

# Active Choice<sup>®</sup> Plan 750 SG

## Blue Shield of California

### Life & Health Insurance Company

Effective January 1, 2011

A health plan designed to allow members to be active participants in their own health care. The Active Choice Plan offers coverage for preventive care services at no charge and with no up-front deductible, as well as a \$750 individual/\$1,500 family "First Dollar Services" coverage for specified services. Each calendar year, the member can spend this First Dollar Services coverage on certain outpatient professional and diagnostic services, from an office visit to physical therapy benefits.

Covered Services		Active Choice Plan 750 SG
Calendar Year In-Network Copayment Maximum <sup>#,1</sup>		\$5,000/\$10,000 (individual/family)
Category One <sup>#,2</sup>	<p>First Dollar Services<sup>2</sup> Coverage:</p> <p><b>Preventive Care</b></p> <ul style="list-style-type: none"> <li>Routine physical exams</li> <li>Well-baby care</li> <li>Immunizations</li> </ul> <p><b>Outpatient Professional &amp; Diagnostic</b></p> <ul style="list-style-type: none"> <li>Office visits</li> <li>Diagnostic testing</li> </ul>	<p>No charge</p> <p>\$750 Individual/\$1,500 Family (Each insured family member has access to the entire amount of the family First Dollar Services credit)</p> <p>Then the Member is responsible for charges up to the Calendar Year Copayment Maximum</p>
Category Two <sup>#</sup>	<p><b>Outpatient &amp; Inpatient Services</b></p> <ul style="list-style-type: none"> <li>Surgeries</li> <li>Emergency room visits</li> <li>Chemotherapy</li> </ul>	<p>20% Preferred Providers 40% Non-Preferred Providers</p> <p>(some copayments apply)</p>
Category Three	<p><b>Prescription Drugs</b></p> <ul style="list-style-type: none"> <li>Generic Drugs</li> <li>Brand Name Drugs<sup>3</sup> <ul style="list-style-type: none"> <li>Calendar-year brand-name drug deductible</li> <li>Formulary brand-name drugs</li> <li>Non-formulary brand-name drugs</li> </ul> </li> <li>Specialty Pharmacies<sup>11</sup> <ul style="list-style-type: none"> <li>Specialty drugs</li> </ul> </li> </ul>	<p>\$15 Copayment</p> <p>\$250 per member</p> <p>Greater of \$30 Copayment (or 30% of Blue Shield's contracted rate) after drug deductible</p> <p>Greater of \$50 Copayment (or 50% of Blue Shield's contracted rate) after drug deductible</p> <p>30% per prescription (member pays up to \$100 copayment maximum per prescription)</p>

No Deductible. No Copayment or Coinsurance until First Dollar Services coverage is spent

No Generic Drug Deductible

An Independent Licensee of the Blue Shield Association

# Charges in excess of the allowable amount do not count toward the calendar year copayment maximum.

1) After the calendar year copayment maximum is met Blue Shield Life covers many benefits at 100 percent of the allowable amount.

2) For more information on First Dollar Services coverage, see page 2.

3) If the member requests a brand-name drug and a generic drug equivalent is available, the member is responsible for paying the difference between the cost to Blue Shield Life of the brand-name drug and its generic drug equivalent, as well as the applicable generic drug copayment.

## Three Categories of Care

Active Choice Plans give you more control over your benefits and out-of-pocket expenses. Under this plan, you have affordable coverage across three categories of healthcare services without paying up-front deductibles for Categories One and Two. In the first category, you receive a set amount of healthcare dollars – these dollars cover routine physician office services and outpatient professional and diagnostic services. At the same time, you have valuable protection against the costly impact of hospital services and prescription drugs through more traditional benefits of coinsurance and copayments. To help you understand each category of care, we've outlined your coverage below.

### Category One. Outpatient Professional and Diagnostic Services

Preventive care is covered at no charge. For other First Dollar Services coverage, each Calendar Year, the member has a set amount to spend on the category of outpatient professional and diagnostic care:

- With Active Choice Plan 750 SG – Up to \$750 per individual and \$1,500 per family  
(Each insured family member has access to the entire amount of the family First Dollar Services)

It's up to you to decide how to spend these amounts on the services covered under Category One, which provides for First Dollar Services coverage. This category includes a wide range of services to pick from, such as outpatient professional and diagnostic care, including physician office visits, testing, and mental health and outpatient substance abuse services. For these services you can choose your own physician from our broad, statewide network of preferred providers, to stretch your dollars even further. If you choose a non-preferred provider, First Dollar Services only cover the allowable amount, and you are responsible for the remainder of the costs. In addition, once the First Dollar Services coverage is spent, you are responsible for 100 percent of medical costs until the calendar year copayment maximum is met.

