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Access+ Value HMO plan monthly rates effective 7/1/2013

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Region	Age	Access+ Value HMO				
		Adult/child	Adult and child	Adult and children	Adult and spouse/ domestic partner	Family
Region 1	Under 1	$804	N/A	N/A	N/A	N/A
Region 1	Age 1	$444	N/A	N/A	N/A	N/A
Region 1	2 – 4	$444	N/A	N/A	N/A	N/A
Region 1	5 – 13	$444	N/A	N/A	N/A	N/A
Region 1	14 – 18	$444	$2203	$3265	$1623	$3274
Region 1	19 – 24	$941	$2203	$3265	$1623	$3274
Region 1	25 – 29	$941	$2203	$3265	$1623	$3274
Region 1	30 – 34	$1093	$2675	$3522	$1904	$3466
Region 1	35 – 39	$1184	$2798	$3187	$2070	$3383
Region 1	40 – 44	$1264	$2590	$2900	$2269	$3426
Region 1	45 – 49	$1434	$2371	$3099	$2507	$3613
Region 1	50 – 54	$1570	$2434	$3210	$2687	$3715
Region 1	55 +	$1635	$2883	$3442	$2895	$3744
Region 2	Under 1	$709	N/A	N/A	N/A	N/A
Region 2	Age 1	$394	N/A	N/A	N/A	N/A
Region 2	2 – 4	$394	N/A	N/A	N/A	N/A
Region 2	5 – 13	$394	N/A	N/A	N/A	N/A
Region 2	14 – 18	$394	$1938	$2871	$1429	$2879
Region 2	19 – 24	$829	$1938	$2871	$1429	$2879
Region 2	25 – 29	$829	$1938	$2871	$1429	$2879
Region 2	30 – 34	$962	$2388	$3099	$1677	$3048
Region 2	35 – 39	$1042	$2466	$2810	$1822	$2976
Region 2	40 – 44	$1115	$2276	$2551	$1995	$3017
Region 2	45 – 49	$1259	$2079	$2725	$2203	$3178
Region 2	50 – 54	$1383	$2143	$2824	$2366	$3268
Region 2	55 +	$1439	$2538	$3027	$2548	$3292
Region 3	Under 1	$943	N/A	N/A	N/A	N/A
Region 3	Age 1	$523	N/A	N/A	N/A	N/A
Region 3	2 – 4	$523	N/A	N/A	N/A	N/A
Region 3	5 – 13	$523	N/A	N/A	N/A	N/A
Region 3	14 – 18	$523	$2587	$3835	$1909	$3845
Region 3	19 – 24	$1106	$2587	$3835	$1909	$3845
Region 3	25 – 29	$1106	$2587	$3835	$1909	$3845
Region 3	30 – 34	$1286	$3148	$4142	$2242	$4076
Region 3	35 – 39	$1392	$3292	$3750	$2436	$3981
Region 3	40 – 44	$1489	$3048	$3411	$2669	$4035
Region 3	45 – 49	$1684	$2789	$3642	$2947	$4251
Region 3	50 – 54	$1847	$2864	$3775	$3165	$4369
Region 3	55 +	$1927	$3388	$4044	$3406	$4403

