blue of california

October 21, 2011

By electronic mail

Centers for Medicare & Medicaid Services,
U.S. Department of Health and Human Services
Attention: CMS-9982-P
P.O. Box 8016
Baltimore, MD 21244-1850

Re: Centers for Medicare and Medicaid Services, Department of Health and Human Services, Notice of Proposed Rulemaking ("NPRM") – Summary of Benefits and Coverage and the Uniform Glossary, 76 Fed. Reg. 52442 (Aug. 22, 2011); and Centers for Medicare and Medicaid Services, Department of Health and Human Services, Solicitation of Comments – Summary of Benefits and Coverage and Uniform Glossary – Templates, Instructions, and Related Materials Under the Public Health Service Act, 76 Fed. Reg. 52475 (Aug. 22, 2011).

Dear Sir or Madam:

I am writing on behalf of Blue Shield of California to offer comments in response to the Proposed Rule, Summary of Benefits and Coverage and the Uniform Glossary, 76 Fed. Reg. 52442 (Aug. 22, 2011); and the Solicitation of Comments – Summary of Benefits and Coverage and Uniform Glossary – Templates, Instructions, and Related Materials Under the Public Health Service Act, 76 Fed. Reg. 52475 (Aug. 22, 2011) (SBC Rules).

Founded in 1939, Blue Shield of California is a not-for-profit health plan with a deep commitment to expanding access to quality health care at a reasonable price for all Californians. We have roughly 3.4 million members and some of the largest provider networks in California. Over the past five years, we have donated more than $160 million to the Blue Shield of California Foundation, which spends most of its funds to support the health care safety net. Blue Shield of California also has a strong track record of leadership in the health reform movement, and our company is committed to successfully implementing the Affordable Care Act (ACA).

Blue Shield of California has a longstanding commitment to increased transparency in health coverage. However, we have concerns that certain requirements in the SBC Rules will significantly increase administrative costs without a corresponding benefit to consumers. For example, California state law requires that certain health plans provide a Uniform Coverage Matrix for individual and small group plans. As detailed below, the California Uniform Coverage Matrix forms broadly overlap with the new SBC Forms,

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but we would be required to provide both to consumers. Without a delay in the effective date to provide time to work with state regulators to address this duplication, the result will be increased consumer confusion rather than an improvement in the ability to compare or understand plan choices.

Additionally, the rigid format required by the SBC Forms does not allow for innovative benefit designs that have real promise to deliver higher quality care at lower costs. Moreover, the requirements around electronic delivery impose significant unnecessary hurdles on employers providing information to their employees, and it will reverse efforts we have made to make our business more "green" and save hundreds of tons of paper. Finally, certain other requirements, including the requirement to provide an SBC 30 days before renewal, do not account for the way purchase decisions are made in practice and could cause significant disruption to small and large employers who often renew business retroactively or without any formal notification to the insurer.

A delay in the effective date of the SBC Proposed Rule is necessary to address overlapping state requirements:

California requires that health insurers provide a Uniform Coverage Matrix for certain individual and small group plans.[1] The Uniform Coverage Matrix is a standardized document that summarizes the benefits provided by the policy (such as outpatient surgery, preventive care, etc.) and the corresponding co-payment. As with the SBC Forms, the Uniform Matrices have their own very proscribed set of requirements, including items to be included, the order, labels used for covered services, etc. We have attached to our comments for your review an example of a Uniform Coverage Matrix document for Blue Shield plans (Attachment A). While many of these requirements overlap with the proposed SBC Forms, it does not appear that the SBC Proposed Rule would preempt the Uniform Matrix requirement since the requirements do not perfectly match and a plan could, in fact, issue both documents. Thus, absent a statutory change, we believe health plans in California will be required to issue both the Uniform Coverage Matrix and the SBC Forms and to comply with both sets of requirements relating to distribution of these documents. As a result, consumers will be receiving numerous confusing documents that may appear to be describing completely different products.

Blue Shield of California and other health plans in California have highlighted this concern with state regulators, and these regulators have agreed on the need to harmonize the requirements. However, it will take time to work through these issues with regulators and reach agreement on the necessary changes. The March 23rd deadline for compliance with the SBC Rule is particularly problematic because the Uniform Coverage Matrix is a

[1] In California, the Uniform Coverage Matrix requirement applies to plans licensed by the Department of Managed Health Care, not those managed by the Department of Insurance. However, as a matter or practice, Blue Shield and many other insurers provide the Uniform Coverage Matrix documents for plans licensed by either regulator.

statutory requirement in California so that it will require a legislative fix to remove the duplicative obligation. Under the best of circumstances it would take until well into the middle of next year to see any legislative action on this issue, which would mean that plans would be required to operationalize the ability to provide both documents.