Also, as long as you are a member of this plan through your current employer, you can roll over unused dollars starting from the 2004 calendar year and thereafter in this category of care. Each insured family member may use any or all of the family carryover credit. Any amounts covered in this category do not apply to the calendar year copayment maximum.

### Category Two. Outpatient and Inpatient Services – Including Emergency Care Services

When you need care the most, you can rely on immediate coverage. If an unexpected illness or injury happens, this category includes emergency care and surgery in hospitals and facilities (including professional services associated with such facility services). We share the cost of care with you at the following levels:

- \* With Active Choice Plan 750 SG – the member pays 20 percent for preferred providers, 40 percent of the allowable amount for non-preferred providers. (some copayments may apply)

### Category Three. Coverage for Prescription Drugs

To keep prescription drugs affordable, Active Choice Plans provide immediate coverage for generic drugs. Brand-name drugs are covered once a deductible is met.

- \$15 generic drug copayment
- With Active Choice Plan 750 SG - \$250 brand deductible per individual for brand-name drugs
- Coverage includes covered brand-name drugs
- Prescription drug coverage includes no annual benefit maximums
- The copayments and any applicable brand-name drug deductible for prescription drugs do not accrue to your calendar year copayment maximum

The following benefits and services do not accrue towards the calendar year copayment maximum. This means that coinsurance, copayments and charges for services that are not included in the calculation of the calendar year copayment maximum remain the member's responsibility, even after the copayment maximum has been reached.

- Copayments and any applicable brand-name drug deductible for prescription drugs.
- \$100 member copayment for emergency room facility services not resulting in an admission.
- Any charges for outpatient services for the treatment of non-severe mental health services and outpatient chemical dependency services that exceed the First Dollar Services amount.
- Any charges above the allowable amounts. When members use non-preferred providers, they must pay the applicable coinsurance or copayments plus any amount that exceeds Blue Shield Life's allowable amount. These charges above the allowable amount do not count toward the calendar year copayment maximum.
- First Dollar Services payments or First Dollar Services carryover credit.

Active Choice<sup>®</sup> Plan 750 SG  
 Benefit Summary (For groups 2 to 50)  
 (Uniform Health Plan Benefits and Coverage Matrix)  
 Effective January 1, 2011

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

The Active Choice Plan has three categories of benefit coverage.

Category One: Outpatient Professional and Diagnostic

Category Two: Outpatient & Inpatient Surgery

Category Three: Outpatient Prescription Drugs

Benefits	Member Responsibility	
	Preferred Providers <sup>2</sup>	Non-Preferred Providers <sup>2</sup>
<ul style="list-style-type: none"> <li>Calendar-Year Medical Deductibles</li> <li>Calendar-Year Copayment Maximum (For many covered services)</li> </ul>	\$0 per individual/\$0 per family \$5,000 per individual /\$10,000 per family	\$0 per individual/\$0 per family \$10,000 per individual /\$20,000 per family
<b>LIFETIME MAXIMUM</b>	None	

Covered Services	First Dollar Services & Member Responsibility	
------------------	---	--

**Category One: Outpatient Professional And Diagnostic<sup>1</sup>**

PREVENTIVE HEALTH SERVICES	Preferred Providers <sup>2</sup>	Non-Preferred Providers <sup>2</sup>
----------------------------	----------------------------------	--------------------------------------

(As recommended by the United States Preventive Services Task Force)

(Preventive health services benefits are paid at 100% of the allowable amount and not subject to the first dollar services credit)

- Annual routine physical exam, screenings, and immunizations
- Preventive laboratory, mammogram and Pap test screening or other FDA-approved cervical cancer screening tests

No charge

**WELL-BABY CARE**

- Office visits and consultations includes: Eye/ear screening, immunizations and vaccinations (Up to 7 visits per calendar year)
- Well-baby care laboratory

**PROFESSIONAL SERVICES**

- Physician and specialist office visits
- Laboratory and X-rays
- Allergy testing or treatment
- Diagnostic testing

