Reconstructive Surgery on either breast and surgically and non-surgically implanted prosthetic devices (including prosthetic bras) provided to restore and achieve symmetry incident to a mastectomy, including treatment of physical complications of a mastectomy and lymphedemas, are covered. Any such Services must be received while the Policy is in force with respect to the Insured. Benefits will be provided in accordance with the guidelines established by the Plan and developed in conjunction with plastic and reconstructive surgeons.
   No benefits will be provided for the following surgeries or procedures unless determined by the Plan to be Medically Necessary to correct or repair abnormal structures of the body caused by congenital defects, developmental abnormalities, trauma, infection, tumors, or disease, and which will result in more than minimal improvement in function or appearance:

   - Surgery to excise, enlarge, reduce, or change the appearance of any part of the body;
   - Surgery to reform or reshape skin or bone;
   - Surgery to excise or reduce skin or connective tissue that is loose, wrinkled, sagging, or excessive on any part of the body;
   - Hair transplantation; and
   - Upper eyelid blepharoplasty without documented significant visual impairment or symptomatology.

   This limitation shall not apply when breast reconstruction is performed subsequent to a Medically Necessary mastectomy, including surgery on either breast to achieve or restore symmetry

8. Chemotherapy for cancer, including catheterization, and associated drugs and supplies;

9. Extra time spent with a Physician is detained to treat an Insured in critical condition;

10. Necessary preoperative treatment;

11. Treatment of burns; and

12. Allergy testing and treatment.

13. Medically Necessary consultations with Internet Ready Preferred Physicians via Blue Shield Life approved Internet portal. Internet based consultations are available to Insured only through Preferred Physicians who have agreed to provide Internet based consultations via the Blue Shield Life approved Internet portal ("Internet Ready"). Internet based consultations for Psychiatric Care or substance abuse care are not covered. Insured must be current patients of the Preferred Physician. Refer to the Online Physician Directory to determine whether a Preferred Physician is Internet Ready and how to initial an Internet based consultation. This information may be accessed at http://www.blueshieldca.com.

    Internet based consultations are not available to Insureds accessing care outside of California.

14. Benefits are provided for Services required to treat involuntary Complications of Pregnancy on the Insured's Effective Date of coverage. Complications of Pregnancy include, but are not limited to, Medically Necessary Cesarean Section, miscarriage, toxemia of pregnancy (preeclampsia and eclampsia), hyperemesis gravidarum, ectopic (tubal or extra-uterine) pregnancy, nephritis or pyelitis of pregnancy, placenta abruptio or puerperal infection.

    Emergency Services and Complications of Pregnancy are paid just as any other illness.

    No benefits are provided for services subsequent to termination of coverage under this Policy.

Radiological Procedure Benefits (Requiring Prior Authorization)
The following radiological procedures, when performed on an Outpatient, non-emergency basis, require prior authorization by the Plan under the Benefits Management Program. Failure to obtain this authorization will result in the Service being paid at a reduced amount or may result in non-payment for procedures that are determined not to be a Covered Service.

1. CT (Computerized Tomography) scans;

2. MRIs (Magnetic Resonance Imaging);

3. MRAs (Magnetic Resonance Angiography);

4. PET (Positron Emission Tomography) scans; and/or

5. Any cardiac diagnostic procedure utilizing Nuclear Medicine.

Skilled Nursing Facility Benefits
Other than Hospice Program Services which are described in a subsequent section.

Benefits are provided for Medically Necessary Services Provided by a Skilled Nursing Facility Unit of a Hospital or by a free-standing Skilled Nursing Facility.

Benefits are provided for confinement in a Skilled Nursing Facility Skilled Nursing Facility Unit of a Hospital up to the Benefit maximum as shown in the Summary of Benefits. The Benefit maximum is per Insured per Calendar Year, except that room and board charges in excess of the facility's established semi-private room rate are excluded.

Benefits are limited to a per Insured, per Calendar Year maximum as shown in the Summary of Benefits.

Transplant Benefits
Organ Transplants
Benefits are provided for Hospital and professional Services provided in connection with human organ transplants, only to the extent that:

1. They are provided in connection with the transplant of a cornea, kidney, or skin; and

2. The recipient of such transplant is a Subscriber or Dependent.

Benefits are provided for Services incident to obtaining the human organ transplant material from a living donor or an organ transplant "bank" and will be charged against the maximum aggregate payment amount.

Special Transplant Benefits
Benefits are provided for certain procedures, listed below, only if (1) performed at a Special Transplant Facility contracting as a Blue Shield Life Provider to provide the procedure or in the case of Insureds accessing this Benefit outside of California, the procedure is performed at a transplant facility designated by Blue Shield Life, (2) prior authorization is obtained, in writing, from the Plan's Medical Director, and (3) the recipient of the transplant is a Subscriber or Dependent.

The Plan reserves the right to review all requests for prior authorization of these Special Transplant Benefits, and to make a decision regarding benefits based on (1.) the medical circumstances of each Insured, and (2.) consistency between the treatment proposed and the Plan's medical policy.

Failure to obtain prior written authorization as described above and/or failure to have the procedure performed at a contracting Special Transplant Facility will result in denial of claims for this Benefit.

Benefits are provided for Services incident to obtaining the transplant material from a living donor or an organ transplant bank. Benefits will be charged against the maximum aggregate payment amount.

The following procedures are eligible for coverage under this provision:

1. Human heart transplants;

2. Human lung transplants;

3. Human heart and lung transplants in combination;

4. Human liver transplants;

5. Human kidney and pancreas transplants in combination;

6. Human bone marrow transplants; including, autologous bone marrow transplantation (ABMT) or autologous peripheral stem cell transplantation used to support high-dose chemotherapy when such treatment is Medically Necessary and is not Experimental or Investigational;

7. Pediatric human small bowel transplants; and

8. Pediatric and adult human small bowel and liver transplants in combination.

Benefits are provided for Services incident to obtaining the transplant materials from a living donor or an organ transplant "bank". Benefits will be charged against the maximum aggregate payment amount.

Principal Limitations, Exceptions, Exclusions, and Reductions

General Exclusions

Unless exceptions to the following exclusions are specifically made elsewhere in this Policy, no benefits are provided for Services:

1. For or incident to Services and supplies for treatment of the teeth and gums (except for tumors) and associated periodontal structures, including, but not limited to, diagnostic, preventive, orthodontic, and other Services such as dental cleaning, tooth whitening, X-Rays, topical fluoride treatment except when used with radiation therapy to the oral cavity, fillings, and root canal treatment; treatment of periodontal disease or periodontal surgery for inflammatory conditions; tooth extractions; dental implants; braces, crowns, dental orthoses and prostheses; except as specifically provided under Hospital Care Services Benefits and Medical Treatment of Teeth, Gums, Jaw Joints, or Jaw Bones Benefits;

2. For or incident to Services rendered in the home or hospitalization or confinement in a health facility primarily to treat or cure chronic pain, except those benefits which would have been provided had the individual been treated on an Outpatient basis. For example, charges for room and board during such hospitalization are not a benefit except as Medically Necessary;

3. For Rehabilitation except as specifically provided under Hospital Care Services Benefits, Home Health Care Benefits, and Outpatient Rehabilitation Benefits:

4. For or incident to services rendered in the home or hospitalization or confinement in a health facility primarily for rest, Custodial, Maintenance, Domiciliary Care, or Residential Care except as provided under Hospice Program Services (see Hospice Program Services Benefits for exception);

5. Performed in a Hospital by Hospital officers, residents, interns and others in training;

6. For routine eye refraction, surgery to correct refractive error (such as but not limited to radial keratotomy / refractive keratoplasty), lenses and frames for eye glasses, contact lenses (except as provided in the Prosthetic Appliances Benefits section), and video-assisted visual aids or video magnification equipment for any purposes;

7. For eyeglasses, contact lenses, and hearing aids, cochlear implants, bone-anchored hearing aids, and auditory brainstem implants;

8. For or incident to Speech Therapy, speech correction, or speech pathology, or speech abnormalities that are not likely the result of a diagnosed, identifiable medical condition, injury, or illness except as specifically listed under Home Health Care Benefits and Speech Therapy Benefits;

9. For or incident to vocational, educational, recreational, art, dance, reading or music therapy; weight control programs; or exercise programs nutritional counseling except as specifically provided for under Diabetes Care Benefits;

10. For transgender or gender dysphoria conditions, including but not limited to intersex surgery (transsexual operations) or any related services or any resulting medical com-

plications, except for treatment of medical complications that are Medically Necessary;

11. For callus, corn paring or excision, toenail trimming and except as may be provided through a Participating Hospice Agency; treatment (other than surgery) of chronic conditions of the foot, e.g., weak or fallen arches; flat or pronated foot; pain or cramp of the foot; for special footwear required for foot disfigurement (e.g., non-custom made or over-the-counter shoe inserts or arch supports), except as specifically listed as covered herein; bunions; muscle trauma due to exertion; or any type of massage procedure on the foot;
12. Which are Experimental or Investigational in Nature, except for Services for Insureds who have been accepted into an approved clinical trial for cancer as provided under Covered Services;

13. For learning disabilities or behavioral problems or social skills training/therapy;

14. For or incident to hospitalization primarily for radiological, laboratory, or any other diagnostic studies or medical observation;

15. For convenience items such as telephones, TVs, guest trays, and personal hygiene items;

16. For Cosmetic Surgery or any resulting complications; except that Medically Necessary Services to treat complications of Cosmetic Surgery (e.g. infections or hemorrhages) will be a benefit but only upon review and approval by a Plan Physician consultant. Without limiting the foregoing, no benefits will be provided for the following surgeries or procedures:
    - Lower eyelid blepharoplasty;
    - Spider veins;
    - Services and procedures to smooth the skin (e.g., chemical face peels, laser resurfacing, and abrasive procedures);
    - Hair removal by electrolysis or other means; and
    - Reimplantation of breast implants originally provided for cosmetic augmentation;

17. Incident to an organ transplant, except as specifically listed;

18. For or incident to the treatment of Infertility, including the cause of Infertility, or any form of assisted reproductive technology, including but not limited to the reversal of surgical sterilization, or any resulting complications, except for Medically Necessary treatment of medical complications;

19. For any services to assisted reproductive technology, including but not limited to the harvesting or stimulation of the human ovum, in vitro fertilization. Gamete Intrafallopian Transfer (G. I. F. T.) procedure, artificial insemination (including related medications, laboratory, and radiology services), services or medications to treat low sperm count, or services incident to or resulting from procedures for a surrogate mother who is otherwise not eligible for covered Pregnancy and Maternity Care Benefits under a Blue Shield Life Plan;

20. For Papanicolaou (Pap) Tests or other FDA (Food and Drug Administration) approved cervical cancer screening tests, mammography and colorectal cancer screenings, except as specifically listed;

21. For routine health appraisals, well-baby care, vision and hearing tests, physical examinations and immunizations, except as specifically listed under Preventive Care Services Benefits; for immunizations and vaccinations by any mode of administration (oral, injection, or otherwise) solely for the

purpose of travel; or for physical examinations required for licensure, employment, or insurance unless the examination is substituted for the Annual Physical Examination;

22. For or incident to sexual dysfunction, sexual inadequacies; except as provided for treatment of organically based conditions;

23. For or incident to family planning, except as specifically listed;

24. For dental care or services incident to the treatment, prevention or relief of pain, or dysfunction of the temporomandibular Joint and/or muscles of mastication except as specifically provided under the sections entitled Hospital Care Services Benefits and Medical Treatment of Teeth, Gums, Jaw Joints, or Jaw Bones Benefits;

25. Performed by a Close Relative or by a person who ordinarily resides in the Subscriber's or Dependent's home;

26. Incident to any injury or disease arising out of, or in the course of, any employment for salary, wage or profit if such injury or disease is covered by any workers' compensation law, occupational disease law or similar legislation. However, if the Plan provides payment for such Services, it shall be entitled to establish a lien upon such other benefits up to the amount paid by the Plan for the treatment of such injury or disease;

27. In connection with private duty nursing, except as provided under the Home Health Care Benefits and Home Infusion/Home Injectable Therapy Benefits and except as provided through a Participating Hospice Agency;

28. For or incident to hospitalization or confinement in a pain management center to treat or cure chronic pain except as Medically Necessary;

29. For substance abuse treatment or rehabilitation on an inpatient, partial hospitalization or outpatient basis, except as specifically listed;

30. For Outpatient Mental Health Services, except as specifically listed;

31. For penile implant devices and surgery and any related Services, except for any resulting complications and Medically Necessary services as provided under Reconstructive Surgery Benefits;

32. For which the Insured is not legally obligated to pay or Services for which no charge is made to the Insured;

33. For or incident to out-of-country services; for medical equipment, drugs and other substances obtained outside the United States except as provided for covered emergency or urgent care;

34. For Reconstructive Surgery and procedures in situations: 1) where there is another more appropriate surgical procedure that is approved by a Plan Physician consultant, or 2) when the surgery or procedure offers only a minimal improvement in function or in the appearance of the enrollees, e.g., spider veins, or 3) as limited in the Reconstructive Surgery Benefit section.;

35. For prescription and non-prescription food and nutritional supplements, except as provided under the Home Infusion/Home Injectable Therapy Benefits, and PKU Related Formulas and Special Food Products Benefits, and except as provided through a Participating Hospice Agency;

36. For drugs and medicines which cannot be lawfully marketed without approval of the

U.S. Food and Drug Administration (the FDA); however, drugs and medicines which have received FDA approval for marketing for one or more uses will not be denied on the basis that they are being prescribed for an off-label use if the conditions set forth in California Insurance Code, Section 10123.195 have been met;

37. For home testing devices and monitoring equipment except for use of the glucose monitor for self-management of diabetes;

38. For contraceptives and contraceptive devices, except as specifically included in the sections entitled Family Planning Services and Outpatient Prescription Drug Benefits; oral contraceptives and diaphragms are excluded, except as may be provided under the Outpatient Prescription Benefit; no benefits are provided for contraceptive implants;

39. For genetic testing except as described in the section entitled Outpatient or Out-of-Hospital X-ray, Laboratory, and/or Pathology Services Benefits;

40. For any type of communicator, voice enhancer, voice prosthesis, electronic voice producing machine, or any other language assistive devices, except as specifically listed under in the section entitled Prosthetic Appliance Benefits;

41. For non-prescription (over-the-counter) medical equipment or supplies that can be purchased without a licensed provider's prescription order, even if a licensed provider writes a prescription order for a non-prescription item, except as specifically provided under Diabetes Care Benefits, Home Health Care Benefits, Home Infusion/Home Injectable Therapy Benefits, and Prosthetic Appliances;

42. For or incident to Services and supplies related to pregnancy and maternity care, routine circumcisions, and prenatal diagnosis of genetic disorders of the fetus by means of diagnostic generic testing;

43. Incident to bariatric surgery services except as specifically provided under the section entitled Bariatric Surgery Services Benefits;

44. For services provided by an individual or entity that is not licensed or certified by the state to provide health care services, or is not operating within the scope of such license or certification, except specifically stated herein;

45. For or incident to acupuncture or acupressure Services;

46. For or incident to spinal manipulations and adjustments;

47. For and incident to Durable Medical Equipment and supplies needed to operate and maintain Durable Medical Equipment;

48. For and incident to orthotic appliances and devices and supplies needed to operate or maintain orthotic appliances and devices;

49. For and incident to Prostheses and supplies needed to operate or maintain Prostheses except as provided in the section entitled Prosthetic Appliances;

50. For or incident to professional charges for Outpatient and office visits for Mental Health other than for severe mental illness or serious emotional disturbances of a child;

51. For or incident to internet consultations;

52. For or incident to circumcision unless as a result of illness or injury;

53. For or incident to rehabilitative services and therapy including, but not limited to, occupational, physical, and respiratory therapies;

54. For or incident to Speech Therapy;

55. For or incident to allergy testing and/or treatment; and

56. Not specifically listed as a benefit.

See the Grievance Process section for information on filing a grievance, your right to seek assistance from the State of California Department of Insurance, and your rights to external independent medical review.

Medical Necessity Exclusion
All services must be Medically Necessary. The fact that a Physician or Other Provider may prescribe, order, recommend, or approve a service does not, in itself, make it Medically Necessary, even though it is not specifically listed as an exclusion or limitation. The Plan may limit or exclude benefits for services that are not Medically Necessary.

Pre-Existing Conditions
Pre-existing Conditions are covered only after you have been continuously covered for six (6) consecutive months, including your waiting period. Your waiting period begins on the date the Plan receives your application.

However, if you or your Dependents had prior Creditable Coverage and you applied for this Plan within sixty-three (63) days after termination of the prior Creditable Coverage, then the Plan will credit the time you or your Dependents were covered under the prior Creditable Coverage toward this Plan's Pre-existing Condition exclusion.

To receive credit for your prior Creditable Coverage, submit to Blue Shield Life a certificate from your prior employer, insurer, or health plan which shows the period of time you were covered under the prior Creditable Coverage. If you are unable to obtain the certificate, you should contact the Plan's Customer Service area for assistance.

Limitations for Duplicate Coverage

When you are eligible for Medicare
1. Your Blue Shield Life plan will provide benefits before Medicare when you become eligible for Medicare benefits prior to age 65, until the first to occur of the following:
   a. The date of your actual enrollment under Medicare, or
   b. The date that you receive notice from Blue Shield Life of your eligibility for such enrollment.
2. Your Blue Shield Life plan will provide benefits after Medicare even if you are eligible but do not enroll once you are age 65 or older. Blue Shield Life will:
   a. Estimate what Medicare would have paid for services received (based upon the reasonable value or Blue Shield Life's Allowable Amount), and

   b. Provide your Blue Shield Life plan benefits as if you were enrolled to receive benefits from Medicare.

When your Blue Shield Life plan provides benefits after Medicare, the combined benefits from Medicare and your Blue Shield Life plan will equal, but not exceed, what Blue Shield Life would have paid if you were not eligible to receive Medicare benefits (payment will be based on an amount that may be lower than, but will not exceed the Medicare allowed amount). Your Blue Shield Life plan deductible, copayments, and/or coinsurance will be applied before plan benefits are provided.