This duplicative disclosure will increase administrative costs with little corresponding benefit to consumers. The result would be more consumer confusion since consumers would not understand the differences between the federal SBC Forms and the state Uniform Coverage Matrix. A delay of the effective date is necessary to work through this and many other compliance issues. The delay will also avoid the additional and unnecessary administrative costs of implementing the ability to issue duplicative and confusing summary documents.

Recommendation: The Proposed SBC Rule should be delayed to provide necessary time for plans to comply and to harmonize overlapping state regulatory requirements.

The SBC Rules should facilitate, not impede, electronic distribution of coverage documents:

Blue Shield is committed to reducing our environmental impact as part of our pledge to support a healthier California. Printing is one of our primary impacts, with millions of pounds of paper printed and mailed each year. We are focused on enhancing online capabilities to better serve our members and medical providers, while reducing our impact. In 2010, we reduced our printed documents by more than 2.5 million pounds over the prior year, and we are on track to further reduce that number in 2011. Our experience with electronic communications to our large group customers is that customers were very satisfied with the speed with which they received their documents and also that they prefer to save important documents on their computer rather than storing a booklet in their house.

While the Administration has shown a commitment to improving environmental stewardship, the SBC Rules create unnecessary impediments that will force insurers to provide millions of pounds of paper documents each year with little benefit to consumers. By relying on the ERISA safe harbor as the only mechanism to distribute electronic SBCs, the SBC Rule severely limits the number of employers who can distribute the required forms electronically.[2] The rules for electronic distribution of SBCs are more

[2] To fall under the safe harbor rule, the ERISA regulations require the document to be delivered either to: (1) an employee who has access to electronic documents at his or her work station; or (2) an individual who has provided affirmative consent. If proposed recipients of an electronic document fall into one of these categories, the plan administrator also must take appropriate and necessary measures reasonably calculated to ensure that the electronic system for furnishing documents: (1) Results in actual receipt, (2) Protects the confidentiality of any personal information, (3) Uses the same style and format as paper documents; and

rigid than those for the distribution of common Summary Plan Documents (SPDs), a much more critical ERISA document. Those rules, which we note are themselves almost 10 years old and warrant reconsideration, require that an employer "use measures reasonably calculated to ensure actual receipt of the material by plan participants and beneficiaries." In our opinion, the rules for electronic delivery of SBCs should be less strict than those for delivery of an SPD and should reflect the pervasive reality of the use of the web and electronic technology in 2011.

Moreover, health plans and employers are now and have been using electronic technology successfully to deliver important information to employees/enrollees. These processes have been well received, successful, are administratively efficient and ecologically friendly. We urge the Agencies to investigate these current procedures and incorporate them as valid methods for delivery of SBCs.

Recommendation: The SBC Rules should facilitate the distribution of electronic documents where reasonably calculated to reach the enrollee. At a minimum, the rules for distribution of the SBC documents should not be more restrictive than for similar SPD documents. Insurers and employers are familiar with the rules for distribution of SPD documents, and they are working effectively in the market. Rather than create conflicting and overlapping requirements, the SBC and SPD requirements should be harmonized. The rules should acknowledge current practices, should be flexible, and should encourage the use of technology.

Rigid formatting requirements will create barriers to plan innovation:

The Proposed Rule sets very rigid formatting requirements for the SBC Forms that are incompatible with innovative plan designs. For example, the rule provides that insurers must only use 12 point Times New Roman Font and replicate all symbols, formatting, etc. exactly. The rules further provide that "items shown on Page 1 must always appear on Page 1."[3] This rigidity is particularly problematic for innovative plans that are designed to improve the delivery of high-value care. The unintended consequence could be to reduce innovation in the market because plans will not want to risk severe financial penalties for non-compliance with the SBC Rules. In this case, the SBC Forms could dictate plan functions and act as a barrier to innovation.

For example, the Administration has repeatedly expressed its support for Value Based Insurance Design (VBID) policies that drive individuals towards high-value care and high-value providers. A basic VBID benefit creates different levels of cost-sharing based

(4) Provides notice to the recipient of the significance of the document and his or her right to obtain a paper copy upon request.

[3] Draft Instructions for Group Policies, page 2.

on the demonstrated clinical effectiveness of a medication, provider, or procedure. The SBC Forms do not provide any flexibility to account for these tiered co-payments.