Preferred Providers <sup>2</sup>	Non-Preferred Providers <sup>2</sup>
----------------------------------	--------------------------------------

The \$750 individual or \$1,500 family First Dollar Services covers any combination of covered outpatient professional and diagnostic services and supplies. Each insured family member has access to the entire amount of the family First Dollar Services. These services are paid at 100 percent of the allowable amount<sup>2</sup>. The member is responsible for all charges above the \$750 individual or \$1,500 family First Dollar Services amount until the member's maximum calendar year copayment amount has been reached.<sup>1</sup>

**DURABLE MEDICAL EQUIPMENT**

- Home medical equipment, prosthetics/orthotics

**MENTAL HEALTH SERVICES (PSYCHIATRIC)<sup>3</sup>**

- Outpatient visits for Severe Mental Illness conditions
- Outpatient visits for non-Severe Mental Illness conditions\*

Once the member's maximum calendar year copayment has been reached, many benefits will be paid at 100 percent of the allowable amount. The member's responsibility for charges over the allowable amount does not accrue to the calendar year copayment maximum.

**CHEMICAL DEPENDENCY SERVICES (SUBSTANCE ABUSE)<sup>3</sup>**

- Outpatient visits\*

\* Outpatient services for the treatment of non-severe mental illness services, outpatient chemical

**OTHER**

## Rehabilitative Therapy Services

- Office visits and related services

**dependency services, and chiropractic services** are only covered under the \$750 individual/\$1,500 family First Dollar Services amount. After the First Dollar Services limit is reached, these services are no longer covered until the next calendar year.

## Covered Services

## First Dollar Services & Member Responsibility

### Category One: Outpatient Professional And Diagnostic<sup>1</sup>

#### Pregnancy and Maternity Care

- Prenatal and postnatal care (Initial office visit to determine the diagnosis only)  
*All subsequent office visits for prenatal and postnatal care, including professional services for delivery and inpatient hospital services are covered under "Hospitalization Services"*

#### Family Planning

- Family planning counseling
- Elective abortion<sup>4</sup>, tubal ligation<sup>4</sup>, vasectomy<sup>4</sup>

#### Diabetes Care

- Equipment, devices and non-testing supplies (For testing supplies, see "Prescription Drug Coverage")
- Self-management training and education (If billed by your provider, you will also be responsible for the office visit copayment)

## Covered Services

## Member Coinsurance

### Category Two: Outpatient & Inpatient Surgery – including emergency care services

#### OUTPATIENT SERVICES

- Outpatient surgery performed in a Participating Ambulatory Surgery Center (ASC)<sup>5</sup>
- Outpatient surgery in hospital/facility
- Outpatient treatment and necessary supplies
- Bariatric surgery (Pre-authorization required; Medically necessary surgery for weight loss, only for morbid obesity)<sup>7</sup>

Preferred Providers<sup>2</sup>  
\$250/surgery + 20%

Non-Preferred Providers<sup>2</sup>  
40%<sup>6</sup>

\$400/surgery + 20%  
20%

40%<sup>6</sup>  
40%<sup>6</sup>

\$400/surgery + 20%

40%<sup>6</sup>

#### HOSPITALIZATION SERVICES

- Inpatient physician services associated with inpatient or outpatient surgery and procedures (Including pregnancy and maternity care and services for medical acute detoxification)
- Semi-private room and board, medically necessary services and supplies
- Bariatric surgery (Pre-authorization required; Medically necessary surgery for weight loss, only for morbid obesity)<sup>7</sup>

20%

40%

\$500/admission + 20%

40%<sup>6</sup>

\$500/admission + 20%

40%<sup>6</sup>

#### SKILLED NURSING FACILITY (SNF) SERVICES

(Combined maximum of up to 100 preauthorized days per calendar year; semi-private accommodations)

- Freestanding SNF
- Hospital SNF unit

20%

20%

20%

40%<sup>6</sup>

#### EMERGENCY HEALTH COVERAGE

- Facility services (The \$100 copayment per emergency room visit is waived if the member is admitted directly to the hospital for inpatient services)
- Emergency room physician visits