When you are eligible for Medi-Cal
Your Blue Shield Life plan always provides benefits first.

When you are a qualified veteran
If you are a qualified veteran your Blue Shield Life plan will pay the reasonable value or Blue Shield Life's Allowable Amount for covered services provided to you at a Veteran's Administration facility for a condition that is not related to military service. If you are a qualified veteran who is not on active duty, your Blue Shield Life plan will pay the reasonable value or Blue Shield Life's Allowable Amount for covered services provided to you at a Department of Defense facility, even if provided for conditions related to military service.

When you are covered by another governmental agency
If you are also entitled to benefits under any other federal or state governmental agency, or by any municipality, county, or other political subdivision:

1. The combined benefits from that coverage and your Blue Shield Life plan will equal, but not exceed, what Blue Shield Life would have paid if you were not eligible to receive benefits under that coverage (based on the reasonable value or Blue Shield Life's Allowable Amount).

2. Your Blue Shield Life plan deductible, copayments, and/or coinsurance will be applied before payment of plan benefits.

Contact the Customer Service department at the telephone number shown at the end of this document if you have any questions about how Blue Shield Life coordinates your plan benefits in the above situations.

Exception for Other Coverage
Participating Providers and Preferred Providers may seek reimbursement from other third party payers for the balance of their reasonable charges for Services rendered under this Policy.

Claims Review
The Plan reserves the right to review all claims to determine if any exclusions or limitations apply, and may use the services of Physician consultants, peer review committees of professional societies or Hospitals, and other consultants.

Reductions - Acts of Third Parties
If an Insured is injured through the act or omission of another person (a "third party"), the Plan shall, with respect to services required as a result of that injury, provide the benefits of this Policy and have an equitable right to restitution or other available remedy to recover the reasonable costs of the Services provided to the Insured paid by the Plan on a fee-for-service basis. The Insured is required to:

1. Notify the Plan in writing of any actual or potential claim or legal action which such Insured anticipates bringing or has brought against the third party arising from the alleged acts or omissions causing the injury or illness, not later than 30 days after submitting or filing a claim or legal action against the third party; and

2. Agree in writing to fully cooperate with the Plan to execute any forms or documents needed to assist them in exercising their equitable right to restitution or other available remedies; and

3. Provide the Plan with a lien, in the amount of reasonable costs of benefits provided calculated in accordance with California Civil Code section 3040. The lien may be filed with the third party, the third party's agent or attorney, or the court, unless otherwise prohibited by law.

An Insured's failure to comply with items one (1) through three (3) above, shall not in any way

act as a waiver, release, or relinquishment of the rights of the Plan.

Further, if the Insured received services from a Participating Hospital for such injuries, the Hospital has the right to collect from the Insured the difference between the amount paid by Blue Shield Life and the Hospital's reasonable and necessary charges for such services when payment or reimbursement is received by the Insured for medical expenses. The Plan Hospital's right to collect shall be in accordance with California Civil Code Section 3045.1.

General Provisions

Non-Assignability
Coverage or any benefits of this Policy may not be assigned without the written consent of Blue Shield Life.
Possession of a Blue Shield Life identification care confers no right to Services or other benefits of this Policy. To be entitled to Services, the Insured must be a Subscriber who has been enrolled by Blue Shield Life and who has maintained enrollment under the terms of this Policy.

Preferred Providers are paid directly by the Plan. The Insured or the provider of Service may not request that payment be made directly to any other party.

If the Insured receives covered Services from a Non-Preferred Provider, payment will be made directly to the Insured, and the Insured is responsible for payment to the Non-Preferred Provider. The Insured or the provider of Service may not request that the payment be made directly to the provider of Service.

Plan Interpretation
Blue Shield Life shall have the power and discretionary authority to construe and interpret the provisions of this Policy, to determine the benefits of this Policy and determine eligibility to receive benefits under this Policy. Blue Shield Life shall exercise this authority for the benefit of all Insureds entitled to receive benefits under this Policy.

Confidentiality of Personal and Health Information
Blue Shield Life protects the confidentiality/privacy of your personal and health information. Personal and health information includes both medical information and individually identifiable information, such as your name, address, telephone number, or Social Security Number. Blue Shield Life will not disclose this information without your authorization, except as permitted by law.

A STATEMENT DESCRIBING BLUE SHIELD LIFE'S POLICIES AND PROCEDURES FOR PRESERVING THE CONFIDENTIALITY OF MEDICAL RECORDS IS AVAILABLE AND WILL BE FURNISHED TO YOU UPON REQUEST.

Blue Shield Life's policies and procedures regarding our confidentiality/privacy practices are contained in the "Notice of Privacy Practices", which you may obtain either by calling the Customer Service Department at the number listed in the back of this booklet or accessing Blue Shield Life's Internet site located at http://www.blueshieldca.com and printing a copy.

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

Correspondence Address:
Blue Shield Life Privacy Official
P. O. Box 272540
Chico, CA 95927-2540

Toll-Free Telephone Number:
1-888-266-8080

E-mail Address:
BlueShieldca_Privacy@blueshieldca.com

Access to Information
Blue Shield Life may need information from medical providers, from other carriers or other entities, or from you, in order to administer benefits and eligibility provisions of this Policy. You agree that any provider or entity can disclose to Blue Shield Life that information that is reasonably needed by Blue Shield Life. You agree to assist Blue Shield Life in obtaining this information, if needed, (including signing any necessary authorizations) and to cooperate by providing Blue Shield Life with information in your possession. Failure to assist Blue Shield Life in obtaining necessary information or refusal to provide information reasonably needed may result in the delay or denial of benefits until the necessary information is received. Any information received for this purpose by Blue Shield Life will be maintained as confidential and will not be disclosed without your consent, except as otherwise permitted by law.

Independent Contractors
Providers are neither agents nor employees of the Plan but are independent contractors. In no instance shall the Plan be liable for the negligence, wrongful acts, or omissions

of any person receiving or providing services, including any Physician, Hospital, or Other Provider or their employees.

Entire Policy: Changes
This Policy, including the appendices, constitutes the entire agreement between parties. Any statement made by an Insured shall, in the absence of fraud, be deemed a representation and not a warranty. No change in this Policy shall be valid unless approved by a corporate officer of Blue Shield Life and a written endorsement issued. No representative has authority to change this Policy or to waive any of its provisions. Blue Shield Life will provide at least 30 days written notice of any changes to this Policy.

Time Limit on Certain Defenses
After an Insured has been covered under this Policy for two (2) consecutive years, Blue Shield Life will not use any misstatement, except a fraudulent misstatement, made by the Applicant in an individual application to void the Policy, deny a claim, or reduce coverage.

Grace Period
After payment of the first Premium, the Subscriber is entitled to a grace period of 28 days for the payment of any Premium due. During this grace period, the Policy will remain in force. However, the Subscriber will be liable for payment of Premiums accruing during the period the Policy continues in force.

Notice and Proof of Claim

Notice and Claim Forms
In the event the provider of Services does not bill Blue Shield Life directly, you should use a Blue Shield Life Insured's Statement of Claim form in order to receive reimbursement. To receive a claim form, written notice of a claim must be given to Blue Shield Life within 20 days of the date of Service. If this is not possible, Blue Shield Life must be notified as soon as it is reasonably possible to do so.

When Blue Shield Life receives Notice of Claim, Blue Shield Life will send you an Insured's Statement of Claim form for filing proof of a claim. If Blue Shield Life fails to furnish the necessary claim forms within 15 days, you may file a claim without using a claim form by sending Blue Shield Life written proof of claim as described below.

Proof of Claim
Blue Shield Life must receive written proof of claim within 90 days after the date of service for which claim is being made from a contracted professional provider and no later than 180 days for claims from a non-contracted professional provider. Send a copy of your itemized bill to the Blue Shield Life service center listed on the last page of this Policy.

A claim will not be reduced or denied for failure to provide proof within this time if it is shown that it was not reasonably possible to furnish proof, and that proof was provided as soon as it was reasonably possible. However, no claim will be paid if proof is received more than one (1) year after the date of loss, unless the Insured was legally unable to notify Blue Shield Life.

Payment of Benefits

Time and Payment of Claims
Claims will be paid promptly upon receipt of proper written proof and determination that benefits are payable.

Payment of Claims
Participating Providers and Preferred Providers are paid directly by Blue Shield Life.
If the Insured receives Services from a Non-Preferred Provider, payment will be made directly to the Subscriber, and the Insured is responsible for payment to the Non-Preferred Provider, except that Hospital charges are generally paid directly to the Hospital.

Refer to the section entitled Outpatient Prescription Drugs for information on reimbursement of prescription drug claims.

Commencement of Legal Action
Any suit or action to recover benefits under this Plan, or damages concerning the provision of coverage or benefits, the processing of claims, or any other matter arising out of this Plan, may not be brought prior to the expiration of 60 days after written proof of claim has been furnished and must be commenced no later than three years after the date the coverage for benefits in question were first denied.

Organ and Tissue Donation
Many residents in the state of California are eligible to become organ and tissue donors. By deciding to be an organ and tissue donor, you can affect the well-being of one or more of the estimated 100,000 people in the United States of America who must face death daily while waiting for an organ transplant. One person on this list dies about every three hours – all the while waiting for an organ or tissue donation.

For more information on organ and tissue donation, or to register as a donor, visit the California Transplant Doctor Network's internet site at http://www.ctdn.org or Donate Life California's internet site at http://www.donatelifecalifornia.org. You may also call

the regional organ procurement agency in the city nearest you for additional information on organ and tissue donation.

Choice of Providers
An Insured may select any Hospital or Physician to provide covered Services hereunder, including providers outside of California. Benefits differ depending on whether a Preferred Provider or a Non-Preferred Provider is selected. It is to the Insured's advantage to select Preferred Providers whenever possible. See the Definitions section for more information. A Directory of Preferred Physicians and Preferred Hospitals has been provided to the Insured. A listing of Participating Physicians and Preferred Hospitals may be viewed by accessing Blue Shield Life's Internet site located at http://www.blueshieldca.com. An extra copy is available upon request by calling the Plan at 1-800-431-2809, or writing to:

Blue Shield Life
PO Box 272610
Chico, CA 95927-2610

If the inability to perform by a Preferred Provider, the breach of the contract to furnish Services by a Preferred Provider, or the termination of a Preferred Provider's contract with Blue Shield Life may materially and adversely affect the Insured, Blue Shield Life will, within a reasonable time, advise the Insured in writing of such inability to perform, breach, or termination.

Endorsements and Appendices
Attached to and incorporated in this Policy by reference are appendices pertaining to deductibles and Premiums. Endorsements may be issued from time to time subject to the notice provisions of the section entitled Duration of the Policy. Nothing contained in any endorsement shall affect this Policy, except as expressly provided in the endorsement.

Notices
Any notice required by this Policy may be delivered by United States mail, postage prepaid. Notices to the Subscriber may be mailed to the address appearing on the records of Blue Shield Life and notice to Blue Shield Life may be mailed to:

Blue Shield Life
50 Beale Street
San Francisco, CA 94105

Commencement or Termination of Coverage
Whenever this Policy provides for a date of commencement or termination of any part or all of the coverage herein, such commencement or termination shall be effective at 12:01 A.M. Pacific Time of that date.

Identification Cards
Identification cards will be issued by Blue Shield Life to all Insureds.

Legal Process
Legal process or service upon Blue Shield Life must be served upon a corporate officer of Blue Shield Life.

Notice
The Subscriber hereby expressly acknowledges its understanding that this Policy constitutes a contract solely between the Subscriber and Blue Shield Life (hereafter referred to as "the Plan"), which is an independent corporation operating under a license from the Blue Cross and Blue Shield Association ("Association"), an Association of independent Blue Cross and Blue Shield plans, permitting the Plan to use the Blue Shield Service Mark in the State of California and that the Plan is not contracting as the agent of the Association.

The Subscriber further acknowledges and agrees that it has not entered into this Policy based upon representations by any person other than the Plan and that neither the Association nor any person, entity or organization affiliated with the Association, shall be held accountable or liable to the Subscriber for any of the Plan's obligations to the Subscriber created under this Policy. This paragraph shall not create any additional obligations whatsoever on the part of the Plan, other than those obligations created under other provisions of this Policy.

Customer Service

For all Services other than Mental Health and substance abuse -
An Insured who has a question about services, providers, benefits, how to use this Plan, or concerns regarding the quality of care or access to care that you have experienced, may call the Plan's Customer Service Department at:

1-800-431-2809

The hearing impaired may contact the Plan's Customer Service Department through the Plan's toll-free TTY telephone number at:

1-800-241-1823

Customer Service can answer many questions over the telephone. Insureds may also submit questions to Customer Service by accessing Blue Shield Life's Internet site located at http://www.blueshieldca.com.

Note: Blue Shield Life has established a procedure for our Subscribers and Dependents to request an expedited decision. An Insured, Physician, or representative of an Insured may request an expedited decision when the routine decision making process might seriously jeopardize the life or health of an Insured, or when the Insured is experiencing severe pain. Blue Shield Life shall make a decision and notify the Insured and Physician as soon as possible to accommodate the Insured's condition not to exceed 72 hours following the receipt of the request. An expedited decision may involve admissions, continued stay, or other healthcare services. If you would like additional information regarding the expedited decision process, or if you believe your particular situation qualifies for an expedited decision, please contact our Customer Service Department at the number noted on the last page of this Policy.

Blue Shield Life may refer inquiries or appeals to a local medical society, hospital utilization review committee, peer review committee of the California Medical Association or a medical specialty society, or other appropriate peer review committee for an opinion to assist in the resolution of these matters.

For all Mental Health and substance abuse Services -
The Plan's Mental Health Service Administrator (MHSA) should be contacted for questions about Mental Health and substance abuse Services, MHSA network Providers, or Mental Health and substance abuse benefits. You may contact the MHSA at the telephone number or address, which appear below:

1-877-214-2928

Blue Shield of California
Life and Health Insurance Company
Mental Health Service Administrator
3111 Camino Del Rio North, Suite 600
San Diego, CA 92108

The MHSA can answer many questions over the telephone.

The MHSA has established a procedure for our Insureds to request an expedited decision. An Insured, Physician, or representative of an Insured may request an expedited decision when the routine decision making process might seriously jeopardize the life or health of an Insured, or when the Insured is experiencing severe pain. The MHSA shall make a decision and notify the Insured and Physician as soon as possible to accommodate the Insured's condition not to exceed 72 hours following the receipt of the request. An expedited decision may involve admissions, continued stay, or other healthcare services. If you would like additional information regarding the expedited decision process, or if you believe your particular situation qualifies for an expedited decision, please contact the MHSA at the telephone number listed above.

Grievance Process

Blue Shield Life has established a grievance procedure for receiving, resolving and tracking Insured's grievances with Blue Shield Life.

For all Services other than Mental Health and substance abuse -
The Insured, a designated representative, or a provider on behalf of the Insured, may contact the Customer Service Department by telephone, letter, or online to request a review of an initial determination concerning a claim of Service. The Insured may contact Blue Shield Life at the telephone number as quoted in this Policy. If the telephone inquiry to Customer Service does not resolve the question or issue to the Insured's satisfaction, the Insured may request a grievance at that time, which the Customer Service Representative will initiate on the Insured's behalf.

The Insured, a designated representative, or a provider on behalf of the Insured, may also initiate a grievance by submitting a letter or completed "Grievance Form". The Insured may request this Form from Customer Service at the address as noted in this Policy. The completed Form should be submitted to:

Blue Shield Life
Customer Service Appeals and Grievance
P.O. Box 5588
El Dorado Hills, CA 95762-0011

The Insured may also submit the grievance online by visiting the web site at http://www.blueshieldca.com.

Blue Shield Life will acknowledge receipt of a grievance within five (5) calendar days. Grievances are resolved within thirty (30) days. The grievance system allows the Insured to file grievances for at least 180 days following any incident or action that is the subject of the Insured's dissatisfaction. See the previous Customer Service section for information on the expedited decision process.

For all Mental Health and substance abuse Services -
The Insured, a designated representative, or a provider on behalf of the Insured, may contact the MHSA by telephone, letter, or online to request an initial determination concerning a claim or Service. The Insured may contact the MHSA at the telephone as noted below. If the telephone inquiry to the MHSA's Customer Service Depart-

ment does not resolve the question or issue to the Insured's satisfaction, the Insured may request a grievance at that time, which the Customer Service Representative will initiate on the Insured's behalf.

The Insured, a designated representative, or a provider on behalf of the Insured, may also initiate a grievance by submitting a letter or a completed "Grievance Form". The Insured may request this Form from the MHSA's Customer Service Department. If the Insured wishes, the MHSA's Customer Service staff will assist in the completing of the Grievance Form. Completed grievance forms must be mailed to the MHSA at the address provided below. The Insured may also submit the grievance to the MHSA online by visiting http://www.blueshieldca.com.

1-877-214-2928

Blue Shield of California
Life and Health Insurance Company
Mental Health Service Administrator
Attn: Customer Services
P. O. Box 880609
San Diego, CA 92168

The MHSA will acknowledge receipt of a grievance within five (5) calendar days. Grievances are resolved within thirty (30) days. The grievance system allows the Insured to file grievances for at least 180 days following any incident or action that is the subject of the Insured's dissatisfaction.

If the grievance involves an MHSA Non-Participating Provider, the Insured should contact the appropriate Blue Shield Life Customer Service Department.

For all Services - External Independent Medical Review
If your grievance involves a claim or services for which coverage was denied by Blue Shield Life or by a contracting provider in whole or in part on the grounds that the service is not Medically Necessary or is experimental/investigational (including the external review available under the Friedman-Knowles Experimental Treatment Act of 1996), you may choose to make a request to the Department of Insurance to have the matter submitted to an independent agency for external review in accordance with California law. You normally must first submit a grievance to Blue Shield Life and wait for at least 30 days before you request external review; however, if your matter would qualify for an expedited decision as described above or involves a determination that the requested service is experimental / investigational; you may immediately request an external review following receipt of notice of denial.