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		Access+ Value HMO				
		Adult/child	Adult and child	Adult and children	Adult and spouse/ domestic partner	Family
Region 4	Under 1	$794	N/A	N/A	N/A	N/A
	Age 1	$438	N/A	N/A	N/A	N/A
	2 – 4	$438	N/A	N/A	N/A	N/A
	5 – 13	$438	N/A	N/A	N/A	N/A
	14 – 18	$438	$2174	$3221	$1603	$3228
	19 – 24	$926	$2174	$3221	$1603	$3228
	25 – 29	$926	$2174	$3221	$1603	$3228
	30 – 34	$1081	$2673	$3476	$1880	$3418
	35 – 39	$1169	$2767	$3148	$2045	$3340
	40 – 44	$1249	$2556	$2862	$2244	$3384
	45 – 49	$1414	$2340	$3061	$2475	$3569
	50 – 54	$1552	$2403	$3167	$2653	$3665
	55 +	$1615	$2849	$3399	$2857	$3697
Region 5	Under 1	$886	N/A	N/A	N/A	N/A
	Age 1	$489	N/A	N/A	N/A	N/A
	2 – 4	$489	N/A	N/A	N/A	N/A
	5 – 13	$489	N/A	N/A	N/A	N/A
	14 – 18	$489	$2414	$3585	$1785	$3597
	19 – 24	$1035	$2414	$3585	$1785	$3597
	25 – 29	$1035	$2414	$3585	$1785	$3597
	30 – 34	$1203	$2942	$3872	$2096	$3809
	35 – 39	$1305	$3073	$3507	$2278	$3721
	40 – 44	$1390	$2847	$3187	$2495	$3770
	45 – 49	$1572	$2606	$3405	$2755	$3972
	50 – 54	$1727	$2682	$3528	$2958	$4086
	55 +	$1800	$3167	$3791	$3184	$4120
Region 6	Under 1	$999	N/A	N/A	N/A	N/A
	Age 1	$555	N/A	N/A	N/A	N/A
	2 – 4	$555	N/A	N/A	N/A	N/A
	5 – 13	$555	N/A	N/A	N/A	N/A
	14 – 18	$555	$2737	$4061	$2021	$4071
	19 – 24	$1171	$2737	$4061	$2021	$4071
	25 – 29	$1171	$2737	$4061	$2021	$4071
	30 – 34	$1361	$3350	$4380	$2369	$4312
	35 – 39	$1475	$3481	$3967	$2577	$4209
	40 – 44	$1574	$3224	$3609	$2825	$4267
	45 – 49	$1783	$2947	$3852	$3119	$4497
	50 – 54	$1955	$3034	$3993	$3347	$4620
	55 +	$2036	$3583	$4280	$3602	$4658

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Region	Age	Access+ Value HMO: Adult/child	Adult and child	Adult and children	Adult and spouse/ domestic partner	Family
Region 7	Under 1	$648	N/A	N/A	N/A	N/A
	Age 1	$363	N/A	N/A	N/A	N/A
	2 – 4	$363	N/A	N/A	N/A	N/A
	5 – 13	$363	N/A	N/A	N/A	N/A
	14 – 18	$363	$1938	$2628	$1280	$2482
	19 – 24	$720	$1938	$2628	$1280	$2482
	25 – 29	$720	$1938	$2628	$1280	$2482
	30 – 34	$850	$2155	$2663	$1533	$2609
	35 – 39	$919	$2142	$2510	$1657	$2650
	40 – 44	$982	$1960	$2483	$1803	$2733
	45 – 49	$1106	$1890	$2643	$1992	$2865
	50 – 54	$1213	$2069	$2691	$2150	$2932
	55 +	$1327	$2538	$3027	$2504	$3051
Region 8	Under 1	$772	N/A	N/A	N/A	N/A
	Age 1	$432	N/A	N/A	N/A	N/A
	2 – 4	$432	N/A	N/A	N/A	N/A
	5 – 13	$432	N/A	N/A	N/A	N/A
	14 – 18	$432	$1760	$2689	$1523	$2695
	19 – 24	$858	$1760	$2689	$1523	$2695
	25 – 29	$858	$1760	$2689	$1523	$2695
	30 – 34	$1009	$2170	$3177	$1825	$3105
	35 – 39	$1096	$2334	$2992	$1975	$3155
	40 – 44	$1169	$2335	$2856	$2157	$3250
	45 – 49	$1319	$2261	$3047	$2376	$3413
	50 – 54	$1446	$2380	$3124	$2563	$3492
	55 +	$1582	$2708	$3359	$2878	$3632
Region 9	Under 1	$603	N/A	N/A	N/A	N/A
	Age 1	$333	N/A	N/A	N/A	N/A
	2 – 4	$333	N/A	N/A	N/A	N/A
	5 – 13	$333	N/A	N/A	N/A	N/A
	14 – 18	$333	$1472	$2257	$1220	$2261
	19 – 24	$702	$1472	$2257	$1220	$2261
	25 – 29	$702	$1472	$2257	$1220	$2261
	30 – 34	$819	$1812	$2612	$1431	$2541
	35 – 39	$890	$1955	$2395	$1557	$2539
	40 – 44	$950	$1910	$2179	$1706	$2576
	45 – 49	$1076	$1783	$2324	$1880	$2713
	50 – 54	$1179	$1823	$2408	$2021	$2788
	55 +	$1229	$2028	$2523	$2176	$2812

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Shield Spectrum PPO 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.