\$100/visit<sup>1</sup> + 20%

20%

<b>AMBULANCE SERVICES</b>	20%	
<b>MENTAL HEALTH SERVICES (PSYCHIATRIC)<sup>3</sup></b>	<b>MHSA Participating Providers<sup>2</sup></b>	<b>MHSA Non-Participating Providers<sup>2</sup></b>
<ul style="list-style-type: none"> <li>Inpatient hospital facility services</li> </ul>	\$500/admission + 20%	40% <sup>6</sup>
<b>CHEMICAL DEPENDENCY SERVICES (SUBSTANCE ABUSE)<sup>3</sup>, PLEASE SEE FOOTNOTE 9</b>	<b>Preferred Providers<sup>2</sup></b>	<b>Non-Preferred Providers<sup>2</sup></b>
<ul style="list-style-type: none"> <li>Inpatient services for medical acute detoxification</li> </ul>	\$500/admission + 20%	40% <sup>6</sup>

Covered Services	Member Coinsurance	
<b>Category Two: Outpatient &amp; Inpatient Surgery – including emergency care services</b>		

<b>HOME HEALTH SERVICES</b>		
<ul style="list-style-type: none"> <li>Home health (Combined maximum of 100 prior authorized visits per calendar year)</li> </ul>	20%	Not covered <sup>10</sup>
<ul style="list-style-type: none"> <li>Home infusion care (See "Specialty Pharmacies" for specialty drugs)</li> </ul>	20%	Not covered <sup>10</sup>

<b>HOSPICE</b>		
<ul style="list-style-type: none"> <li>Routine home care</li> </ul>	No charge	Not covered <sup>10</sup>
<ul style="list-style-type: none"> <li>Inpatient respite care</li> </ul>	No charge	Not covered <sup>10</sup>
<ul style="list-style-type: none"> <li>24 hour continuous home care</li> </ul>	20%	Not covered <sup>10</sup>
<ul style="list-style-type: none"> <li>General inpatient care</li> </ul>	20%	Not covered <sup>10</sup>

<b>Covered Out-of-State Benefits (BlueCard<sup>®</sup> Program)</b>	See Applicable Benefit Line	See Applicable Benefit Line
---	-----------------------------	-----------------------------

Benefits provided through the BlueCard Program for out-of-state emergency and non-emergency care, are provided at the Preferred Level of the local BlueCross and BlueShield Association Plan's Allowable Amount, when members use a BlueCross and BlueShield Association Plan provider. The \$750 individual or \$1,500 family First Dollar Services amount covers any combination of outpatient professional services and supplies, including benefits provided through the BlueCard Program.

Covered Services	Member Coinsurance	
<b>Category Three: Outpatient Prescription Drugs</b>		

<b>PRESCRIPTION DRUG COVERAGE<sup>1, 8, 11</sup></b> (including oral contraceptives, diaphragms, and covered diabetic drugs and testing supplies.)	<b>Participating Retail Pharmacy</b> (For up to a 30-day supply)	<b>Mail Service Prescriptions</b> (For up to a 90-day supply)
<b>Calendar-Year Brand-Name Drug Deductible</b>	\$250 per member per calendar year; applies to all covered brand-name and specialty drugs.	
<ul style="list-style-type: none"> <li>Generic drugs</li> </ul>	\$15/prescription	\$30/prescription
<ul style="list-style-type: none"> <li>Formulary brand-name drugs</li> </ul>	\$30 copay or 30% of Blue Shield Life contracted rate (whichever is greater)	\$60 copay or 30% of Blue Shield Life contracted rate (whichever is greater)
<ul style="list-style-type: none"> <li>Non-Formulary brand-name drugs</li> </ul>	\$50 copay or 50% of Blue Shield Life contracted rate (whichever is greater)	\$100 copay or 50% of Blue Shield Life contracted rate (whichever is greater)

Specialty Pharmacies Specialty drugs (May require prior authorization from Blue Shield Life Pharmacy Services. Specialty drugs are covered only when dispensed by select participating pharmacies in the Specialty Pharmacy Network. Drugs from non-participating pharmacies are not covered except in emergency and urgent situations. <b>Member pays up to \$100 copayment maximum per prescription.</b> )	30%/prescription	Not covered
---	------------------	-------------

Optional Benefits	
-------------------	--

<b>Optional Benefits</b>	Optional dental, vision, inpatient substance abuse treatment or infertility benefits are available. If your employer purchased any of these benefits, a description of the benefit is provided separately.
--------------------------	--