You may initiate this review by completing an application for external review, a copy of which can be obtained by contacting Customer Service. The Department of Insurance will review the application and, if the request qualifies for external review, will select an external review agency and have your records submitted to a qualified specialist for an independent determination of whether the care is Medically Necessary. You may choose to submit additional records to the external review agency for review. There is no cost to you for this external review.

You and your Physician will receive copies of the opinions of the external review agency. The decision of the external review agency is binding on Blue Shield Life; if the external reviewer determines that the service is Medically Necessary, Blue Shield Life will promptly arrange for the service to be provided or the claim in dispute to be paid.
This external review process is in addition to any other procedures or remedies available to you and is completely voluntary on your part; you are not obligated to request external review. However, failure to participate in external review may cause you to give up any statutory right to pursue legal action against Blue Shield Life regarding the disputed service. For more information regarding the external review process, or to request an application form, please contact Customer Service.

California Department of Insurance Review

The California Department of Insurance is responsible for regulating health insurance. The Department's Consumer Communications Bureau has a toll-free number (1-800-927-HELP (4357) or TDD 1-800-482-4833) to receive complaints regarding health insurance from either the Insured or his or her provider.

If you have a complaint against Blue Shield of California Life & Health Insurance Company, you should contact Blue Shield Life first and use their grievance process. If you need the Department's help with a complaint or grievance that has not been satisfactorily resolved by Blue Shield Life, you may call the Department's toll-free telephone number from 8:00 a.m. to 6:00 p.m., Monday through Friday (excluding holidays). You may also submit a complaint in writing to: California

Department of Insurance, Consumer Communications Bureau, 300 S. Spring Street, South Tower, Los Angeles, California 90013 or through the website www.insurance.ca.gov..

Definitions

Plan Provider Definitions

Whenever any of the following terms are capitalized in this Policy, the terms will have the meaning below:

Alternate Care Services Providers — Durable Medical Equipment suppliers, individual certified orthotists, prosthetists and prosthetist-orthotists.

Doctor of Medicine — a licensed medical doctor (M.D.) or doctor of osteopathic medicine (D.O.).

Hospice or Hospice Agency – an entity which provides Hospice Services to Terminally Ill persons and holds a license, currently in effect as a Hospice pursuant to Health and Safety Code Section 1747, or a home health agency licensed pursuant to Health and Safety Code Sections 1726 and 1747.1 which has Medicare certification.

Hospital —

1. A licensed institution primarily engaged in providing, for compensation from patients, medical, diagnostic and surgical facilities for care and treatment of sick and injured persons on an Inpatient basis, under the supervision of an organized medical staff, and which provides 24 hour a day nursing service by registered nurses. A facility which is principally a rest home, or nursing home, or home for the aged is not included.

2. A psychiatric Hospital accredited by the Joint Commission on Accreditation of Healthcare Organizations.

3. A "psychiatric health facility" as defined in Section 1250.2 of the California Health and Safety Code.

MHSA Non-Participating Provider — a provider who does not have an agreement in effect with the MHSA for the provision of Mental Health and substance abuse Services. Note: MHSA Non-Participating Providers may include Blue Shield Life Preferred/Participating Providers if the Provider does not also have an agreement with the MHSA.

MHSA Participating Provider — a provider who has an agreement in effect with the MHSA for the provision of Mental Health and substance abuse Services.

Non-Participating Home Health Care and Home Infusion Agency — agencies which have not contracted with Blue Shield Life Provider Network and whose services are not covered unless prior authorized by the Plan.

Non-Participating / Non-Preferred Provider — any provider who has not contracted with Blue Shield Life to accept Blue Shield Life's payment, plus any applicable deductible, Copayment, Coinsurance or amount in excess of specified benefit maximums, as payment-in-full for covered Services, except as provided in the section entitled Preventive Care Benefits.

Note: this definition does not apply to Mental Health and substance abuse Services. For Non-Participating Providers for Mental Health and substance abuse Services see the Mental Health Service Administrator (MHSA) Non-Participating Providers definition.

Non-Preferred Bariatric Surgery Services Providers – any provider that has not contracted with Blue Shield Life to furnish bariatric surgery services and accept reimbursement at negotiated rates, and that has not been designated as a contracted bariatric surgery services provider by Blue Shield life. Non-Preferred Bariatric Surgery Services Providers may include Blue Shield Life Preferred / Participating Providers if the Provider does not also have an agreement with Blue Shield Life to provide bariatric surgery services.

Note: bariatric surgery services are not covered for Persons who reside in designated counties in California if the service is provided b a Non-Preferred Bariatric Surgery Services Provider. (See the section entitled Bariatric Surgery Benefits for more information.)

Other Provider —

1. Independent Practitioners — licensed vocational nurses; licensed practical nurses; registered nurses; licensed psychiatric nurses; registered dieticians; certified nurse midwives; licensed occupational therapists; certified respiratory therapists; enterostomal therapists; licensed speech therapists or pathologists; certified acupuncturist; dental technicians; and laboratory technicians.

2. Healthcare Organizations — nurses registries; licensed mental health, freestanding public health, rehabilitation, and Outpatient clinics not MD owned; portable x-ray companies; blood banks, speech and hearing centers; dental labs; dental supply companies; nursing homes; ambulance companies; Easter Seal Society; American Cancer Society; Catholic Charities; and Skilled Nursing Facilities.

Outpatient Facility — a licensed facility, not a Physician's office or Hospital, that provides medical and/or surgical Services on an Outpatient basis.

Participating Ambulatory Surgery Center – an Outpatient surgery facility which:

1. Is either licensed by the State of California as an ambulatory surgery center or is a licensed facility accredited by an ambulatory surgery center accrediting body; and

2. Provides Services as a free-standing ambulatory surgery center which licensed separately and bills separately from a Hospital and is not otherwise affiliated with a Hospital; and

3. Has contracted with Blue Shield Life to provide Services on an Outpatient basis.

Participating Home Health Care and Home Infusion Agency — an agency which has contracted with Blue Shield Life Provider Network to furnish Services and accept reimbursement at negotiated rates, and which has been designated as a Participating Home Health Care and Home Infusion Agency by the Plan. (See Non-Participating Home Health Care and Home Infusion Agency definition.

Participating Provider — All Preferred Providers are Participating Providers. These providers include Physicians, Hospitals, Alternate Care Services Providers, Ambulatory Surgery Centers, a Certified Registered Nurse Anesthetist, and Home Health Care and Home Infusion agencies that have contracted with Blue Shield Life Provider Network to furnish Services and to accept the Plan's payment, plus applicable deductibles, Copayments and Coinsurance, or amounts in excess of specified benefit maximums, as payment in full for covered Services, except as provided under in the section entitled Professional (Physician) Services.

Note: this definition does not apply to Mental Health and substance abuse Services or Hospice Program Services. For Participating Providers for Mental Health and substance abuse Services and Hospice Program Services, see the Mental Health Service Administrator (MHSA) Participating Providers and Participating Hospice or Participating Hospice Agency definition.

Physician — a licensed Doctor of Medicine, clinical psychologist, research psychoanalyst, dentist, licensed clinical social worker, optometrist, chiropractor, podiatrist, audiologist, registered physical therapist, or licensed marriage and family therapist.

Physician Member — a Doctor of Medicine who has contracted with Blue Shield Life Provider Network, has agreed to furnish Services to Insureds covered by Blue Shield Life, and has agreed to accept Blue Shield Life's payment as payment-in-full for covered Services, except for applicable deductibles, Copayments, Coinsurance or amounts in excess of specified benefit maximums, and except as provided in the section entitled Preventive Care Benefits.

Preferred Bariatric Surgery Services Provider – a Preferred Hospital or a Physician Member that has contracted with Blue Shield Life to furnish bariatric surgery Services and accept reimbursement at negotiated rates, and that has been designated as a contracted bariatric surgery Services provider by Blue Shield Life.

Preferred Dialysis Center – a dialysis services facility contracted as a Blue Shield Life Network Provider to provide dialysis services on an Outpatient basis and accept reimbursement at negotiated rates.

Preferred Hospital — a Hospital which has contracted with Blue Shield Life Provider Network and which has agreed to furnish Services and accept reimbursement at negotiated rates, and which has been designated as a Preferred Hospital by the Plan.

Preferred Provider – A Preferred Provider is a Participating Provider who has contracted with the Blue Shield Life Provider Network to furnish Services and to accept the Plan's payment, except for applicable deductibles, Copayments, Coinsurance or amounts in excess of specified benefit maximums, and except as provided in the section entitled Preventive Care Benefits.

Note, for Participating Providers for Mental Health and substance abuse Services, see the Mental Health Service Administrator (MHSA) Participating Providers definition.

Preferred Physicians — a Physician who has agreed to accept Blue Shield Life's payment, plus any Insured payments of any applicable deductible, Copayment, and/or Coinsurance as payment-in-full for covered Services. Please refer to the Summary of Benefits for Copayment and/or Coinsurance information.

Skilled Nursing Facility — a facility licensed by the California Department of Health Services as a "Skilled Nursing Facility" or any similar institution licensed under the laws of any other state, territory, or foreign country.

All Other Definitions

Whenever any of the following terms are capitalized in this Policy, the terms will have the meaning below:

Accidental Injury — definite trauma resulting from a sudden, unexpected and unplanned event, occurring by chance, caused by an independent external source

Activities of Daily Living (ADL) — mobility skills required for independence in normal everyday living. Recreational, leisure, or sports activities are not included.

Acute Care — care rendered in the course of treating an illness, injury or condition marked by a sudden onset or change of status requiring prompt attention, which may include hospitalization, but which is of limited duration and which is not expected to last indefinitely.

Allowable Amount — the Blue Shield Life Allowance (as defined below) for the Service (or Services) rendered, or the provider's billed charge, whichever is less. The Blue Shield Life Allowance, unless otherwise specified for a particular Service elsewhere in this Policy, is:

1. For a Participating Provider, the amount that the Provider and Blue Shield Life have agreed by contract will be accepted as payment in full for the Services rendered; or

2. For a non-participating provider anywhere within or outside of the United States who provides Emergency Services:

   a. For physicians and hospitals – the Out-of-Network Emergency Allowable;

   b. For other providers - the provider's billed charge for covered Services, unless the provider and the local Blue Cross and/or Blue Shield plan have agreed upon some other amount; or

3. For a non-participating provider in California, including an Other Provider, who provides Services on other than an emergency basis, the amount Blue Shield Life would have allowed for a Participating Provider performing the same service in the same geographical area; or

4. For a provider anywhere, other than in California, within or outside of the United States, which has a contract with the local Blue Cross and/or Blue Shield plan, the amount that the provider and the local Blue Cross and/or Blue Shield plan have agreed by contract will be accepted as payment in full for service rendered; or

5. For a non-participating provider (i.e., that does not contract with a local Blue Cross and/or Blue Shield plan) anywhere, other than in California, within or outside of the United States, who provides Services on other than an emergency basis, the amount that the local Blue Cross and/or Blue Shield would have allowed for a non-participating provider performing the same services. If the local plan has no non-participating provider allowance, Blue Shield Life will assign the Allowable Amount used for a non-participating provider in California.

Blue Shield Life — the Blue Shield of California Life & Health Insurance Company, a California corporation licensed as a life and disability insurer.

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

Chronic Care — care (different from Acute Care) furnished to treat an illness, injury or condition, which does not require hospitalization (although confinement in a lesser facility may be appropriate), which may be expected to be of long duration without any reasonably predictable date of termination, and which may be marked by reoccurrence requiring continuous or periodic care as necessary.

Close Relative — the spouse or Domestic Partner, child, brother, sister or parent of a Subscriber or Dependent.

Coinsurance — the percentage of the Allowable Amount or billed charges that an Insured is required to pay for certain Services after meeting any applicable deductible.

Complications of Pregnancy — conditions, which require medical treatment prior to or subsequent to termination of pregnancy and which, are distinct from but adversely affected by or related to pregnancy.

Copayment — the dollar amount that an Insured is required to pay for certain Services after meeting any applicable deductible.

Cosmetic Surgery — surgery that is performed to alter or reshape normal structures of the body to improve appearance.

Creditable Coverage —

1. Any individual or group policy, contract or program, that is written or administered by a disability insurer, health care service plan, fraternal benefits society, self-insured employer plan, or any other entity, in this state or elsewhere, and that arranges or provides medical, hospital, and surgical coverage not designed to supplement other private or governmental plans.

The term includes continuation or conversion coverage but does not include accident only, credit, disability income, Medicare supplement, long-term care, dental, vision, coverage issued as a supplement to liability insurance, insurance arising out of a workers' compensation or similar law, automobile medical payment insurance, or insurance under which benefits are payable with or without regard to fault and that is statutorily required to be contained in any liability insurance policy or equivalent self-insurance.

2. Title XVIII of the Social Security Act, e.g., Medicare.

3. The Medicaid/Medi-Cal program pursuant to Title XIX of the Social Security Act.

4. Any other publicly sponsored or funded program of medical care.

Custodial or Maintenance Care — care furnished in the home primarily for supervisory care or supportive services, or in a facility primarily to provide room and board (which may or may not include nursing care, training in personal hygiene and other forms of self care or supervisory care by a Doctor of Medicine); or care furnished to an Insured who is mentally or physically disabled, and:

1. Who is not under specific medical, surgical or psychiatric treatment to reduce the disability to the extent necessary to enable the individual to live outside an institution providing such care; or

2. When, despite such treatment, there is no reasonable likelihood that the disability will be so reduced.

Deductible – the Calendar Year amount you must pay for specific Covered Services that are a benefit of the Plan before you become entitled to receive certain Benefit payments from the Plan for those Services.

Dependent —

1. A Subscriber's legally married spouse who is:
   a. Resident of California; and
   b. Not covered for benefits as a Subscriber; and
   c. Not legally separated from the Subscriber; or

2. A Subscriber's Domestic Partner, who is:
   a. Not covered for Benefits as a Subscriber; and
   b. A Resident of California.

3. A Subscriber's, spouse's, or Domestic Partner's unmarried child (including any stepchild or child placed for adoption or any other child for whom the Subscriber, spouse, or Domestic Partner has been appointed as a non-temporary legal guardian by a court of appropriate legal jurisdiction) or child who is not one of the partners in a domestic partnership and who is, not covered for benefits as a Subscriber and is:
   a. Resident of California (unless a full-time student); and
   b. Primarily dependent upon the Subscriber, spouse, or Domestic Partner for support and maintenance; or
   c. Dependent on the Subscriber, spouse, or Domestic Partner for medical support pursuant to a court order; and
   d. Less than 19 years of age; or
   e. Less than 23 years of age, if a full-time student and proof of student status is submitted to the Plan.* (This item e. does not apply to a child of a legal guardian unless a court has specifically ordered that the guardianship continue beyond the attainment of age 19.) (Full-time student means enrolled in a college, university, vocational or technical school for a minimum of 12 units as an undergraduate, or 6 units as a graduate student.); and
   f. Who has been enrolled and accepted by Blue Shield Life as a Dependent and has maintained membership in accordance with this Policy.

* Note: For approved full-time students as described in 3.e. above:

(1) any break in the school calendar shall not disqualify the Dependent from coverage;

(2) the coverage for a Dependent on an approved medical leave of absence will not be terminated for a period of 12 months or the date on which the coverage should terminate per the provisions of the Plan whichever comes first;

(3) for a medical leave of absence from school to be approved by Blue Shield, the Insured must submit documentation or certification of the medical necessity of the leave. This submission should be sent to Blue Shield at least 30 days prior to the first day of the leave or, if not possible, must be sent no later than 30 days after the leave commences.

4. If coverage for a Dependent child would be terminated because of the attainment of age 19 (or age 23, if Dependent has been a full-time student), and the Dependent child is disabled, benefits for such Dependent will be continued upon the following conditions:

a. The child must be chiefly dependent upon the Subscriber, spouse, or Domestic Partner for support and maintenance and be incapable of self-sustaining employment by reason of physically or mentally disabling injury, illness, or condition;
b. The Subscriber, spouse, or Domestic Partner submits to the Plan a Physician's written certification of disability within 60 days from the date of the Plan's request; and
c. Thereafter, certification from a Physician is submitted to the Plan on the following schedule:
    i. Within 24 months after the month when the Dependent would otherwise have been terminated; and
    ii. Annually thereafter on the same month when certification was made in accordance with item (1) above. In no event will coverage be continued beyond the date when the Dependent child becomes ineligible for coverage under this plan for any reason other than attained age.

Domestic Partner - an individual who is personally related to the Subscriber by a domestic partnership that meets the following requirements:

1. Both partners are:
    a. 18 years of age or older; and
    b. Of the same or different sex; and
    c. Residents of California.

2. The partners share:
    a. An intimate and committed relationship of mutual caring; and
    b. The same principal residence.

3. The partners are:
    a. Not currently married; and
    b. Not so closely related by blood that legal marriage or registered domestic partnership would otherwise be prohibited

4. Both partners were mentally competent to consent to a contract when their domestic partnership began.

Domiciliary Care — care provided in a Hospital or other licensed facility because care in the individual's home is not available or is unsuitable.

Durable Medical Equipment — equipment designed for repeated use which is Medically Necessary to treat an illness or injury, to improve the functioning of a malformed body member, or to prevent further deterioration of the individual's medical condition. Durable Medical Equipment includes wheelchairs, hospital beds, respirators, and other items that the Plan determines are Durable Medical Equipment.

Effective Date — the date an applicant meets all enrollment and prepayment requirements and is accepted by Blue Shield Life.

Emergency Services — Services for a medical condition, including a psychiatric emergency medical condition, manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected to result in any of the following:

1. Placing the patient's health in serious jeopardy;
2. Serious impairment to bodily functions;
3. Serious dysfunction of any bodily organ or part.

Experimental or Investigational in Nature — Any treatment, therapy, procedure, drug or drug usage, facility or facility usage, equipment or equipment usage, device or device usage, or supplies which are not recognized in accordance with generally accepted professional medical standards as being safe and effective for use in the treatment of the illness, injury, or condition at issue. Services which require approval by the Federal government or any agency thereof, or by any State government agency, prior to use and where such approval has not been granted at the time the services or supplies were rendered, shall be considered Experimental or Investigational in Nature
Services or supplies which themselves are not approved or recognized in accordance with accepted professional medical standards, but nevertheless are authorized by law or by a government agency for use in testing, trials, or other studies on human patients, shall be considered Experimental or Investigational in Nature.