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	Preferred Providers[1]	Non-preferred Providers[1]
Calendar Year Medical Deductible (For family coverage, an individual is responsible for satisfying their own individual deductible and that amount accumulates to the family deductible.)	$5,000 per individual / $10,000 per family (all providers combined)	
Calendar Year Copayment Maximum (Includes the medical plan deductible. Copayments for Preferred Providers apply to both Preferred and Non-Preferred Provider Calendar Year Copayment Maximum amounts.)	$7,000 per individual / $14,000 per family	$10,000 per individual / $20,000 per family
Calendar Year Brand Name Drug Deductible	$500 per individual	Not covered
Lifetime Benefit Maximum	None	

Covered Services	Member Copayments	
	Preferred Providers[1]	Non-preferred Providers[1]
PROFESSIONAL SERVICES		
Professional (Physician) Benefits		
Physician and specialist office visits	$35	50%
Other outpatient X-ray, pathology, and laboratory (Diagnostic testing by providers other than outpatient laboratory, pathology, and imaging departments of hospitals/facilities)	30%	50%
CT scans, MRIs, MRAs, PET scans, and cardiac diagnostic procedures utilizing nuclear medicine (prior authorization is required)	30%	50%
Preventive Health Benefits		
Preventive Health Services (As required by applicable federal and California law)	$0[2]	Not covered
OUTPATIENT SERVICES		
Outpatient surgery in a hospital	30%	50%[3,4]
Outpatient surgery performed at an Ambulatory Surgery Center	30%	50%[3,5]
Outpatient Services for treatment of illness or injury and necessary supplies	30%	50%[3,4]
Other outpatient X-ray, pathology and laboratory performed in a hospital	30%	50%
Bariatric Surgery (prior authorization required by the Plan; medically necessary surgery for weight loss, for morbid obesity only)[6]	30%	50%[3,4]
CT scans, MRIs, MRAs, PET scans, and cardiac diagnostic procedures utilizing nuclear medicine performed in a hospital (prior authorization is required)	30%	50%
HOSPITALIZATION SERVICES		
Inpatient Physician Services	30%	50%
Inpatient Non-emergency Facility Services (Semi-private room and board, and medically-necessary Services and supplies, including Subacute Care)	30%	50%[3,4]
Bariatric Surgery (prior authorization required by the Plan; medically necessary surgery for weight loss, for morbid obesity only)[6]	30%	50%[3,4]
EMERGENCY HEALTH COVERAGE		
Emergency room Services not resulting in admission	30%	30%
Emergency room Services resulting in admission	30%	30%
Emergency room Physician Services	30%	30%
AMBULANCE SERVICES		
Emergency or authorized transport	30%	30%

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Covered Services	Member Copayments	
PRESCRIPTION DRUG COVERAGE[7,8]	**Participating Pharmacy**	**Non-Participating Pharmacy**
Retail prescriptions (up to a 30-day supply)		
Formulary Generic Drugs	$10 per prescription[2,9]	Not Covered
Formulary Brand Name Drugs	$35 per prescription[9,10]	Not Covered
Non-Formulary Brand Name Drugs	$50 or 50% (whichever is greater) per prescription[9,10]	Not Covered
Mail Service Prescriptions (up to a 60-day supply)		
Formulary Generic Drugs	$20 per prescription[2,9]	Not Covered
Formulary Brand Name Drugs	$70 per prescription[9,10]	Not Covered
Non-Formulary Brand Name Drugs	$100 or 50% (whichever is greater) per prescription[9,10]	Not Covered
Specialty Pharmacies (up to a 30-day supply)		
Home Self-Administered Injectables	30% of negotiated rate[9,10]	Not Covered
	Preferred providers[1]	**Non-preferred Providers**[1]
PROSTHETICS/ORTHOTICS		
Prosthetic equipment and devices (Separate office visit copay may apply)	30%	50%
Orthotic equipment and devices (Separate office visit copay may apply)	30%	50%
DURABLE MEDICAL EQUIPMENT		
Other Durable Medical Equipment	30%	50%
Breast Pump	$0[2]	Not covered
MENTAL HEALTH SERVICES (PSYCHIATRIC)[11]		
Inpatient Hospital Services	30%	50%[3,4]
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 outpatient chemical dependency visits)[12]	30%	Not covered
CHEMICAL DEPENDENCY SERVICES[11] **(SUBSTANCE ABUSE)**		
Inpatient Hospital Services for medical acute detoxification	30%	50%[3,4]
Outpatient visits (up to 20 visits per Calendar Year combined with outpatient non-severe mental health visits)[12]	30%	Not covered
HOME HEALTH SERVICES		
Home health care agency Services (up to 90 prior authorized visits per Calendar Year)	30%	Not covered
OTHER		
Pregnancy and Maternity Care Benefits		
Prenatal and postnatal Physician office visits	30%	50%
All necessary Inpatient Hospital Services for normal delivery and Cesarean section	30%	50%[3,4]
Family Planning Benefits		
Counseling and consulting[13]	$0[2]	Not covered
Tubal ligation	$0[2]	Not covered
Vasectomy	30%	Not covered
Elective abortion	30%	Not covered
Rehabilitation Benefits		
Office location	30%	50%
Chiropractic Benefits		
Chiropractic Services	Not covered	Not covered
Acupuncture Benefits		
Acupuncture	Not covered	Not covered
Care Outside of Plan Service Area (Benefits provided through the BlueCard® Program for out-of-state emergency and non-emergency care are provided at the preferred level of the local Blue Plan allowable amount when you use a Blue Cross/Blue Shield provider)		
Within US: BlueCard Program	See Applicable Benefit	See Applicable Benefit
Outside of US: BlueCard Worldwide	See Applicable Benefit	See Applicable Benefit