- 
- 1 Copayments marked with a "1" do not accrue to the calendar-year copayment maximum and continue to be charged after they are reached, except for the percentage copayment for the Outpatient Surgery in hospital/facility benefit which does accrue to the calendar-year copayment maximum. Coinsurance or copayments for services not accruing to the member's calendar-year copayment maximum continue to be the member's responsibility after the calendar-year copayment maximum is reached. After the First Dollar Services amount is reached, covered First Dollar Services will accrue to the calendar-year copayment maximum.
  - 2 Member is responsible for coinsurance or copayments in addition to any charges above the allowable amounts. Preferred providers accept Blue Shield of California Life & Health Insurance Company's (Blue Shield Life's) Allowable Amount as full payment for covered services. Non-preferred providers can charge more than these amounts. When members use Non-Preferred Providers, they must pay the applicable Coinsurance or Copayment plus any amount that exceeds Blue Shield Life's allowable amount. Charges above the allowable amount do not count toward the calendar-year copayment maximum or First Dollar Services amounts. Mental health and chemical dependency services, other than services for medical acute detoxification, are accessed through Blue Shield Life's Mental Health Service Administrator (MHSA) utilizing MHSA participating and MHSA non-participating providers.
  - 3 Mental health and chemical dependency services, other than medical acute detoxification, are accessed through Blue Shield Life's Mental Health Service Administrator (MHSA) – using Blue Shield Life's MHSA participating and non-participating providers. Only Blue Shield Life's MHSA contracted providers are administered by the Blue Shield Life's MHSA. Behavioral health services rendered by non participating providers are administered by Blue Shield Life. Services for medical acute detoxification are accessed through Blue Shield Life using Blue Shield Life's preferred providers or non-preferred providers. For a listing of Severe Mental Illnesses, including Serious Emotional Disturbances of a Child, and other benefit details, please refer to the *Certificate of Insurance* or the group policy.
  - 4 Physician's services are covered under Category One. If the procedure is performed in a facility setting (outpatient or inpatient surgery center), the benefit will be covered under Category Two.
  - 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.
  - 6 The maximum allowed charges for non-emergency hospital services received from a Non-Preferred Hospital are \$600 per day. Members are responsible for 40% of this \$600 per day, plus all charges in excess of \$600.
  - 7 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 of bariatric services from non-preferred providers. In addition, if prior authorized by Blue Shield of California, 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 *Certificate of Insurance* for further benefit details.
  - 8 If the member requests a brand-name drug and a generic drug equivalent is available, the member is responsible for paying the difference between the cost to Blue Shield Life for the brand-name drug and its generic drug equivalent, as well as the applicable generic drug copayment. Drugs obtained from a non-participating pharmacy are not covered except in emergency and urgent situations. Please note that if you switch from another plan, the prescription drug deductible credit from the previous plan during the calendar-year, if applicable, will not carry forward to the new plan. 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). Since this plan's prescription drug coverage is creditable, you do not have to enroll in Medicare Part D 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 before enrolling in Medicare Part D you could be subject to payment of higher Medicare Part D premiums.
  - 9 **Optional inpatient substance abuse treatment benefits are available. If your employer purchased these benefits, a description of the benefit is attached hereto as "Additional Substance Abuse Treatment Benefits".**
  - 10 Out of network home health care, home infusion and hospice services are not covered unless pre-authorized. When these services are pre-authorized, the member pays the Preferred benefits.
  - 11 Specialty Drugs are specific Drugs used to treat complex or chronic conditions which usually require close monitoring such as multiple sclerosis, hepatitis, rheumatoid arthritis, cancers, and other conditions that are difficult to treat with traditional therapies. Specialty Drugs are listed in the Blue Shield Outpatient Drug Formulary. Specialty Drugs may be self-administered in the home by injection by the patient or family member (subcutaneously or intramuscularly), by inhalation, orally or topically. Infused or Intravenous (IV) medications are not included as Specialty Drugs. These Drugs may also require special handling, special manufacturing processes, and may have limited prescribing or limited pharmacy availability. Specialty Drugs must be considered safe for self-administration by Blue Shield's Pharmacy & Therapeutics Committee, be obtained from a Blue Shield Specialty Pharmacy and may require prior authorization for Medical Necessity by Blue Shield.

This is an overview of the plan benefits offered. All plans are subject to limitations and exclusions. Please refer to the *Certificate of Insurance* and the group policy for exact terms and conditions of coverage.

*Plan designs may be modified to ensure compliance with state and federal requirements.*

Active Choice® Plan 750 SG is pending regulatory approval