Family — the Subscriber and all enrolled Dependents.

Hospital Services — Services provided under the direction of a Physician, in a licensed Hospital to treat illness or injury and which require the facilities of a Hospital.

Incurred — a charge shall be deemed to be "Incurred" on the date the particular Service, which gives rise to it, is provided or obtained.

Inpatient — an individual who has been admitted to a Hospital as a registered bed patient and is receiving Services under the direction of a Doctor of Medicine.

Insured — either a Subscriber or Dependent.

Intensive Outpatient Care Program — an Outpatient Mental Health (or substance abuse) treatment program utilized when a patient's condition requires structure,

monitoring, and medical/psychological intervention at least three (3) hours per day, three (3) times per week.

Mental Health Services — see definition of Psychiatric Care.

Mental Health Service Administrator (MHSA) —The MHSA is a specialized health care service plan that will underwrite and deliver the Plan's Mental Health and substance abuse Services through a separate network of MHSA Participating Providers.

Negotiated Rate — the amount a Preferred Hospital has agreed to accept as payment-in-full for covered Services, except for applicable deductibles, Copayments, Coinsurance or amounts in excess of specified benefit maximums, and except as provided under the section entitled Covered Services.

Occupational Therapy - treatment under the direction of a Doctor of Medicine and provided by a certified occupational therapist utilizing arts, crafts, or specific training in daily living skills, to improve and maintain a patient's ability to function.

Orthosis — an orthopedic appliance or apparatus used to support, align, prevent, or correct deformities or to improve the function of movable body parts.

Out-of-Country Services — Medical services received outside the United States of America.

Out-of-Network Emergency Allowable – In California: The lower of (1) the provider's billed charge, or (2) the amount determined by Blue Shield Life to be the reasonable and customary value for the services rendered by a non-Plan Provider based on statistical information that is updated at least annually and considers many factors including, but not limited to, the provider's training and experience, and the geographical area where the services are rendered; Outside of California: The lower of (1) the provider's billed charge, or (2) the amount, if any, established by the laws of the state to be paid for Emergency Services.

Outpatient — an Insured receiving Services, but not as an Inpatient.

Partial Hospitalization / Day Treatment Program — a treatment program that may be freestanding or Hospital-based and provides Services at least five (5) hours per day and at least four (4) days per week. Patients may be admitted directly to this level of care, or transferred from acute Inpatient care following acute stabilization.

Physical Therapy - treatment provided by a Doctor of Medicine or under the direction of a Doctor of Medicine when provided by a registered physical therapist, certified occupational therapist, or licensed Doctor of Podiatric Medicine. Treatment utilizes physical agents and therapeutic procedures such as ultrasound, heat, range of motion testing, and massage, to improve a patient's musculoskeletal, neuromuscular, and respiratory systems.

Plan — the Blue Shield of California Life & Health Insurance Company and/or the Vital Shield Plus 400 Generic Rx.

Policy — this Policy, the appendices, all endorsements to it, and all applications for coverage and health statements.

Pre-Existing Condition — an illness, injury, or condition (including disability) which existed during the six (6) months prior to the Effective Date with Blue Shield Life if, during that time, any medical advice, diagnosis, care, or treatment was recommended or received from a licensed health practitioner.

Prosthesis — an artificial part, appliance, or device used to replace a missing part of the body.

Psychiatric Care (Mental Health Services) — psychoanalysis, psychotherapy, counseling, medical management, or other services provided by a psychiatrist, psychologist, licensed clinical social worker, or licensed marriage and family therapist for diagnosis or treatment of a mental or emotional disorder, or the mental or emotional problems associated with an illness, injury or other condition.

Reconstructive Surgery — surgery to correct or repair abnormal structures of the body caused by congenital defects, developmental abnormalities, trauma, infection, tumors or disease to do either of the following: 1) to improve functions, or 2) to create a normal appearance to the extent possible.

Rehabilitation — Inpatient or Outpatient care furnished primarily to restore an individual's ability to function as normally as possible after a disabling illness or injury. Rehabilitation services may consist of Physical Therapy, Occupational Therapy, and/or Respiratory Therapy and are provided with the expectation that the patient has restorative potential. Benefits for Speech Therapy are described in the section on Speech Therapy.

Resident of California — an individual who spends in the aggregate more than 180 days each year within the State of California and has not established a permanent residence in another state or country.

Residential Care – services provided in a facility or a free-standing residential treatment center that provides overnight/extended-stay services for Insured who do not qualify for Acute Care or Skilled Nursing Services

Respiratory Therapy - treatment under the direction of a Doctor of Medicine and provided by a certified respiratory therapist, to preserve or improve a patient's pulmonary function.

Serious Emotional Disturbances of a Child — refers to individuals who are minors under the age of 18 years who:

1. Have one or more mental disorders in the most recent edition of the Diagnostic and Statistical manual of Mental Disorders (other than a primary substance use disorder or developmental disorder), that results in behavior inappropriate for the child's age according to expected developmental norms, and

2. Meet the criteria in paragraph (2) of subdivision (a) of Section 5600.3 of the Welfare and Institutions Code. This section states that members of this population shall meet one or more of the following criteria:

    a. As a result of the mental disorder the child has substantial impairment in at least two of the following areas: self-care, school functioning, family relationships, or ability to function in the community: and either of the following has occurred: the child is at risk of removal from home or has already been removed from the home or the mental disorder and impairments have been present for more than six (6) months or are likely to continue for more than one (1) year without treatment;

    b. The child displays one of the following: psychotic features, risk of suicide or risk of violence due to a mental disorder.

Services — Medically Necessary health care Services and Medically Necessary supplies furnished incident to those Services.

Severe Mental Illnesses — conditions with the following diagnoses: schizophrenia, schizo-affective disorder, bipolar disorder (manic depressive illness), major depressive disorders, panic disorder, obsessive-compulsive disorder, pervasive developmental disorder or autism, anorexia nervosa, bulimia nervosa.

Special Food Products — a food product which is both of the following:

1. Prescribed by a Physician or Nurse Practitioner for the treatment of phenylketonuria (PKU) and is consistent with the recommendations and best practices of qualified health professionals with expertise germane to, and experience in the treatment and care of, phenylketonuria (PKU). It does not include a food that is naturally low in protein, but may include a food product that is specially formulated to have less than one gram of protein per serving;

2. Used in place of normal food products, such as grocery store foods, used by the general population.

Speech Therapy — treatment, under the direction of a Doctor of Medicine and provided by a licensed speech pathologist or speech therapist, to improve or retrain a patient's vocal skills which have been impaired by a diagnosed illness or injury.

Subacute Care — skilled nursing or skilled rehabilitation provided in a Hospital or Skilled Nursing Facility to patients who require skilled care such as nursing Services, physical, occupational or speech therapy, a coordinated program of multiple therapies or who have medical needs that require daily Registered Nurse monitoring. A facility, which is primarily a rest home, convalescent facility, or home for the aged is not included.

Subscriber — an individual who is a Resident of California and has made application individually or also on behalf of eligible Dependents, has been enrolled by Blue Shield Life, and has maintained Blue Shield Life membership in accord with this Policy.

Notice of the Availability of Language Assistance Services

No Cost Language Services. You can get an interpreter. You can get documents read to you and some sent to you in your language. For help, call us at 1-866-346-7198. For more help call the CA Dept. of Insurance at 1-800-927-4357.
English

Servicios de idiomas sin costo. Puede obtener un intérprete. Le pueden leer documentos y que le envíen algunos en español. Para obtener ayuda, llámenos al 1-866-346-7198. Para obtener más ayuda, llame al Departamento de Seguros de CA al 1-800-927-4357. Spanish

免費語言服務。您可獲得口譯員服務。可以用中文把文件唸給您聽，有些文件有中文的版本，也可以把這些文件寄給您。欲取得協助，請撥打1-866-346-7198 與我們聯絡。欲取得其他協助，請致電 1-800-927-4357 與加州保險部聯絡。Chinese

Các Dịch Vụ Trợ Giúp Ngôn Ngữ Miễn Phí. Quý vị có thể được nhận dịch vụ thông dịch. Quý vị có thể được người khác đọc giúp các tài liệu và nhận một số tài liệu bằng tiếng Việt. Để được giúp đỡ, hãy gọi cho chúng tôi 1-866-346-7198. Để được trợ giúp thêm, xin gọi Sở Bảo Hiểm California tại số 1-800-927-4357. Vietnamese

무료 통역 서비스. 귀하는 한국어 통역 서비스를 받으실 수 있으며 한국어로 서류를 낭독해주는 서비스를 받으실 수 있습니다. 도움이 필요하신1-866-346-7198 번으로 문의해 주십시오. 보다 자세한 사항을 문의하실 분은 캘리포니아 주 보험국, 안내 전화 1-800-927-4357번으로 연락해 주십시오. Korean

Walang Gastos na mga Serbisyo sa Wika. Makakakuha ka ng interpreter o tagasalin at maipababasa mo sa Tagalog ang mga dokumento. Para makakuha ng tulong, tawagan kami sa 1-866-346-7198. Para sa karagdagang tulong, tawagan ang CA Dept. of Insurance sa 1-800-927-4357 Tagalog

Անվճար Լեզվական Ծառայություններ: Դուք կարող եք թարգման ձեռք բերել և փաստաթղթերը ընթերցել տալ ձեզ համար հայերեն լեզվով: Օգնության համար մեզ զանգահարեք 1-866-346-7198 համարով: Լրացուցիչ օգնության համար 1-800-927-4357 համարով զանգահարեք Կալիֆորնիայի Ապահովագրության Բաժանմունք: Armenian

Бесплатные услуги перевода. Вы можете воспользоваться услугами переводчика, и ваши документы прочтут для вас на русском языке. Если вам требуется помощь, звоните нам по 1-866-346-7198. Если вам требуется дополнительная помощь, звоните в Департамент страхования штата Калифорния (Department of Insurance) по телефону 1-800-927-4357. Russian

無料の言語サービス 日本語で通訳をご提供し、書類をお読みします。サービスをご希望の方は、1-866-346-7198までお問い合わせください。更なるお問い合わせは、カリフォルニア州保険庁、1-800-927-4357までご連絡ください。Japanese

خدمات مجانی مربوط به زبان. میتوانید از خدمات یک مترجم شفاهی استفاده کنید و بگوئید مبارک به زبان فارسی برایتان خوانده شوند. برای دریافت کمک، با ما از طریق شماره 1-866-346-7198 تماس بگیرید. برای دریافت کمک بیشتر، به CA Dept. of Insurance (اداره بیمه کالیفرنیا) به شماره 1-800-927-4357 تلفن کنید. Persian

ਮੁਫ਼ਤ ਭਾਸ਼ਾ ਸੇਵਾਵਾਂ. ਤੁਸੀਂ ਦੁਭਾਸ਼ੀਏ ਦੀਆਂ ਸੇਵਾਵਾਂ ਹਾਸਲ ਕਰ ਸਕਦੇ ਹੋ ਅਤੇ ਦਸਤਾਵੇਜ਼ਾਂ ਨੂੰ ਪੰਜਾਬੀ ਵਿੱਚ ਸੁਣ ਸਕਦੇ ਹੋ। ਕੁਝ ਦਸਤਾਵੇਜ਼ ਤੁਹਾਨੂੰ ਪੰਜਾਬੀ ਵਿੱਚ ਭੇਜੇ ਜਾ ਸਕਦੇ ਹਨ। ਮਦਦ ਲਈ, 1-866-346-7198 'ਤੇ ਸਾਨੂੰ ਫ਼ੋਨ ਕਰੋ। ਵਧੇਰੇ ਮਦਦ ਲਈ ਕੈਲੀਫ਼ੋਰਨੀਆ ਡਿਪਾਰਟਮੈਂਟ ਆਫ਼ ਇਨਸ਼ੋਰੈਂਸ ਨੂੰ 1-800-927-4357 'ਤੇ ਫ਼ੋਨ ਕਰੋ। Punjabi

សេវាកម្មភាសាជាំនួយ។ អ្នកអាចទទួលបានអ្នកបកប្រែភាសា និងអានឯកសារជូនអ្នកជា ភាសាខ្មែរ។ សម្រាប់ជំនួយ សូមទូរស័ព្ទមកយើងខ្ញុំតាមលេខ 1-866-346-7198។ សម្រាប់ជំនួយបន្ថែមទៀត សូមទូរស័ព្ទទៅក្រសួងធានារ៉ាប់រងរដ្ឋកាលីហ្វ័រញ៉ា តាមលេខ 1-800-927-4357 Khmer

خدمات ترجمة بدون تكلفة. يمكنك الحصول على مترجم وقراءة الوثائق لك باللغة العربية. للحصول على المساعدة، اتصل بنا على الرقم 1-866-346-7198. للحصول على المزيد من المعلومات، اتصل بإدارة التأمين لولاية كاليفورنيا على الرقم 1-800-927-4357 Arabic.

Cov Kev Pab Txhais Lus Tsis Them Nqi. Koj yuav thov tau kom muaj neeg los txhais lus rau koj thiab kom neeg nyeem cov ntawv ua lus Hmoob. Yog xav tau kev pab, hu rau peb ntawm 1-866-346-7198. Yog xav tau kev pab ntxiv hu rau CA lub Caj Meem Fai Muab Kev Tuav Pov Hwm ntawm 1-800-927-4357 Hmong

IN WITNESS WHEREOF, Blue Shield of California Life & Health Insurance Company, through its duly authorized Officers, execute this Policy, to take effect on the Subscriber's Effective Date.

Seth A. Jacobs, Secretary
Blue Shield of California Life & Health Insurance Company

Duncan Ross, President & Chief Executive Officer
Blue Shield of California Life & Health Insurance Company

For claims submission and information contact:

Blue Shield of California Life and Health Insurance Company
P. O. Box 272540
Chico, CA 95927-2540

You may call Customer Service toll free:
1-800-431-2809

The hearing impaired may call Blue Shield Life's
Customer Service Department through
Blue Shield Life's toll-free TTY number at
1-800-241-1823.

Benefits Management Program
for Pre-admission and/or Prior Authorization,
please call the Customer Service telephone number
as indicated on the back of the Insured's identification card.

Benefits Management Program
for Prior-Authorization of Radiological Services:
1-888-642-2583

For Prior Authorization for Inpatient Mental Health and substance abuse services,
contact the Mental Health Service Administrator at:
1-877-214-2928

Please refer to the section entitled Benefits Management Program
for additional information.

Exhibit C

blue of california

Blue Shield of California Introduces New Lower Cost PPO Plan for Individuals

Vital Shield 2900 designed for cost-conscious online purchasers

(SAN FRANCISCO, July 11, 2007) - With more individual health insurance purchasers using online comparison sites, Blue Shield of California Life & Health Insurance Company has introduced a lower-cost PPO plan designed to grab the attention of web-savvy consumers. The Vital Shield 2900 plan* provides essential first-dollar coverage for generic drug prescriptions and two physician office visits prior to meeting the deductible.

The Vital Shield 2900 plan provides individuals with affordable access to quality health coverage and protection against a medical event, such as hospitalization, and provides benefits that include preventive screenings and gynecological exams, as well as inpatient and outpatient services. It carries a monthly premium as low as $42 with a moderate annual deductible of $2900 (rates for individuals ages 19-29 in good health for Alameda, Contra Costa, and Santa Clara counties. Other rates may apply.).

"More and more consumers are looking for lower-cost options that will help them receive routine medical coverage," said Karen Vigil, senior vice president of Blue Shield's Individual, Small Group and Government Business. "That's what this plan delivers - and with a price structure that will make sure that those consumers will find it, whether they're buying coverage online or working with a trusted broker."

Vital Shield 2900 provides members with health care coverage with $10 copayments for generic prescription drugs at network pharmacies, and full access to Blue Shield's extensive network of PPO providers. The new plan is an individual-only plan and does not offer brand name drug coverage or maternity benefits.

Background on Blue Shield of California

Blue Shield of California, an independent member of the Blue Shield Association, is a not-for-profit health plan dedicated to providing Californians with access to high quality care at a reasonable price. Founded in 1939, it now has 3.2 million members, 4,500 employees, one of the largest provider networks and more than 20 office locations, providing a wide range of commercial and government products throughout the state. The company contributes $30 million annually to the Blue Shield of California Foundation to fund nonprofit organizations that improve access to quality health care in California. Contact your local agent or broker for more information about Blue Shield products and services, or visit the Blue Shield web site at www.blueshieldca.com.

Blue Shield of California Life & Health Insurance Company (Blue Shield Life) is an independent licensee of the Blue Shield Association. Blue Shield Life, headquartered in San Francisco, is a wholly owned subsidiary of Blue Shield of California. More information is available at www.bscalife.com or by calling (800) 443-8284.

* pending regulatory approval

Vital Shield Plus
Individual and Family Plans

Please note: These plans are planned to close effective July 2, 2012. We must receive your client's application by June 15th if they wish to apply for one of these plans. Learn more about our new plans available for effective dates of July 1, 2012 and later.

Vital Shield[SM] Plus* offers valuable health insurance coverage for individuals and families as a low-cost option for those who rarely go to the doctor, but want to know they're covered when they do. Built on the success of the Vital Shield* plans, the Vital Shield Plus plans offer all the same great benefits **plus** a whole lot more.