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

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Endnotes for Shield Spectrum PPO 5000

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 the Plan's 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 the Plan's allowable amount. Charges above the allowable amount do not apply toward the medical deductible or copayment/coinsurance maximum.
2. Benefit is available prior to meeting any deductible.
3. These copayments do not apply toward the copayment/coinsurance maximum. They will continue to be charged once the copayment/coinsurance maximum is reached. See Policy for details.
4. 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.
5. Participating ambulatory surgery centers may not be available in all areas. Regardless of their availability, you can obtain outpatient surgery services from a hospital, or an ambulatory surgery center affiliated with a hospital with payment according to your health plan's hospital services benefits. Blue Shield's payment is limited to $150 per day. Members are responsible for all charges that exceed $150 per day.
6. Bariatric surgery is covered when pre-authorized by the Plan. 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 the Plan, 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.
7. This plan's prescription drug coverage is on average equivalent to or better than the standard benefit set by the federal government for Medicare Part D (also called creditable coverage). Because this plan's prescription drug coverage is creditable, you do not have to enroll in a Medicare prescription drug plan while you maintain this coverage. However, you should be aware that if you have a subsequent break in this coverage of 63 days or more anytime after you were first eligible to enroll in a Medicare prescription drug plan, you could be subject to a late enrollment penalty in addition to your Medicare Part D premium.
8. Contraceptive drugs and devices covered under the outpatient prescription drug benefits do not require a copayment and will not be subject to the calendar-year brand-name drug deductible. However, if a brand-name contraceptive is requested when a generic equivalent is available, the member will still be responsible for paying the difference between the cost to the Plan for the brand-name contraceptive and its generic drug equivalent. In addition, select contraceptives may need prior authorization to be covered without a copayment.
9. These copayments do not apply toward the medical deductible or copayment/coinsurance maximum. They will continue to be charged once the copayment/coinsurance maximum is reached. See Policy for details.
10. If a member or physician requests a brand name drug when a generic drug equivalent is available, and the brand name drug deductible has been satisfied, the member is responsible for paying the difference between the Participating Pharmacy contracted rate for the brand name drug and its generic drug equivalent, as well as the applicable generic drug copayment. See Policy for details.
11. Blue Shield has contracted with a specialized health care service plan to act as our mental health services administrator (MHSA). The MHSA provides mental health and chemical dependency services, other than inpatient services for medical acute detoxification, through a separate network of MHSA participating providers. Inpatient medical acute detoxification is a medical benefit provided by Blue Shield preferred or non-preferred (not MHSA) providers.
12. For MHSA participating providers, the initial visit is treated as if the condition was a severe mental illness or serious emotional disturbance of a child. For MHSA non-participating providers, the initial visit is treated as if it were an MHSA participating provider.
13. Includes insertion of IUD, as well as injectable and implantable contraceptives for women.

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Shield Spectrum PPO 5500

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	Preferred Providers[1]	Non-preferred Providers[1]
Calendar Year Medical Deductible (For family coverage, an individual is responsible for satisfying their own individual deductible and that amount accumulates to the family deductible.)	$5,500 per individual / $11,000 per family (all providers combined)	
Calendar Year Copayment Maximum (Includes the medical plan deductible. Copayments for Preferred Providers apply to both Preferred and Non-Preferred Provider Calendar Year Copayment Maximum amounts.)	$7,500 per individual / $15,000 per family	$10,000 per individual / $20,000 per family
Calendar Year Brand Name Drug Deductible	$750 per individual	Not covered
Lifetime Benefit Maximum	None	

Covered Services	Member Copayments	
	Preferred Providers[1]	Non-preferred Providers[1]
PROFESSIONAL SERVICES		
Professional (Physician) Benefits		
Physician and specialist office visits	35%[2]	50%
Other outpatient X-ray, pathology, and laboratory (Diagnostic testing by providers other than outpatient laboratory, pathology, and imaging departments of hospitals/facilities)	35%	50%
CT scans, MRIs, MRAs, PET scans, and cardiac diagnostic procedures utilizing nuclear medicine (prior authorization is required)	35%	50%
Preventive Health Benefits		
Preventive Health Services As required by applicable federal and California law	$0[3]	Not covered
OUTPATIENT SERVICES		
Outpatient surgery in a hospital	35%	50%[2,4]
Outpatient surgery performed at an Ambulatory Surgery Center	35%	50%[2,5]
Outpatient Services for treatment of illness or injury and necessary supplies	35%	50%[2,4]
Other outpatient X-ray, pathology and laboratory performed in a hospital	35%	50%
Bariatric Surgery (prior authorization required by the Plan; medically necessary surgery for weight loss, for morbid obesity only)[6]	35%	50%[2,4]
CT scans, MRIs, MRAs, PET scans, and cardiac diagnostic procedures utilizing nuclear medicine performed in a hospital (prior authorization is required)	35%	50%
HOSPITALIZATION SERVICES		
Inpatient Physician Services	35%	50%
Inpatient Non-emergency Facility Services (Semi-private room and board, and medically necessary Services and supplies, including Subacute Care)	35%	50%[2,4]
Bariatric Surgery (prior authorization required by the Plan; medically necessary surgery for weight loss, for morbid obesity only)[6]	35%	50%[2,4]
EMERGENCY HEALTH COVERAGE		
Emergency room Services not resulting in admission	$100 per visit + 35%	$100 per visit + 35%
Emergency room Services resulting in admission	35%	35%
Emergency room Physician Services	35%	35%
AMBULANCE SERVICES		
Emergency or authorized transport	35%	35%