Vital Shield Plus Features [1]

Lower annual out-of-pocket maximum and a lower annual deductible than with Vital Shield plans

- Members can have the confidence they're protected in case of unexpected medical problems or emergencies, without copayments after the out-of-pocket maximum is met, for most covered services
- Annual out-of-pocket maximums as low as $2,900
- Annual medical Deductibles as low as $400

Generic-only or coverage with brand-name prescription drugs

- Vital Shield Plus plans give your clients prescription drug coverage options:
  - Generic prescription drug only plan ($10 copayment)
  - Generic/brand-name prescription drug combination plan ($10 copayment for generic prescription drugs/$45 copayment for brand-name prescription drugs, after an annual $500 brand-name deductible)
- Prescription drug coverage is not subject to medical deductible

Fourth quarter deductible carry-over

- The fourth quarter deductible carry-over allows members who do not meet their annual deductible to apply covered expenses from October to December toward the next year's deductible
- Vital Shield Plus plans also offer a range of annual deductible options to fit your clients' specific needs

Four physician office visits before the annual deductible and a lower copayment than Vital Shield plans

- Four physician office visits are covered for a $30 copayment per visit prior to meeting the annual deductible

Broker Resources

- Current product cycle
- Monthly rates
- Evidence of coverage/policy
- Sales resources and collateral

Ideal Vital Shield Plus Clients

- Individuals who only expect to go to the doctor a few times a year
- Individuals who are not planning to have children or additional children in the near future
- Younger adults may want to consider lower deductibles ($400 for "young invincibles", $900 for couples)
- Older adults may want to consider higher deductibles ($2,900 for established families and empty nesters)

Tips for Families

- Families can save money with Vital Shield Plus by enrolling as a family instead of enrolling individually
- If there are three or more family members, total family deductibles and out-of-pocket maximums would be lower per person on a family plan than with individual plans
- Benefits are per member, so each family member gets the same number of office visits

Return to top

1 Please note that Vital Shield Plus plans do not include maternity benefits.
2 Amounts shown represent the member's financial responsibility when using Blue Shield network provides.
* Vital Shield and Vital Shield Plus plans are underwritten by Blue Shield of California Life and Health Insurance Company and are pending regulatory approval.

Exhibit D

Vital Shield and Vital Shield Plus

Individual and Family Plans

Vital Shield 2900
Vital Shield Plus 2900
Vital Shield Plus 2900 Generic Rx

Vital Shield 900
Vital Shield Plus 900
Vital Shield Plus 900 Generic Rx

Vital Shield Plus 400
Vital Shield Plus 400 Generic Rx

The coverage you need. The price you want.

Vital Shield℠* plans offer you valuable health coverage at an affordable price. You choose the benefits you consider important, without having to pay for those you don't.[1] Vital Shield plans are a great option for those who rarely go to the doctor, but want to know they're covered when they do.

Vital Shield and Vital Shield Plus advantages:

- Low monthly rates
- Office visits and generic prescription benefits prior to meeting a deductible
- A range of deductible options to fit your specific needs
- 100% coverage for most services after meeting the out-of-pocket maximum

With Vital Shield Plus, you also get:

- 3 additional office visits at a lower copayment
- Optional brand name prescription coverage
- $1,000 lower out-of-pocket maximum
- Fourth-quarter deductible carryover – if you don't meet your annual deductible, any charges applied to your deductible in October through December will carry over toward next year's deductible.

Comparing benefits of Vital Shield and Vital Shield Plus plans[2]

	Vital Shield	Vital Shield Plus
Available for	**Individuals**	**Individuals or families**
Office visits and preventive exams	First 2: $40 (deductible n/a), then $0 after out-of-pocket maximum	First 5: $30 (deductible n/a), then $0 after out-of-pocket maximum
Brand Rx	Not covered	$45 after $500 brand Rx deductible (optional)
Generic Rx	$10 (deductible n/a)	
Gynecological	40% (deductible n/a) + preventive exam copayment	
Lab and X-ray	$0 after out-of-pocket maximum	
Emergency room	$100 + 40% after deductible	
Ambulance	40% after deductible	
Hospitalization	40% after deductible	
Maternity	Not covered	

Deductible and out-of-pocket maximum options

	Vital Shield		Vital Shield Plus		
	900	**2900**	**400**	**900**	**2900**
Deductible	$900	$2,900	$400 ($800 family)	$900 ($1,800 family)	$2,900 ($5,800 family)
Out-of-pocket maximum	$4,900	$5,900	$2,900 ($5,800 family)	$3,900 ($7,800 family)	$4,900 ($9,800 family)

Tips for families

Families can save money with Vital Shield Plus by enrolling as a family (versus enrolling individually).

- Rates are often lower
- If you have 3 or more family members, total family deductibles and out-of-pocket maximums would be lower on a family plan versus individual plans
- Benefits are per member, so you don't have to share office visits

Advantages of Blue Shield Individual and Family plans

- Affordable – we've negotiated with providers for lower fees, so you'll pay less for covered medical services. A lot less.
- 12-month rate guarantee.
- It's easy to find a doctor you want, because with more than 50,000 doctors, Blue Shield has some of California's largest PPO provider networks. If you already have a doctor, chances are he or she is in one of our networks.
- Lots of extras such as around-the-clock access to a registered nurse, wellness programs and discounts, and out-of-state coverage at no additional cost.
- 20% vision discounts for eye exams, frames and lenses, and other products.[3]

Understanding your plan

To make health coverage more understandable, here is a simple description of how these plans work:

- Most benefits are subject to your annual deductible or out-of-pocket maximum, however some benefits, like the first two or five office visits and generic prescription drugs, you get right away for a small fee called a copayment.
- For most other services, you'll pay the reduced fee we negotiated with your provider until you've reached your annual deductible amount. After that, you'll pay only the amount shown on the previous page, and we'll pay the rest.
- If you reach your annual out-of-pocket maximum, then we'll pay 100% of your costs for all covered services (except prescription drugs).[4]

Protect yourself with Vital Shield today!

* Vital Shield and Vital Shield Plus plans are underwritten by Blue Shield of California Life & Health Insurance Company. Pending regulatory approval.

1 Some of the benefits not covered by Vital Shield and Vital Shield Plus plans include maternity, physical therapy, and non-formulary brand prescription drugs. For a detailed description of plan benefits and exclusions, you can request a copy of the Policy by calling Member Services at **(800) 431-2809.**

2 Amounts shown represent the member's financial responsibility when using Blue Shield network providers.

3 The Discount Vision Program through MESVision is an added-value feature for Blue Shield members who reside in California. It is not a covered benefit of Blue Shield health plans. None of the terms or conditions of Blue Shield's health plans applies. Disposable and replaceable contact lenses, eyeglass frame repairs, promotional eyecare offers, medical and surgical eye treatment, and any services not specifically included in this program are excluded from the Discount Vision Program. Blue Shield does not review the program's practitioner services and products for medical necessity or efficacy, and makes no representations, claims, or guarantees regarding their services or products. Members who use the discount program are responsible for the payment of services provided by participating providers, 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 described in the Grievance Process section of the Evidence of Coverage or Certificate of Insurance. Blue Shield reserves the right to terminate this program without notice.

4 Member payments for office visits, X-rays, labs and prescriptions do not count toward the deductible or out of pocket maximum.

Exhibit E

choosing your health plan

Effective July 1, 2008

we can help

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

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

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

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

what's inside

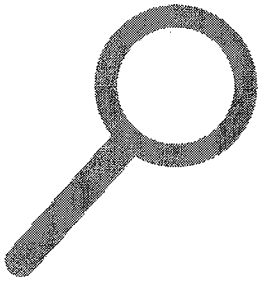
Find the right plan

Understanding plan benefits: plan details and benefit summaries

Additional coverage

Important legal information

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



find the right plan

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

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

How a health plan works

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

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

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

Allowable amount	The dollar amount considered payment in full for services rendered by Blue Shield and an associated network of healthcare providers.
Calendar year	The period beginning at 12:01 a.m. on January 1 and ending at 12:01 a.m. on January 1 of the next year.
Coinsurance	The percentage share of the cost of covered healthcare services that the patient must pay. For example, if the allowable amount is $100 and your coinsurance is 20%, you pay $20 (20%) and your health plan pays $80 (80%). (Note that some plans may not pay for some services until after you meet your deductible.)
Copayment (or copay)	The fixed fee for utilizing network services such as doctor or emergency room visits and filling a prescription. If your office visit copayment is $20, you would pay that amount each time you see your doctor. (Note that some plans may not pay for some services until after you meet your deductible.)
Copayment/coinsurance maximum	A dollar limit on the amount a member may have to pay for many covered services in a calendar year. This limit *may include* the plan deductible, depending on the plan.
Covered services	Medical services that are covered by your health plan.
Deductible	The amount you must pay each year for most covered services before your plan begins to pay. For some covered services, such as preventive care, your plan may pay for treatment before you meet the deductible.
Family deductible	This applies if you have family coverage and a plan with a family deductible. The individual deductibles paid by covered family members count toward the family deductible, and once the family deductible is met, the individual deductibles are also met. Certain payments for services with preferred and non-preferred providers may count toward the deductible.
Formulary	Our preferred list of covered generic and brand-name drugs. You pay less for formulary than for non-formulary drugs.
Non-preferred provider (PPO plans only)	A provider that is not in the Blue Shield PPO network (also called a non-network provider).
Out-of-pocket maximum	A dollar limit on the total amount you have to pay for many covered services in a calendar year, *including* the deductible.
Personal Physician (HMO plans only)	The network physician who serves as an HMO member's designated primary healthcare provider and provides or coordinates all of the member's care.
Preferred provider (PPO plans only)	A provider who is part of the Blue Shield PPO network (also called a network provider). PPO members pay less when they see preferred providers.

Why health coverage is important

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

You have to spend a day in the hospital after an accident.

Average day in hospital: **$11,989**

You badly injure your knee.

Knee replacement surgery and care (average day in hospital): **$21,011**

You have a head injury.

Skull fracture, intracerebral hemorrhage: **$8,913**

You need to be flown to the hospital.

Air ambulance, plus a day in the hospital: **$25,756**

You **can** afford a health plan

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

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

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

FAQs

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

Is my doctor part of a Blue Shield network?

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

Is my prescription on the Blue Shield formulary?

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

What is the difference between an HMO and a PPO?

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

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

Here are some basic differences:

- In general, the higher the calendar-year deductible for a PPO plan, the lower the monthly rates.
- Each of our PPO plans has a different calendar-year deductible and benefit levels.
- Plans with lower deductibles tend to have more generous prescription drug benefits and lower office visit copayments.
- Some plans offer individual coverage only, which means that they don't have two-party or family coverage options.
- Some of our plans do not include maternity benefits or brand-name prescription drug benefits, and may also have certain limits on benefits (such as doctor visits in a calendar year).
- Some of our plans do not have a medical deductible.

How do deductibles work?

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

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

Is preventive care covered?

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

Can individual family members have different plans?

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

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

Which Blue Shield plan is best for you?

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

Who	Plan to consider	Why?
David and Victoria are married, go to the doctor for their regular checkups, and prefer to pay lower monthly dues. Because they have enough savings, they feel comfortable paying a higher deductible in an emergency.	**Shield Spectrum PPO Savings Plan***	• With three deductible levels to choose from, the couple can pick the plan that best fits their coverage needs and cost. • Preventive care, office visits, and ER care are covered right away, before they meet the deductible. • Health Savings Account eligible
Brandon is a recent college graduate who works for a friend's moving company. He goes to the doctor infrequently, but wants coverage in case of a major medical event like hospitalization or surgery. He also wants low monthly rates, and office-visit coverage before meeting the deductible.	**Vital Shield plan***	• Monthly rates start at $45** • The plan covers two office visits each calendar year before Brandon needs to meet his deductible. • In case of a major medical event, Brandon is covered 100% after he meets the copayment maximum ($4,900 or $5,900).
Kelly works part-time in retail sales and does not have health coverage through her employer. She goes to the doctor infrequently and is not planning to get pregnant right now.	**Essential plan***	• It's affordable individual coverage with low copayments for preventive-care office visits. • Manageable out-of-pocket medical costs so she's covered at 100% after the deductible is met.
Frank and Maria are a young couple who want comprehensive coverage for themselves and their daughter. They don't go to the doctor often, but their daughter does. They want a plan that will make their daughter's healthcare costs predictable.	**PPO Plan 5000* for Frank and Maria; Access+ Value HMO YouthCare plan for their daughter**	With two different plans, they can best meet their family's coverage needs. **PPO Plan 5000** • Covers Frank and Maria in an emergency, and covers their annual physical exams for a flat copayment before they meet their deductible. **Access+ Value HMO** • Lets them take their daughter to the doctor as often as necessary and keeps their out-of-pocket costs down. • Has fixed copayments for physician office visits, hospital services and prescription drugs, and no charge for preventive care services. • YouthCare rates reduce their monthly premiums.

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

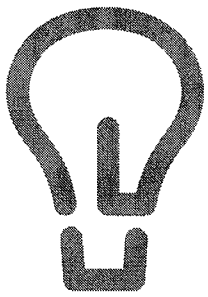
** Individual ages 19-29, Tier – living in Contra Costa, CA, July 2008. Vital Shield rates may vary and are for people in good health.

Which Blue Shield plan is best for you?

(continued)

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

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



understanding plan benefits

Vital Shield plans

NEW! Vital Shield 900

Vital Shield 2900

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

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

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

Vital Shield advantages

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

Is a Vital Shield plan right for you?

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

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

Vital Shield plans

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

Uniform Health Plan Benefits and Coverage Matrix

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

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

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

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

Covered services Subject to the plan deductible, unless noted.	Member copayments **With preferred providers,[1] you pay**	**With non-preferred providers,[1] you pay**
Professional services		
Office visits (first 2 visits/calendar year for any combination of preventive care and physician office visits – subsequent visits are subject to the copayment maximum)	$40[2,*] ●	No charge after copay maximum[2]
Preventive care		
Annual routine physical exam, well-baby care office visits, and gynecological exam office visit (first 2 visits/calendar year for any combination of preventive care and physician office visits – subsequent visits are subject to the copayment maximum)	$40[2,*] ●	Not covered
Annual Pap test or other approved cervical cancer screening tests, routine mammography, and immunizations when received as part of the annual exam or preventive care visit	40% ●	Not covered
Outpatient services		
Non-emergency services and procedures, outpatient surgery in hospital	40%	50%[2,3]
Outpatient surgery performed in an ambulatory surgery center (ASC)[4]	40%	50%[2]
Outpatient or out-of-hospital X-ray and laboratory	No charge after copay maximum[2]	No charge after copay maximum[2]
Hospitalization services		
Inpatient physician visits and consultations, surgeons and assistants, and anesthesiologists	40%	50%
Inpatient semiprivate room and board, services and supplies, and subacute care	40%	50%[2,3]
Bariatric surgery inpatient services (pre-authorization required; medically necessary surgery for weight loss, only for morbid obesity)[5]	40%	50%[2,3]
Emergency health coverage		
Emergency room services ($100 copayment/visit waived if member is admitted directly to the hospital as an inpatient)	$100/visit + 40%	$100/visit + 40%
ER physician visits	40%	40%
Ambulance services (surface or air)	40%	40%
Prescription drug coverage[6] (outpatient)	**At participating pharmacies** (up to a 30-day supply)	**Mail service prescriptions** (up to a 60-day supply)
Generic formulary drugs	$10/prescription[2] ●	$20/prescription[2] ●
Formulary brand-name drugs	Not covered	Not covered
Non-formulary brand-name drugs	Not covered	Not covered
	With preferred providers,[1] you pay	**With non-preferred providers,[1] you pay**
Durable medical equipment	Not covered	Not covered

Vital Shield plans

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

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

* Member has two visits per calendar year before the calendar-year copayment/coinsurance maximum is met. After the two visits are used for any one purpose, the member pays 100% of the allowable amount for all of these services until the calendar-year copayment/coinsurance maximum is met, with no accrual to deductible or copayment/coinsurance maximum.

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

2 These copayments do not count toward the copayment/coinsurance maximum. They will continue to be charged once it is reached (except for office visits, X-ray and laboratory, home health services, and family planning). See Policy for details.

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

4 Participating ASCs may not be available in all areas. Regardless of their availability, you can obtain outpatient surgery services from a hospital, or an ASC affiliated with a hospital with payment according to your health plan's hospital services benefits. The maximum allowed charge for non-emergency surgery and services performed in a non-participating ASC is $300 per day. Members are responsible for 50% of this $300 per day, plus all charges in excess of $300.

5 Bariatric surgery is covered when pre-authorized by Blue Shield. However, for members residing in Imperial, Kern, Los Angeles, Orange, Riverside, San Bernardino, San Diego, Santa Barbara, and Ventura counties ("designated counties"), bariatric surgery services are covered only when performed at designated contracting bariatric surgery facilities and by designated contracting surgeons; coverage is not available for bariatric services from any other preferred provider, and there is no coverage for bariatric services from non-preferred providers. In addition, if prior authorized by Blue Shield, a member in a designated county who is required to travel more than 50 miles to a designated bariatric surgery facility will be eligible for limited reimbursement for specified travel expenses for the member and one companion. Refer to the Policy for further benefit details.

6 Prescription coverage differs for home self injectables. Please review the Policy before you purchase the plan.

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

8 For MHSA participating providers, initial visit treated as if the condition were a severe mental illness or serious emotional disturbance of a child. For MHSA non-participating providers, initial visit treated as a MHSA participating provider.

Essential plans

Essential Plan 1750
Essential Plan 3000
Essential Plan 4500

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

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

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

Essential plan advantages

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

Is an Essential plan right for you?

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

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

Essential plans

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

Uniform Health Plan Benefits and Coverage Matrix

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

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

The benefits below apply to all Essential plans.