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Covered Services	Member Copayments	
PRESCRIPTION DRUG COVERAGE[7,8]	**Participating Pharmacy**	**Non-Participating Pharmacy**
Retail prescriptions (up to a 30-day supply)		
Formulary Generic Drugs	$10 per prescription[3,9]	Not Covered
Formulary Brand Name Drugs	$45 per prescription[9,10]	Not Covered
Non-Formulary Brand Name Drugs	$60 or 50%, whichever is greater (Maximum copayment of $150 per prescription)[9,10]	Not Covered
Mail Service Prescriptions (up to a 60-day supply)		
Formulary Generic Drugs	$20 per prescription[3,9]	Not Covered
Formulary Brand Name Drugs	$90 per prescription[9,10]	Not Covered
Non-Formulary Brand Name Drugs	$120 or 50%, whichever is greater (Maximum copayment of $300 per prescription)[9,10]	Not Covered
Specialty Pharmacies (up to a 30-day supply)		
Home Self-Administered Injectables	35% of negotiated rate[9,10]	Not Covered
	Preferred providers[1]	**Non-preferred Providers**[1]
PROSTHETICS/ORTHOTICS		
Prosthetic equipment and devices (Separate office visit copay may apply)	35%	50%
Orthotic equipment and devices (Separate office visit copay may apply)	35%	50%
DURABLE MEDICAL EQUIPMENT		
Other Durable Medical Equipment	35%	50%
Breast Pump	$0[2]	Not covered
MENTAL HEALTH SERVICES (PSYCHIATRIC)[11]		
Inpatient hospital Services	35%	50%[2,4]
Outpatient visits for severe mental health conditions	35%[2]	50%
Outpatient visits for non-severe mental health conditions (up to 20 visits per Calendar Year combined with outpatient chemical dependency visits)[12]	35%	Not covered
CHEMICAL DEPENDENCY SERVICES[11] **(SUBSTANCE ABUSE)**		
Inpatient Hospital Services for medical acute detoxification	35%	50%[2,4]
Outpatient visits (up to 20 visits per Calendar Year combined with outpatient non-severe mental health visits)[12]	35%	Not covered
HOME HEALTH SERVICES		
Home health care agency Services (up to 90 prior authorized visits per Calendar Year)	35%	Not covered
OTHER		
Pregnancy and Maternity Care Benefits		
Prenatal and postnatal Physician office visits	35%	50%
All necessary Inpatient Hospital Services for normal delivery and Cesarean section	35%	50%[2,4]
Family Planning Benefits		
Counseling and consulting[13]	$0[3]	Not covered
Tubal ligation	$0[3]	Not covered
Vasectomy	35%	Not covered
Elective abortion	35%	Not covered
Rehabilitation Services		
Office location	35%	50%
Chiropractic Benefits		
Chiropractic Services	Not covered	Not covered
Acupuncture Benefits		
Acupuncture	Not covered	Not covered
Care Outside of Plan Service Area (Benefits provided through the BlueCard® Program for out-of-state emergency and non-emergency care are provided at the preferred level of the local Blue Plan allowable amount when you use a Blue Cross/Blue Shield provider)		
Within US: BlueCard Program	See Applicable Benefit	See Applicable Benefit
Outside of US: BlueCard Worldwide	See Applicable Benefit	See Applicable Benefit

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

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Endnotes for Shield Spectrum PPO 5500

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 the Plan's 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 the Plan's allowable amount. Charges above the allowable amount do not apply toward the medical deductible or copayment/coinsurance maximum.

2 These copayments do not apply toward the copayment/coinsurance maximum. They will continue to be charged once the copayment/coinsurance maximum is reached. See the EOC for details.

3 Benefit is available prior to meeting any deductible.

4 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.

5 Participating ambulatory surgery centers may not be available in all areas. Regardless of their availability, you can obtain outpatient surgery services from a hospital, or an ambulatory surgery center affiliated with a hospital with payment according to your health plan's hospital services benefits. Blue Shield's payment is limited to $150 per day. Members are responsible for all charges that exceed $150 per day.

6 Bariatric surgery is covered when pre-authorized by the Plan. 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 the Plan, 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 Evidence of Coverage for further benefit details.

7 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 non-creditable coverage). It is important to know that generally you may only enroll in a Medicare Part D plan from October 15th through December 7th of each year. If you do not enroll in a Medicare Part D plan when you are first eligible to join, you may be subject to a late enrollment penalty in addition to your Part D premium when you enroll at a later date. For more information about your current plan's prescription drug coverage, call the Customer Service telephone number on your identification card, Monday through Thursday between 8:00 a.m. and 5:00 p.m. or on Friday between 9:00 a.m. and 5:00 p.m. The hearing impaired may call the TTY number at (888) 239-6482.

8 Contraceptive drugs and devices covered under the outpatient prescription drug benefits do not require a copayment and will not be subject to the calendar-year brand-name drug deductible. However, if a brand-name contraceptive is requested when a generic equivalent is available, the member will still be responsible for paying the difference between the cost to the Plan for the brand-name contraceptive and its generic drug equivalent. In addition, select contraceptives may need prior authorization to be covered without a copayment.

9 These copayments do not apply toward the medical deductible or copayment/coinsurance maximum. They will continue to be charged once the copayment/coinsurance maximum is reached. See the EOC for details.

10 If a member or physician requests a brand name drug when a generic drug equivalent is available, and the brand name drug deductible has been satisfied, the member is responsible for paying the difference between the Participating Pharmacy contracted rate for the brand name drug and its generic drug equivalent, as well as the applicable generic drug copayment. See EOC for details.

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

12 For MHSA participating providers, the initial visit is treated as if the condition was a severe mental illness or serious emotional disturbance of a child. For MHSA non-participating providers, the initial visit is treated as if it were an MHSA participating provider.

13 Includes insertion of IUD, as well as injectable and implantable contraceptives for women.

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