Covered services Subject to the plan deductible, unless noted.	Member copayments **With preferred providers,[1] you pay**	**With non-preferred providers,[1] you pay**
Professional services		
Office visits (first 3 visits/calendar year – subsequent visits are subject to the deductible)	$40 (no charge after deductible) ●	50%
Preventive care		
Annual routine physical exam, well-baby care office visits, and gynecological exam office visit (includes Pap test or other approved cervical cancer screening tests, routine mammography, and immunizations when received as part of the annual exam or preventive care visit)	$40[2] ●	Not covered
Outpatient services		
Non-emergency services and procedures	No charge after deductible	50%[2,3]
Outpatient surgery in hospital	No charge after deductible	50%[2,3]
Outpatient surgery performed in an ambulatory surgery center (ASC)[4]	No charge after deductible	50%[2]
Outpatient or out-of-hospital X-ray and laboratory	No charge after deductible	50%
Hospitalization services		
Inpatient physician visits and consultations, surgeons and assistants, and anesthesiologists	No charge after deductible	50%
Inpatient semiprivate room and board, services and supplies, and subacute care	No charge after deductible	50%[2,3]
Bariatric surgery inpatient services (pre-authorization required: medically necessary surgery for weight loss, only for morbid obesity)[5]	No charge after deductible	50%[2,3]

Essential plans

Covered services	Member copayments	
Subject to the plan deductible unless noted.	**With preferred providers,[1] you pay**	**With non-preferred providers,[1] you pay**
Emergency health coverage		
Emergency room services ($100 copayment/visit waived if the member is admitted directly to the hospital as an inpatient)	$100/visit[2] ●	$100/visit[2] ●
ER physician visits	No charge after deductible	No charge after deductible
Ambulance services (surface or air)	No charge after deductible	No charge after deductible
Prescription drug coverage (outpatient)	**At participating pharmacies** (up to a 30-day supply)	**Mail service prescriptions** (up to a 60-day supply)
Generic formulary drugs	$10/prescription[2] ●	$20/prescription[2] ●
Formulary brand-name drugs	Not covered	Not covered
Non-formulary brand-name drugs	Not covered	Not covered
	With preferred providers,[1] you pay	**With non-preferred providers,[1] you pay**
Durable medical equipment[6]	No charge after deductible	50%
	With MHSA participating providers,[1,7] you pay	**With MHSA non-participating providers,[1,7] you pay**
Mental health services		
Inpatient hospital facility services	No charge after deductible	50%[2,3]
Inpatient physician services	No charge after deductible	50%
Outpatient visits for severe mental health conditions (first 3 visits/ calendar year – subsequent visits subject to the deductible)	$40 (no charge after deductible) ●	50%
Outpatient visits for non-severe mental health conditions (up to 20 visits per calendar year combined with chemical dependency visits)[8]	No charge after deductible	Not covered
Chemical dependency services (substance abuse)		
Inpatient hospital facility services for medical acute detoxification	No charge after deductible	50%[2,3]
Inpatient physician services for medical acute detoxification	No charge after deductible	50%
Outpatient visits (up to 20 visits per calendar year combined with non-severe mental health visits)[8]	No charge after deductible	Not covered
	With preferred providers,[1] you pay	**With non-preferred providers,[1] you pay**
Home health services (up to 60 pre-authorized visits per calendar year)	No charge after deductible	Not covered
Other		
Pregnancy and maternity care		
Outpatient prenatal and postnatal care	Not covered	Not covered
Delivery and all necessary inpatient hospital services	Not covered	Not covered
Family planning		
Tubal ligation, vasectomy, elective abortion	Not covered	Not covered
Rehabilitation services (up to 15 visits per calendar year combined with speech therapy visits)		
Provided in the office of a physician or physical therapist	No charge after deductible	50%
Chiropractic services	Not covered	Not covered
Out-of-state services (full plan benefits covered nationwide with the BlueCard Program)	No charge after deductible with BlueCard participating providers	50% with all other providers
Vision services[9]		
Vision exam	$5[2] ●	$5[2] ● (and charges above the allowable amount)

Essential plans

Covered services	Member copayments	
Subject to the plan deductible unless noted.	**With preferred providers,[1] you pay**	**With non-preferred providers,[1] you pay**
Dental services are NOT subject to the plan medical deductible, but there is a $50 dental deductible for some minor restorative services.		
Dental services[10]		
Preventive and diagnostic (including routine oral exams, X-rays, and cleaning)	No charge[11]	All charges above the allowable amount
Minor restorative[2] (subject to $50 dental deductible, including amalgam and resin-based fillings)	$35-$100[11] (depending on procedure)	Member reimbursed per procedure reimbursement schedule

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

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

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 Participating ASCs may not be available in all areas. Regardless of their availability, you can obtain outpatient surgery services from a hospital, or an ASC affiliated with a hospital with payment according to your health plan's hospital services benefits. The maximum allowed charge for non-emergency surgery and services performed in a non-participating ASC is $300 per day. Members are responsible for 50% of this $300 per day, plus all charges in excess of $300.

5 Bariatric surgery is covered when pre-authorized by Blue Shield. However, for members residing in Imperial, Kern, Los Angeles, Orange, Riverside, San Bernardino, San Diego, Santa Barbara, and Ventura counties ("designated counties"), bariatric surgery services are covered only when performed at designated contracting bariatric surgery facilities and by designated contracting surgeons; coverage is not available for bariatric services from any other preferred provider, and there is no coverage for bariatric services from non-preferred providers. In addition, if prior authorized by Blue Shield, a member in a designated county who is required to travel more than 50 miles to a designated bariatric surgery facility will be eligible for limited reimbursement for specified travel expenses for the member and one companion. Refer to the Policy for further benefit details.

6 All covered orthoses have a benefit maximum of $500 per member per calendar year, except those services covered under the Diabetes Care benefit. All covered prosthetics have a benefit maximum of $2,000 per member per calendar year. See Policy for details.

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

8 For MHSA participating providers, initial visit treated as if the condition were a severe mental illness or serious emotional disturbance of a child. For MHSA non-participating providers, initial visit treated as an MHSA participating provider.

9 Vision exams are provided through MESVision network.

10 Dental services provided through Dental Benefit Providers (DBP). Benefits limited to $500 per calendar year combined. Three-month waiting period following the effective date of coverage for minor restorative services. Calendar-year medical deductible does not apply to preventive dental services.

11 Blue Shield's payment is limited to $500 per calendar year for Preventive and Diagnostic and Minor Restorative. Members are responsible for all charges that exceed $500 per calendar year.

Active Start plans

Active Start Plan 25
Active Start Plan 25 Generic Rx
Active Start Plan 35
Active Start Plan 35 Generic Rx

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

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

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

Active Start plan advantages

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

Is an Active Start plan right for you?

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

Active Start plans

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

Uniform Health Plan Benefits and Coverage Matrix

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

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

Covered services — Member copayments

	With preferred providers,[1] you pay		With non-preferred providers,[1] you pay
	Active Start Plan 25, Active Start Plan 25 Generic Rx	**Active Start Plan 35, Active Start Plan 35 Generic Rx**	
Professional services			
Office visits	$25	$35	50%
Preventive care			
Annual routine physical exam, well-baby care office visits, and gynecological exam office visit (includes Pap test or other approved cervical cancer screening tests, routine mammography, and immunizations when received as part of the annual exam or preventive care visit)	$25	$35	Not covered
Outpatient services			
Non-emergency services and procedures	40%		50%[2,3]
Outpatient surgery in hospital	$500/admit + 40%		50%[2,3]
Outpatient surgery performed in an ambulatory surgery center (ASC)[4]	40%		50%[2]
Outpatient or out-of-hospital X-ray and laboratory	40%		50%
Hospitalization services			
Inpatient physician visits and consultations, surgeons and assistants, and anesthesiologists	40%		50%
Inpatient semiprivate room and board, services and supplies, and subacute care	$500/admit + 40%		50%[2,3]
Bariatric surgery inpatient services (pre-authorization required: medically necessary surgery for weight loss, only for morbid obesity)[5]	$500/admit + 40%		50%[2,3]

Active Start plans

Covered services	Member copayments		
	With preferred providers,[1] you pay		**With non-preferred providers,[1] you pay**
	Active Start Plan 25, Active Start Plan 25 Generic Rx	**Active Start Plan 35, Active Start Plan 35 Generic Rx**	
Emergency health coverage			
Emergency room services ($100 copayment/visit waived if the member is admitted directly to the hospital as an inpatient)	$100/visit + 40%		Covered at same level as preferred provider
ER physician visits	$25	$35	Covered at same level as preferred provider
Ambulance services (surface or air)	40%		40%
	Active Start Plan 25 and Active Start Plan 35		
Prescription drug coverage[4] (outpatient)	**At participating pharmacies** (up to a 30-day supply)		**Mail service prescriptions** (up to a 60-day supply)
Generic formulary drugs	$10/prescription[2]		$20/prescription[2]
Formulary brand-name drugs	$35/prescription[2]		$70/prescription[2]
Non-formulary brand-name drugs	$50 or 50%/prescription (whichever is greater)[2]		$100 or 50%/prescription (whichever is greater)[2]
Brand-name drug deductible (brand-name drugs are subject to a brand-name drug deductible per person, per calendar year)	**Active Start plan 25**		**Active Start plan 35**
	$500		$750

Active Start Plan 25 Generic Rx and Active Start Plan 35 Generic Rx are also available. These plans do not cover brand-name drugs. All other plan benefits are the same.

	With preferred providers,[1] you pay		**With non-preferred providers,[1] you pay**
	Active Start Plan 25, Active Start Plan 25 Generic Rx	**Active Start Plan 35, Active Start Plan 35 Generic Rx**	
Durable medical equipment[7]	40%		50%
	With MHSA participating providers,[1,8] you pay		**With MHSA non-participating providers,[1,8] you pay**
Mental health services			
Inpatient hospital facility services	$500/admit + 40%		50%[2,3]
Inpatient physician services	40%		50%
Outpatient visits for severe mental health conditions	$25	$35	50%
Outpatient visits for non-severe mental health conditions (up to 20 visits per calendar year combined with chemical dependency visits)[5]	40%[2]		Not covered
Chemical dependency services (substance abuse)			
Inpatient hospital facility services for medical acute detoxification	$500/admit + 40%		50%[2,3]
Inpatient physician services for medical acute detoxification	40%		50%
Outpatient visits (up to 20 visits per calendar year combined with non-severe mental health visits)[5]	40%[2]		Not covered

Active Start plans

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

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

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. Member is responsible for all charges that exceed $250 per day.

4 Participating ASCs may not be available in all areas. Regardless of their availability, you can obtain outpatient surgery services from a hospital, or an ASC affiliated with a hospital with payment according to your health plan's hospital services benefits. The maximum allowed charge for non-emergency surgery and services performed in a non-participating ASC is $300 per day. Members are responsible for 50% of this $300 per day, plus all charges in excess of $300.

5 Bariatric surgery is covered when pre-authorized by Blue Shield. However, for members residing in Imperial, Kern, Los Angeles, Orange, Riverside, San Bernardino, San Diego, Santa Barbara, and Ventura counties ("designated counties"), bariatric surgery services are covered only when performed at designated contracting bariatric surgery facilities and by designated contracting surgeons; coverage is not available for bariatric services from any other preferred provider, and there is no coverage for bariatric services from non-preferred providers. In addition, if prior authorized by Blue Shield, a member in a designated county who is required to travel more than 50 miles to a designated bariatric surgery facility will be eligible for limited reimbursement for specified travel expenses for the member and one companion. Refer to the Policy for further benefit details.

6 If a member requests a brand-name drug or the physician indicates "dispense as written" (DAW) for a prescription when an equivalent generic drug is available, and the brand-name drug deductible has been satisfied, the member pays the generic copayment plus the difference between the brand and generic drug cost. Prescription coverage differs for home self-injectables. Blue Shield Life's payments for brand-name prescriptions are limited to $2,000 per calendar year. Please review the Policy before you purchase the plan.

7 All covered durable medical, orthoses, and prostheses equipment and services have a combined benefit maximum of $2,000 per member per calendar year, except those services covered under the diabetes care benefit and medically necessary oxygen.

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

9 For MHSA participating providers, initial visit treated as if the condition were a severe mental illness or serious emotional disturbance of a child. For MHSA non-participating providers, initial visit treated as an MHSA participating provider.

Balance plans

Balance Plan 1000
Balance Plan 1700
Balance Plan 2500

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

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

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

Balance plan advantages

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

Is a Balance plan right for you?

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

Balance plans

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

Uniform Health Plan Benefits and Coverage Matrix

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

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

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

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

The benefits below apply to all Balance plans.

Covered services 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[2] ●	50%
Preventive care		
Annual routine physical exam, well-baby care office visits, and gynecological exam office visit (includes Pap test or other approved cervical cancer screening tests, routine mammography, and immunizations when received as part of the annual exam or preventive care visit)	$30[2] ●	Not covered
Outpatient services		
Non-emergency services and procedures	30%	50%[2,3]
Outpatient surgery in hospital	$250/visit + 30%	50%[2,3]
Outpatient surgery performed in an ambulatory surgery center (ASC)[4]	30%	50%[2]
Outpatient or out-of-hospital X-ray and laboratory	30%	50%

Balance plans

Covered services	Member copayments	
Subject to the plan deductible unless noted.	**With preferred providers,[1] you pay**	**With non-preferred providers,[1] you pay**
Hospitalization services		
Inpatient physician visits and consultations, surgeons and assistants, and anesthesiologists	30%	50%
Inpatient semiprivate room and board, services and supplies, and subacute care	30%	50%[2,3]
Bariatric surgery inpatient services (pre-authorization required: medically necessary surgery for weight loss, only for morbid obesity)[5]	30%	50%[2,3]
Emergency health coverage		
Emergency room services ($100 copayment/visit waived if the member is admitted directly to the hospital as an inpatient)	$100/visit + 30% ●	$100/visit + 30% ●
ER physician visits	30%	30%
Ambulance services (surface or air)	30%	30%
Prescription drug coverage[4] (outpatient)	**At participating pharmacies** (up to a 30-day supply)	**Mail service prescriptions** (up to a 60-day supply)
Generic formulary drugs	$10/prescription[2] ●	$20/prescription[2] ●
Formulary brand-name drugs	$35/prescription[2]	$70/prescription[2]
Non-formulary brand-name drugs	$50 or 50%, whichever is greater/prescription[2]	$100 or 50%, whichever is greater/prescription[2]
Brand-name drug deductible (brand-name drugs are subject to a brand-name drug deductible per person, per calendar year)	$500	
	With preferred providers,[1] you pay	**With non-preferred providers,[1] you pay**
Durable medical equipment[7]	30%	50%
	With MHSA participating providers,[1,8] you pay	**With MHSA non-participating providers,[1,8] you pay**
Mental health services		
Inpatient hospital facility services	30%	50%[2,3]
Inpatient physician services	30%	50%
Outpatient visits for severe mental health conditions	$30[2] ●	50%
Outpatient visits for non-severe mental health conditions (up to 20 visits per calendar year combined with chemical dependency visits)[9]	30%	Not covered
Chemical dependency services (substance abuse)		
Inpatient hospital facility services for medical acute detoxification	30%	50%[2,3]
Inpatient physician services for medical acute detoxification	30%	50%
Outpatient visits (up to 20 visits per calendar year combined with non-severe mental health visits)[9]	30%	Not covered
	With preferred providers,[1] you pay	**With non-preferred providers,[1] you pay**
Home health services (up to 90 pre-authorized visits per calendar year)	30%	Not covered

Balance plans

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

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

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

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

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

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

4 Participating ASCs may not be available in all areas. Regardless of their availability, you can obtain outpatient surgery services from a hospital, or an ASC affiliated with a hospital with payment according to your health plan's hospital services benefits. The maximum allowed charge for non-emergency surgery and services performed in a non-participating ASC is $300 per day. Members are responsible for 50% of this $300 per day, plus all charges in excess of $300.

5 Bariatric surgery is covered when pre-authorized by Blue Shield. However, for members residing in Imperial, Kern, Los Angeles, Orange, Riverside, San Bernardino, San Diego, Santa Barbara, and Ventura counties ("designated counties"), bariatric surgery services are covered only when performed at designated contracting bariatric surgery facilities and by designated contracting surgeons; coverage is not available for bariatric services from any other preferred provider, and there is no coverage for bariatric services from non-preferred providers. In addition, if prior authorized by Blue Shield, a member in a designated county who is required to travel more than 50 miles to a designated bariatric surgery facility will be eligible for limited reimbursement for specified travel expenses for the member and one companion. Refer to the Policy for further benefit details.

6 If a member requests a brand-name drug or the physician indicates "dispense as written" (DAW) for a prescription when an equivalent generic drug is available, and the brand-name drug deductible has been satisfied, the member pays the generic copayment plus the cost difference between the brand and generic drug. Prescription coverage differs for home self-injectables. Please review the Policy before you purchase the plan. Blue Shield Life's payments for brand-name prescriptions are limited to $2,500 per calendar year.

7 All covered durable medical equipment, orthoses, and prostheses have a combined benefit maximum of $5,000 per member per calendar year, except those services covered under the diabetes care benefit. See Policy for details.

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

9 For MHSA participating providers, initial visit treated as if the condition were a severe mental illness or serious emotional disturbance of a child. For MHSA non-participating providers, initial visit treated as an MHSA participating provider.

Shield Spectrum PPO plans

- PPO Plan 5000*
- PPO Plan 2000/Blue Shield Life PPO plan 2000*
- PPO Plan 1500/Blue Shield Life PPO plan 1500*
- PPO Plan 750
- PPO Plan 500

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

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

Shield Spectrum PPO℠ Plan advantages

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

Is a Shield Spectrum PPO plan right for you?

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

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

Shield Spectrum PPO Plan 5000

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

Uniform Health Plan Benefits and Coverage Matrix

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.

	PPO 5000
Deductible*	$5,000 ($10,000 family)
Copayments	$35 with preferred providers Not applicable with non-preferred providers
Coinsurance	30% with preferred providers 50% with non-preferred providers
Calendar-year copayment/coinsurance maximum (includes the plan deductible – some services do not apply)	Services with preferred providers: $7,000 ($14,000 family) Services with all providers: $10,000 ($20,000 family)
Lifetime maximum	$6,000,000
Critical Condition Protection	$10,000 per member, per lifetime

* Benefits for covered brand-name drugs are subject to a separate $500 brand-name drug deductible per person per calendar year.

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

Covered services 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 hospital	30%	50%[2,3]
Outpatient surgery performed in an ambulatory surgery center (ASC)[4]	30%	50%[2]
Outpatient or out-of-hospital X-ray and laboratory	30%	50%
Hospitalization services		
Inpatient physician visits and consultations, surgeons and assistants, and anesthesiologists	30%	50%
Inpatient semiprivate room and board, services and supplies, and subacute care	30%	50%[2,3]
Bariatric surgery inpatient services (pre-authorization required: medically necessary surgery for weight loss, only for morbid obesity)[5]	30%	50%[2,3]
Emergency health coverage		
Emergency room services	30%	30%
ER physician visits	30%	30%
Ambulance services (surface or air)	30%	30%
Prescription drug coverage[6] outpatient	**At participating pharmacies** (up to a 30-day supply)	**Mail service prescriptions** (up to a 60-day supply)
Generic formulary drugs	$10/prescription[2] ●	$20/prescription[2] ●
Formulary brand-name drugs	$35/prescription[2]	$70/prescription[2]
Non-formulary brand-name drugs	$50 or 50%/prescription (whichever is greater)[2]	$100 or 50%/prescription (whichever is greater)[2]
Brand-name drugs are subject to a $500 brand-name drug deductible per person, per calendar year	$500	
	With preferred providers,[1] you pay	**With non-preferred providers,[1] you pay**
Durable medical equipment[7]	30%	50%

Shield Spectrum PPO Plan 5000

Covered services	Member copayments	
Subject to the plan deductible, unless noted.	**With MHSA participating providers,[1,8] you pay**	**With MHSA non-participating providers,[1,8] you pay**
Mental health services		
Inpatient hospital facility services	30%	50%[2,3]
Inpatient physician services	30%	50%
Outpatient visits for severe mental health conditions	$35	50%
Outpatient visits for non-severe mental health conditions (up to 20 visits per calendar year combined with chemical dependency visits)[9]	30%	Not covered
Chemical dependency services (substance abuse)		
Inpatient hospital facility services for medical acute detoxification	30%	50%[2,3]
Inpatient physician services for medical acute detoxification	30%	50%
Outpatient visits (up to 20 visits per calendar year combined with non-severe mental health visits)[9]	30%	Not covered
	With preferred providers,[1] you pay	**With non-preferred providers,[1] you pay**
Home health services (up to 90 pre-authorized visits per calendar year)	30%	Not covered
Other		
Pregnancy and maternity care		
Outpatient prenatal and postnatal care	30%	50%
Delivery and all necessary inpatient hospital services	30%	50%[2,3]
Family planning		
Consultations, tubal ligation, vasectomy, elective abortion	30%	Not covered
Rehabilitation services (up to 12 visits per calendar year combined with speech therapy visits)		
Provided in the office of a physician or physical therapist	30%	50%
Out-of-state services (full plan benefits covered nationwide with the BlueCard Program)	30% with BlueCard participating providers	50% with all other providers

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

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

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

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

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

4 Participating ASCs may not be available in all areas. Regardless of their availability, you can obtain outpatient surgery services from a hospital, or an ASC affiliated with a hospital with payment according to your health plan's hospital services benefits. The maximum allowed charge for non-emergency surgery and services performed in a non-participating ASC is $300 per day; members are responsible for 50% of this $300 per day, plus all charges in excess of $300.

5 Bariatric surgery is covered when pre-authorized by Blue Shield. However, for members residing in Imperial, Kern, Los Angeles, Orange, Riverside, San Bernardino, San Diego, Santa Barbara, and Ventura counties ("designated counties"), bariatric surgery services are covered only when performed at designated contracting bariatric surgery facilities and by designated contracting surgeons; coverage is not available for bariatric services from any other preferred provider, and there is no coverage for bariatric services from non-preferred providers. In addition, if prior authorized by Blue Shield, a member in a designated county who is required to travel more than 50 miles to a designated bariatric surgery facility will be eligible for limited reimbursement for specified travel expenses for the member and one companion. Refer to the Policy for further benefit details.

6 If a member requests a brand-name drug, or the physician indicates "dispense as written" (DAW) for a prescription when an equivalent generic drug is available, and the brand-name drug deductible has been satisfied, the member pays the generic copayment plus the cost difference between the brand and generic drug. Prescription coverage differs for home self-injectables. Please review the Policy before you purchase the plan.

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

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

9 For MHSA participating providers, initial visit treated as if the condition were a severe mental illness or serious emotional disturbance of a child. For MHSA non-participating providers, initial visit treated as an MHSA participating provider.

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

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

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

Uniform Health Plan Benefits and Coverage Matrix

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

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

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

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

Covered services	Member copayments				
Subject to the plan deductible, unless noted.	**With preferred providers,[1] you pay**				**With non-preferred providers,[1] you pay**
	PPO 500	**PPO 750**	**PPO 1500**	**PPO 2000**	
Professional services					
Office visits	$30[2] ●	$35[2] ●	$40[2] ●	$45[2] ●	50%
Preventive care					
Annual routine physical exam, well-baby care office visits and gynecological exam (includes Pap test or other approved cervical cancer screening tests, routine mammography, and immunizations when received as part of the annual exam or preventive care visit)	$30[2] ●	$35[2] ●	$40[2] ●	$45[2] ●	Not covered
Outpatient services					
Non-emergency services and procedures	25%	30%			50%[2,3]
Outpatient surgery in hospital	$250/admit + 25%	$250/admit + 30%			50%[2,3]
Outpatient surgery in performed in an Ambulatory Surgery Center (ASC)[4]	25%	30%			50%[2]
Outpatient or out-of-hospital X-ray and laboratory	25%	30%			50%

Shield Spectrum PPO Plans

Covered services Subject to the plan deductible, unless noted.	Member copayments **With preferred providers,[1] you pay**				**With non-preferred providers,[1] you pay**
	PPO 500	**PPO 750**	**PPO 1500**	**PPO 2000**	
Hospitalization services					
Inpatient physician visits and consultations, surgeons and assistants, and anesthesiologists	25%	30%			50%
Inpatient semiprivate room and board, services and supplies, and subacute care	$250/visit + 25%	$250/visit + 30%			50%[2,3]
Bariatric surgery inpatient services (pre-authorization required: medically necessary surgery for weight loss, only for morbid obesity)[5]	$250/visit + 25%	$250/visit + 30%			50%[2,3]
Emergency health coverage					
Emergency room services ($100 copayment/visit waived if admitted as an inpatient)	$100/visit + 25%	$100/visit + 30%			Covered at same level as preferred providers
ER physician visits	25%	30%			Covered at same level as preferred providers
Ambulance services (surface or air)	25%	30%			Covered at same level as preferred providers
	PPO Plans 500–2000				
Prescription drug coverage[6] (outpatient)	**At participating pharmacies** (up to a 30-day supply)			**Mail service prescriptions** (up to a 60-day supply)	
Generic formulary drugs	$10/prescription[2] ●			$20/prescription[2] ●	
Formulary brand-name drugs	$35/prescription[2]			$70/prescription[2]	
Non-formulary brand-name drugs	$50 or 50%/prescription, whichever is greater (maximum copayment of $150 per prescription)[2]			$100 or 50%/prescription, whichever is greater (maximum copayment of $300 per prescription)[2]	
Brand-name drug deductible (brand-name drugs are subject to a brand-name drug deductible per person, per calendar year)	**PPO plans 500 and 750**			**PPO plans 1500 and 2000**	
	$250			$500	
	With preferred providers,[1] you pay				**With non-preferred providers,[1] you pay**
	PPO 500	**PPO 750**	**PPO 1500**	**PPO 2000**	
Durable medical equipment[7]	25%	30%			50% (not covered for PPO 500 and 1500)
Mental health services	**With MHSA participating providers,[1,8] you pay**				**With MHSA non-participating providers,[1,8] you pay**
Inpatient hospital facility services	$250/admit + 25%	$250/admit + 30%			50%[2,3]
Inpatient physician services	25%	30%			50%
Outpatient visits for severe mental health conditions	$30[2] ●	$35[2] ●	$40[2] ●	$45[2] ●	50%
Outpatient visits for non-severe mental health conditions (up to 20 visits per calendar year combined with chemical dependency visits)[9]	25%	30%			Not covered
Chemical dependency services (substance abuse)					
Inpatient hospital facility services for medical acute detoxification	$250/admit + 25%	$250/admit + 30%			50%[2,3]
Inpatient physician services for medical acute detoxification	25%	30%			50%
Outpatient visits (up to 20 visits per calendar year combined with non-severe mental health visits)[9]	25%	30%			Not covered

Shield Spectrum PPO Plans

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

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

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

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

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

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

4 Participating ASCs may not be available in all areas. Regardless of their availability, you can obtain outpatient surgery services from a hospital, or an ASC affiliated with a hospital with payment according to your health plan's hospital services benefits. The maximum allowed charge for non-emergency surgery and services performed in a non-participating ASC is $300 per day; members are responsible for 50% of this $300 per day, plus all charges in excess of $300.

5 Bariatric surgery is covered when pre-authorized by Blue Shield. However, for members residing in Imperial, Kern, Los Angeles, Orange, Riverside, San Bernardino, San Diego, Santa Barbara, and Ventura counties ("designated counties"), bariatric surgery services are covered only when performed at designated contracting bariatric surgery facilities and by designated contracting surgeons; coverage is not available for bariatric services from any other preferred provider, and there is no coverage for bariatric services from non-preferred providers. In addition, if prior authorized by Blue Shield, a member in a designated county who is required to travel more than 50 miles to a designated bariatric surgery facility will be eligible for limited reimbursement for specified travel expenses for the member and one companion. Refer to the EOC/Policy for further benefit detail.

6 If a member requests a brand-name drug, or the physician indicates "dispense as written" (DAW) for a prescription when an equivalent generic drug is available, and the brand-name drug deductible has been satisfied, the member pays the generic copayment plus the cost difference between the brand and generic drug. The $150/$300 max/prescription for non-formulary brand-name drugs does not apply to Blue Shield Life Shield Spectrum PPO Plans 2000 or 1500. Prescription coverage differs for home self-injectables. Please review the EOC/Policy before you purchase the plan.

7 All covered orthotic equipment and services have a benefit maximum of $1,000 per member per calendar year, except those services covered under the diabetes care benefit. All covered prostheses and durable medical equipment have a benefit maximum of $2,000 per member per calendar year.

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

9 For MHSA participating providers, initial visit treated as if the condition were a severe mental illness or serious emotional disturbance of a child. For MHSA non-participating providers, initial visit treated as an MHSA participating provider.

Shield Spectrum PPO Savings Plans

NEW! PPO Savings Plan 1800/3600*
PPO Savings Plan 2400/4800
PPO Savings Plan 4000/8000**

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

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

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

Shield Spectrum PPO Savings Plan℠ advantages

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

A Health Savings Account adds value to your plan

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

What is an HSA?

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

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

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

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

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

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

NOTICE: Blue Shield does not provide tax advice. If you intend to purchase this plan to use with an HSA for tax purposes, you should consult with your tax advisor about whether you are eligible and whether your HSA meets all legal requirements. Although we believe that these plans meet these legal requirements, the Internal Revenue Service has not ruled on whether the plans are qualified as high-deductible health plans. If you purchase one of these plans to obtain the income tax benefits associated with an HSA and the Internal Revenue Service rules that these plans do not qualify as high-deductible health plans, you may not be eligible for the income tax benefits associated with an HSA. In this instance, you may have adverse income tax consequences with respect to your HSA for all years in which you were not eligible. However, if there were such a ruling, or if government requirements for an HSA-eligible high-deductible health plan change, we intend to amend the Shield Spectrum PPO Savings Plans, if necessary, to meet the requirements of a qualified plan. The plan's monthly rates may also change as a result of a change in the plan(s).

Shield Spectrum PPO Savings Plans

HSA-compatible

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

Uniform Health Plan Benefits and Coverage Matrix

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

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

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

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

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

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

Covered services	Member copayments		
Subject to the plan deductible, unless noted.	**With preferred providers,[1] you pay**		**With non-preferred providers,[1] you pay**
	1800/3600 and 2400/4800	**4000/8000**	
Professional services			
Office visits	$35	No charge after deductible	50%
Preventive care			
Annual routine physical exam, gynecological exam, well-baby care office visits (includes Pap test or other approved cervical cancer screening tests, routine mammography, and immunizations when received as part of the annual exam or preventive care visit)	$35 ●	$35 (no charge after deductible) ●	Not covered
Outpatient services			
Non-emergency services and procedures, outpatient surgery in a hospital	30%	No charge after deductible	50%[2]
Outpatient surgery performed in an ambulatory surgery center (ASC)[3]	30%	No charge after deductible	50%
Outpatient X-ray and laboratory	30%	No charge after deductible	50%
Hospitalization services			
Inpatient physician visits and consultations, surgeons and assistants, and anesthesiologists	30%	No charge after deductible	50%
Inpatient semiprivate room and board, services and supplies, and subacute care	30%	No charge after deductible	50%[2]
Bariatric surgery inpatient services (pre-authorization required: medically necessary surgery for weight loss, only for morbid obesity)[4]	30%	No charge after deductible	50%[2]

Shield Spectrum PPO Savings Plans

Covered services	Member copayments			
Subject to the plan deductible, unless noted.	**With preferred providers,[1] you pay**		**With non-preferred providers,[1] you pay**	
	1800/3600 and 2400/4800	**4000/8000**		
Emergency health coverage				
Emergency room services ($75 copayment/visit waived if the member is admitted directly to the hospital as an inpatient)	$75/visit + 30%	No charge after deductible	Covered at same level as preferred provider	
ER physician visits	30%	No charge after deductible	Covered at same level as preferred provider	
Ambulance services (surface or air)	30%	No charge after deductible	Covered at same level as preferred provider	
	At participating pharmacies (up to a 30-day supply)		**Mail service prescriptions** (up to a 60-day supply)	
Prescription drug coverage[5] (outpatient, subject to the plan medical deductible)	**1800/3600 and 2400/4800**	**4000/8000**	**1800/3600 and 2400/4800**	**4000/8000**
Generic formulary drugs	$10/prescription	No charge	$20/prescription	Covered at same level as participating pharmacies
Formulary brand-name drugs	$35/prescription	No charge	$70/prescription	
Non-formulary brand-name drugs	$50 or 50%/prescription, whichever is greater (maximum of $150/ prescription)	No charge	$100 or 50%/ prescription, whichever is greater (maximum of $300/ prescription)	
	With preferred providers,[1] you pay		**With non-preferred providers,[1] you pay**	
	1800/3600 and 2400/4800	**4000/8000**		
Durable medical equipment[6]	30%	No charge after deductible	50%	
	With MHSA participating providers,[1,7] you pay		**With MHSA non-participating providers,[1,7] you pay**	
	1800/3600 and 2400/4800	**4000/8000**		
Mental health services				
Inpatient hospital facility services	30%	No charge after deductible	50%[2]	
Inpatient physician services	30%	No charge after deductible	50%	
Outpatient visits for severe mental health conditions	$35	No charge after deductible	50%	
Outpatient visits for non-severe mental health conditions (up to 20 visits per calendar year combined with chemical dependency visits)[9]	30%	No charge after deductible	Not covered	
Chemical dependency services (substance abuse)				
Inpatient hospital facility services for medical acute detoxification	30%	No charge after deductible	50%[2]	
Inpatient physician services for medical acute detoxification	30%	No charge after deductible	50%	
Outpatient visits (up to 20 visits per calendar year combined with non-severe mental health visits)[9]	30%	No charge after deductible	Not covered	
	With preferred providers,[1] you pay		**With non-preferred providers,[1] you pay**	
Home health services (up to 90 pre-authorized visits per calendar year)[9]	30%	No charge after deductible	Not covered	

Shield Spectrum PPO Savings Plans

Covered services	Member copayments		
Subject to the plan deductible, unless noted.	**With preferred providers,[1] you pay**		**With non-preferred providers,[1] you pay**
	1800/3600 and 2400/4800	**4000/8000**	
Other			
Pregnancy and maternity care			
Outpatient prenatal and postnatal care	30% (not covered for 1800/3600)	Not covered	50% (not covered for PPO Savings Plans 1800/3600 and 4000/8000)
Delivery and all necessary inpatient hospital services	30% (not covered for 1800/3600)	Not covered	50%[2] (not covered for PPO Savings Plans 1800/3600 and 4000/8000)
Family planning			
Consultations, tubal ligation, vasectomy, elective abortion	30%	No charge after deductible	Not covered
Rehabilitation services[8]			
Provided in the office of a physician or physical therapist	30%[8] (up to 20 visits per calendar year)	No charge after deductible	50%
Chiropractic services (up to 12 visits per calendar year – Blue Shield's payment is limited to $25/visit)	50%	No charge after deductible	Not covered
Out-of-state services (full plan benefits covered nationwide with the BlueCard Program)	30% with BlueCard participating providers	No charge after deductible with BlueCard participating providers	50% with all other providers

Please note: Benefits are subject to modification for subsequently enacted state or federal legislation. Shield Spectrum PPO Savings Plan 1800/3600 is subject to regulatory approval.

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

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

2 For non-emergency hospital services and supplies received from a non-preferred (non-network) hospital, Blue Shield's maximum payment is $300 per day. After the deductible is met, members are responsible for all charges that exceed $300 per day.

3 Participating ASCs may not be available in all areas. Regardless of their availability, you can obtain outpatient surgery services from a hospital, or an ASC affiliated with a hospital with payment according to your health plan's hospital services benefits. The maximum allowed charge for non-emergency surgery and services performed in a non-participating ASC is $300 per day. Members are responsible for 50% of this $300 per day, plus all charges in excess of $300.

4 Bariatric surgery is covered when pre-authorized by Blue Shield. However, for members residing in Imperial, Kern, Los Angeles, Orange, Riverside, San Bernardino, San Diego, Santa Barbara, and Ventura counties ("designated counties"), bariatric surgery services are covered only when performed at designated contracting bariatric surgery facilities and by designated contracting surgeons; coverage is not available for bariatric services from any other preferred provider, and there is no coverage for bariatric services from non-preferred providers. In addition, if prior authorized by Blue Shield, a member in a designated county who is required to travel more than 50 miles to a designated bariatric surgery facility will be eligible for limited reimbursement for specified travel expenses for the member and one companion. Refer to the EOC/Policy for further benefit details.

5 If a member requests a brand-name drug or the physician indicates dispense as written (DAW) for a prescription, when an equivalent generic drug is available, and the brand-name drug deductible has been satisfied, the member pays the generic copayment plus the cost difference between the brand and generic drug, and it will not accrue to the copayment maximum. Prescription coverage differs for home self-injectables. Some prescriptions will require prior authorization to obtain coverage (see formulary). Use of ID card is required to obtain prescriptions from pharmacy or claim(s) will be denied. Please review the EOC/Policy before you purchase the plan.

6 For PPO Savings Plans 1800/3600 and 2400/4800, all covered orthotic equipment and services have a benefit maximum of $2,000 per member per calendar year, except those services covered under the prosthetic appliances, durable medical equipment, or the diabetes care benefit. For PPO Savings Plan 4000/8000, all covered durable medical equipment, prosthetic, and orthotic equipment and services have a combined benefit maximum of $2,000 per member per calendar year, except those services covered under the diabetes care benefit.

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

8 Limit applies to visits to participating and non-participating providers combined for PPO Savings Plans 1800/3600 and 2400/4800. Additional visits will be authorized if Blue Shield determines that additional treatment is medically necessary.

9 For MHSA participating providers, initial visit treated as if the condition were a severe mental illness or serious emotional disturbance of a child. For MHSA non-participating providers, initial visit treated as an MHSA participating provider.

HMO Plans

Access+ Value HMO

Access+ HMO

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

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

Access+ Value HMO℠ and Access+ HMO® plan advantages

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

Personal care from your Personal Physician

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

He or she:

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

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

Special features

Direct access to specialists

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

Direct access to gynecological exams and OB/GYN visits

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

HMO Plans

Uniform Health Plan Benefits and Coverage Matrix

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

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

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

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

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

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

HMO Plans

Covered services	Member copayments	
	Access+ Value HMO and Access+ HMO	
Prescription drug coverage[5,6]	**At participating pharmacies** (up to a 30-day supply)	**Mail service prescriptions** (up to a 60-day supply)
Generic drugs	$10/prescription[2] ●	$20/prescription[2] ●
Formulary brand-name drugs	$35/prescription[2]	$70/prescription[2]
Brand name drug deductible (brand-name drugs subject to a brand-name drug deductible per person, per calendar year)	**Access+ Value HMO**	**Access+ HMO**
	$400	$200
	Access+ Value HMO	**Access+ HMO**
Durable medical equipment[7]	50%[2] ●	50%[2] ●
Mental health services[8]		
Inpatient hospital facility services	40%/admit	$250/admit
Inpatient physician services	$35/visit ●	$20/visit ●
Outpatient visits for severe mental health conditions	$35/visit ($50/visit[2] if provider is MHSA Access+ *Specialist* provider)[3] ●	$20/visit ($35/visit[2] if provider is MHSA Access+ *Specialist* provider)[3] ●
Outpatient visits for non-severe mental health conditions (up to 20 visits per calendar year combined with chemical dependency visits)[9]	$35/visit[2] ($50/visit[2] if provider is MHSA Access+ *Specialist* provider)[3] ●	$20/visit[2] ($35/visit[2] if provider is MHSA Access+ *Specialist* provider)[3] ●
Chemical dependency services (substance abuse)[4]		
Inpatient hospital facility services for medical acute detoxification	40%/admit	$250/admit
Outpatient visits (up to 20 visits per calendar year combined with non-severe mental health visits)[9]	$35/visit[2] ($50/visit[2] if provider is MHSA Access+ *Specialist* provider)[3] ●	$20/visit[2] ($35/visit[2] if provider is MHSA Access+ *Specialist* provider)[3] ●
Home health services (up to 100 visits per calendar year)		
Home health agency visits (up to 4 visits per day, 2 hours per visit)	$35 ●	$20 ●
Other		
Pregnancy and maternity care[10]		
Outpatient prenatal and postnatal physician office visits	$35/visit ●	$20/visit ●
Delivery and all necessary inpatient hospital services	40%/admit	$250/admit
Family planning		
Counseling	$35/visit ●	$20/visit ●
Tubal ligation,[11] elective abortion	$100/occurrence ●	$100/occurrence ●
Vasectomy	$75/occurrence ●	$75/occurrence ●
Rehabilitation services – physical, occupational and respiratory therapy		
Received in a physician's office visit or in hospital outpatient department	$35/visit ●	$20/visit ●
In inpatient rehabilitation unit of hospital	40%/admit	$250/admit
Urgent care (outside your plan service area)[12]	$50/visit ●	$50/visit ●
Dental services (for details please see the Dental Highlights Matrix, page 40)		
Access+ *Dentist*	Not covered	Included within this plan

HMO plan footnotes

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

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

1 Access+ HMO and Access+ Value HMO benefits are provided only for services that are medically necessary, as determined by the Personal Physician or Access+ Value HMO/Access+ HMO, except in an emergency or as otherwise specified, and must be received while the patient is a current member.

2 These copayments do not accrue to the copayment maximum.

3 To use the Access+ *Specialist* option, for other than mental health or chemical dependency services, your Personal Physician must belong to a medical group or IPA that has decided to become an Access+ Provider Group. Access+ *Specialist* visits for mental health services for other than severe mental illnesses or serious emotional disturbances of a child, and for chemical dependency care, will accrue toward the 20-visit-per-calendar-year maximum. In addition, all Access+ *Specialist* visits require a copayment per visit. Mental health and chemical dependency Access+ *Specialist* visits are accessed through the MHSA utilizing MHSA participating providers.

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

5 Only medically necessary outpatient formulary drugs are covered, unless prior authorization is obtained from Blue Shield Pharmacy Services. Non-formulary drugs may be covered only if prior authorization is obtained from Blue Shield Pharmacy Services. After all necessary documentation is available from your physician, prior authorization approval or denial will be provided to your physician within two working days of the request. Member is then responsible for the brand prescription copayment. Prescription coverage differs for home self-injectables. Please review the EOC before you purchase the plan.

6 If a member or the physician requests a brand-name drug when an equivalent generic drug is available, the member pays the generic copayment plus the cost difference between the brand and generic drug at retail or mail order pharmacies.

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

8 Blue Shield of California has contracted with a specialized healthcare service plan to act as the plan's mental health services administrator (MHSA) and to provide mental health and chemical dependency services, other than inpatient services for medical acute detoxification, through a separate network of MHSA participating providers. Inpatient services for medical acute detoxification are accessed through Blue Shield utilizing HMO network (not MHSA) providers. For all other mental health and chemical dependency services, members should access MHSA participating providers.

9 For MHSA participating providers, initial visit treated as if the condition were a severe mental illness or serious emotional disturbance of a child. For MHSA non-participating providers, initial visit treated as an MHSA participating provider.

10 Except for the treatment of involuntary complications of pregnancy, pregnancy/maternity benefits for a pregnancy that qualifies as a waivered condition are not available during the six-month period beginning as of the effective date of coverage.

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

12 Authorization by Blue Shield is required for more than two out-of-area follow-up outpatient visits or for out-of-area follow-up care that involves a surgical or other procedure or inpatient stay. After all necessary documentation is available from your physician, prior authorization approval or denial will be provided to your physician within two working days of the request.

Additional services for no added cost

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

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

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

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

LifeReferrals 24/7℠ – Experienced professionals offer:

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

Pre-Surgical Guided Imagery Program

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

Chart Your Course Diabetes Management Program

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

Discount Vision Program*

When you use MESVision providers in the Discount Vision Program[1], you will receive a 20% discount off the published retail prices on the following services and supplies:

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

Mylifepath Alternative Health Services Discount Program

Through the *Mylifepath*℠ Alternative Health Services Discount Program, you can save money on alternative health and wellness services. This program provides members with discounts for acupuncture, chiropractic, and massage therapy services.**

The *Mylifepath* network includes thousands of screened and qualified acupuncturists, chiropractors, and massage therapists throughout California. Members can receive the discount simply by presenting their Blue Shield ID card to any *Mylifepath* network practitioner and pay at least 25% off the practitioner's usual published fee for certain services.

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

** The *Mylifepath* Alternative Care Discount Program is an exclusive offer to Blue Shield members, made available through an arrangement with American Specialty Health Networks (ASH Networks) and is not a covered service of any Blue Shield health plan. ASH Networks credentials and manages the program's practitioners. None of the terms and conditions of Blue Shield health plans apply. Blue Shield of California and ASH Networks do not review the program's practitioner services and products for medical necessity or efficacy, and make no representations, claims, or guarantees regarding their services or products. Members who use the discount program are responsible for the payment of services provided by participating network practitioners, including payment for cancelled or missed appointments. Members who are not satisfied with services received from the program's practitioners may use the Blue Shield grievance process. Blue Shield reserves the right to terminate this program without notice.

1 Discount program services are provided by MESVision. MESVision network practitioners are screened, credentialed, and managed by MESVision. The MESVision Discount Program is not a covered service of any Blue Shield health plan. None of the terms or conditions of Blue Shield health plans apply to the discount program. Members are responsible for all charges incurred and must pay the practitioner directly. Members who are not satisfied with services received from the program's practitioners may use the Blue Shield grievance process.

blueshieldca.com

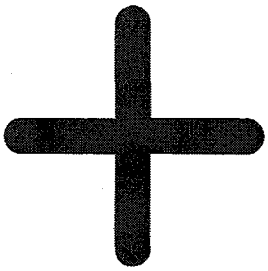
Our innovative Web site offers you valuable tools and reliable information to help you manage your health plan benefits. Once you become a member and register on **blueshieldca.com**, you'll have access to:

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

Health management programs

Our health management programs provide up-to-date information and wellness strategies to help members take control of their health. And Blue Shield's Center for Health Improvement offers valuable programs and resources for members living with chronic conditions such as asthma and diabetes.

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



additional coverage

Dental coverage

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

Dental coverage

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

Blue Shield Dental

PPO

Choose any dental provider. Out-of-pocket costs for covered services are lowest when you receive care from network dentists.

	Monthly rate
Subscriber	$35
Subscriber and spouse	$74
Subscriber and child	$53
Subscriber and children	$79
Family	$123

Plan features:

- Access to over 19,000 general care and specialty dentists in California*
- Coverage when using a non-network dentists
- Fixed copayments in network
- Calendar-year deductible of $50 per member
- Calendar-year benefit maximum of $1,000 per member
- Wide range of dental benefits, with most diagnostic and preventive services fully covered when using network providers
- Orthodontic benefits for children and adults
- No waiting period, after enrollment, for diagnostic or preventive services
- Enhanced dental benefits for pregnant women

HMO

Choose a dental care provider from our dental HMO provider network to provide all of your family's network dental care.

	Monthly rate
Subscriber	$17
Subscriber and spouse	$34
Subscriber and child	$30
Subscriber and children	$35
Family	$66

Plan features:

- Access to over 8,600 dental provider locations in California*
- No calendar-year maximums
- Fixed copayments and no deductibles
- Wide range of dental benefits, including most diagnostic and preventive services at no out-of pocket cost to you
- Specialty care available with referral from your dental provider
- Orthodontic benefits for children and adults
- No waiting period for any type of service, other than orthodontics
- Practically no claims forms

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

Please note: Monthly rates for the dental HMO and dental PPO plans are in addition to the monthly rates for medical benefits covered by the Blue Shield health plan. However, you will receive one bill that combines your health, dental and, if applicable, life insurance premiums. If you select the HMO medical plan, your dental HMO plan and health coverage effective dates must be the first of the month. (No benefits are paid for services received before the effective date.) If you select the PPO medical plan along with a dental HMO or dental PPO plan, you may request any effective date for both plans.

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

Dental PPO and Dental HMO Highlights Matrix

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

Service	**Dental PPO[1]**		**Dental HMO[3,4]**	**Access+ Dentist**
	With network dentists, you pay:	**With non-network dentists, the plan reimburses you up to:**	**You pay:**	**(Access+ HMO members only)[5] You pay:**
Diagnostic services				
Comprehensive oral exams	$0	$40	$0	$20 (plus $10 for full-mouth series X-rays)
Preventive care				
Prophylaxis (cleanings, every 6 months)				
Adult	$0	$48	$0	$20
Child	$0	$34	$0	$20
Sealant/per tooth[6] (covered to age 16)	$0	$22	$11	$10
Restorative services[2]				
One-surface composite (filling)	$37	$30	$15	80%**
Crown (porcelain fused to noble metal)	$320	$256	$300*	80%**
Endodontics[2]				
Anterior root canal	$156	$125	$155	80%**
Molar root canal	$234	$187	$290	Not covered
Periodontics[2]				
Osseous surgery/per quadrant	$263	$210	$303	Not covered
Periodontal root planing/per quadrant	$65	$52	$75	80%**
Prosthetics[2]				
Bridge pontic/false tooth - high noble metal (per unit)	$293	$234	$300*	80%**
Bridge retainer - porcelain fused to high noble metal (per unit)	$313	$250	$300*	80%**
Complete denture (upper or lower)	$388	$310	$400	80%**
Oral surgery[2]				
Extraction (single tooth)	$40	$32	$34	80%**
Removal of impacted tooth (complete bony)	$113	$90	$125	Not covered
Enhanced dental services for pregnant women[7] (not subject to plan deductibles with network dentists)	$0	100% of charge	Not covered	Not covered
Orthodontics[2,4,8]				
Fully banded (2-year) case – child	$2,350***	Not covered	$2,350***	Not covered
Fully banded (2-year) case – adult	$2,650***	Not covered	$2,650***	Not covered

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

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

*** Plus up to $250 for records.

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

2 Dental PPO members have certain waiting periods: three months for minor restorative services and procedures (such as fillings), endodontics, periodontics, and oral surgery; 12 months for major restorative services and procedures (such as crowns), orthodontics, and removable and fixed prosthetics.

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

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

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

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

7 One additional routine adult prophylaxis (including periodontal prophylaxis for gingivitis) for women during pregnancy and one periodontal maintenance visit if warranted by a history of periodontal treatment and one course (up to four quadrants) of periodontal scaling and root planing for women during pregnancy with a documented existing periodontal condition.

8 Orthodontic services have a fixed patient copayment and do not apply to your $1,000 in-network plan maximum.

Life insurance

Individual term life insurance* coverage

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

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

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

Monthly individual term life insurance rates

Amount of insurance

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

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

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

It's easy to enroll

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

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

If you choose to apply for individual term life insurance after you are approved for a Blue Shield health plan, you must request a Blue Shield Life Evidence of Insurability form by calling us at (800) 431-2809, or download it from blueshieldca.com. If coverage is approved, your life insurance effective date will be the first day of the month following approval.

notes:

blue of california

50 Beale Street, San Francisco, CA 94105
phone 415 229.5000

Exhibit F

Vital Shield Plus
Individual and Family Plans

Please note: These plans are planned to close effective July 2, 2012. We must receive your client's application by June 15th if they wish to apply for one of these plans. Learn more about our new plans available for effective dates of July 1, 2012 and later.

Vital Shield[SM] Plus* offers valuable health insurance coverage for individuals and families as a low-cost option for those who rarely go to the doctor, but want to know they're covered when they do. Built on the success of the Vital Shield* plans, the Vital Shield Plus plans offer all the same great benefits **plus** a whole lot more.

Vital Shield Plus Features [1]

Lower annual out-of-pocket maximum and a lower annual deductible than with Vital Shield plans

- Members can have the confidence they're protected in case of unexpected medical problems or emergencies, without copayments after the out-of-pocket maximum is met, for most covered services
- Annual out-of-pocket maximums as low as $2,900
- Annual medical Deductibles as low as $400

Generic-only or coverage with brand-name prescription drugs

- Vital Shield Plus plans give your clients prescription drug coverage options:
  - Generic prescription drug only plan ($10 copayment)
  - Generic/brand-name prescription drug combination plan ($10 copayment for generic prescription drugs/$45 copayment for brand-name prescription drugs, after an annual $500 brand-name deductible)
- Prescription drug coverage is not subject to medical deductible

Fourth quarter deductible carry-over

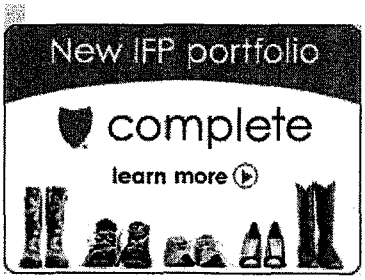
- The fourth quarter deductible carry-over allows members who do not meet their annual deductible to apply covered expenses from October to December toward the next year's deductible
- Vital Shield Plus plans also offer a range of annual deductible options to fit your clients' specific needs

Four physician office visits before the annual deductible and a lower copayment than Vital Shield plans

- Four physician office visits are covered for a $30 copayment per visit prior to meeting the annual deductible

Broker Resources

- Current product cycle
- Monthly rates
- Evidence of coverage/policy
- Sales resources and collateral



Ideal Vital Shield Plus Clients

- Individuals who only expect to go to the doctor a few times a year
- Individuals who are not planning to have children or additional children in the near future
- Younger adults may want to consider lower deductibles ($400 for "young invincibles", $900 for couples)
- Older adults may want to consider higher deductibles ($2,900 for established families and empty nesters)

Tips for Families

- Families can save money with Vital Shield Plus by enrolling as a family instead of enrolling individually
- If there are three or more family members, total family deductibles and out-of-pocket maximums would be lower per person on a family plan than with individual plans
- Benefits are per member, so each family member gets the same number of office visits

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1 Please note that Vital Shield Plus plans do not include maternity benefits.
2 Amounts shown represent the member's financial responsibility when using Blue Shield network provides.
* Vital Shield and Vital Shield Plus plans are underwritten by Blue Shield of California Life and Health Insurance Company and are pending regulatory approval.

PROOF OF SERVICE

Bodner v. Blue Shield / Case No. BC516868

STATE OF CALIFORNIA,
COUNTY OF LOS ANGELES

I am employed in the County of Los Angeles, State of California. I am over the age of 18 years and not a party to the within action; my business address is 550 South Hope Street, Suite 1645, Los Angeles, CA 90071.

On May 21, 2014, I served the foregoing document described as **FIRST AMENDED CLASS ACTION COMPLAINT** on the interested parties in this action by placing a true copy of the original thereof enclosed in a sealed envelope addressed as follows:

SEE ATTACHED SERVICE LIST

X **By Electronic Service,** I caused a true and correct copy of the above-entitled documents to be electronically transferred onto **CASE ANYWHERE FILE AND SERVE** via the Internet, which constitutes service, pursuant to *Order Authorizing Electronic Service dated 11/15/*2013.

X **(State)** I declare under penalty of perjury under the laws of the State of California that the foregoing is true and correct. Executed on May 21, 2014 at Los Angeles, California.

Concepcion Gonzales

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