To further illustrate this point, Blue Shield attempted to fill out an SBC Form for several of its more innovative plans that all work to drive individuals to high-value care. These SBC Forms are attached as Attachments B-D, and they demonstrate that these plan designs cannot be captured in the rigid one-size-fits-all parameters of the SBC Forms. Notably, Blue Shield recently developed a new "Blue Groove" product [Attachment B] which uses VBID benefits and a medical home model to provide highly-coordinated and clinically effective care, with a focus on enrollees with chronic conditions. As enrollees in the Blue Groove plan take responsibility for their health, by participating in a wellness program for example, they are rewarded with reduced cost-sharing to encourage enrollees to get the care they need. This plan implements many of the delivery reforms encouraged by the Affordable Care Act, yet it cannot conform to the SBC Rules without additional flexibility. Moreover, the SBC does not permit Blue Shield to include critical information for the consumer about important features of the various benefit levels in the product – the resulting SBC is incomplete and misleading.[4]

Recommendation: The SBC Rule should provide a "best efforts" test to determine if insurers are in compliance with the SBC Formatting requirements. If necessary, health plans should be able to adjust the formatting and information provided to ensure that enrollees have accurate information relevant to the coverage they are choosing. The SBC Format rules should not, in effect, dictate innovation. And carriers should not be limited to selling only those products that can be adequately described on the very proscriptive SBC Form.

The requirement for SBCs to be provided 30 days in advance of renewals will cause significant disruptions in the market:

The SBC Rule provides that an employee must receive an SBC upon renewal and at least 30 days prior to the start of the new policy year. While this requirement appears

[4] Additionally, we have attached a mock-up SBC Form for our popular "active choice" [Attachment C] plan that improves on a high-deductible health plan model by providing first dollar coverage and a range of services up to a certain limit, at which point there is a coverage gap until an out of pocket maximum is reached. This is a very popular product in the small group market, but simply doesn't fit the SBC Form. Finally, we modeled a three-tier point of service plan [Attachment D] that provides the lowest out of pocket costs when enrollees participate in the HMO network with the highest quality providers and most engaged utilization management. The cost sharing then goes up progressively for providers who are in two other network tiers. Again, the plan design cannot be adequately presented while also complying with the restrictive SBC Formatting rules.

innocuous, it will cause serious disruption in the market and could leave many employers with a gap in coverage. Many decisions made by employers about coverage are made less than 30 days before the plan is renewed. In fact, employers—especially small employers—frequently change benefit plans or carriers less than 30 days before renewal. Many other employers renew simply by paying their bill that is due on the first day of the new policy year without any notice to the insurer. Some employers even renew retroactively or change carriers retroactively.

The percentage of small employers who make plan changes on renewal varies depending on the market conditions, but in most years the vast majority of those changes are communicated to Blue Shield much less than 30 days prior to the renewal effective date. Depending upon the actual market conditions at the time of specific renewals, as few as 25%, and as many as 90%, of small employers make plan changes and communicate them to Blue Shield during the period of two weeks before the renewal date and the 30 day period after the renewal date. Thus, for as many as 90% of small employers, it would be impossible to issue SBCs to enrollees at least 30 days prior to the renewal date.

The new rule could have the unintended effect of penalizing common behavior in the market and forcing carriers to withdraw offers of renewal, or even cancel coverage, if there is not sufficient time to provide the SBC as required by the Proposed Rule. The Departments should talk to brokers and employers about the reality of the decision making process and how renewals occur in the market. This discussion will help inform whether this requirement to provide 30 day notice will have adverse unintended impacts on the market.

Recommendation: For renewals, the SBC should be provided the later of 30 days before the beginning of the new policy year, or 15 days after the insurer is notified of the decision to renew the policy. At a minimum, we recommend that enforcement of this requirement be postponed to permit the Departments to conduct the necessary investigation with brokers and employers.

The requirement that the insurer provide premium information is not workable in practice:

The SBC Forms require that insurers provide premium information even though the ACA does not include premiums as a required element. The SBC Proposed Rule solicits comments on whether and how to include premium information. Blue Shield believes that the requirement to provide premium information creates unnecessary regulatory burdens because the enrollee will ultimately receive the information they need about premiums when they enroll in coverage.

Group Coverage: The instructions to the SBC Forms provide information on how issuers in group health plans can provide premium information. For group plans, the instructions provide that the insurer should provide the following statement: "Please contact your employer for your share of the premium amount." This statement acknowledges that insurers do not have access to premium information for employees enrolling in group coverage. The employer will provide this premium information to employees with their enrollment materials, so this additional requirement in the SBCs is confusing and duplicative.

Additionally, for small groups where the premiums are based on a rate table, the Proposed SBC Rule provides that an insurer can provide the premium by attaching the rate table to the SBC Forms. A rate table will be incomprehensible to an average enrollee and will only cause confusion. [We have attached as Attachment E a portion (5 of 37 pages) of a sample small group rate table for review.]. And it will not tell the enrollee what portion of the premium they must pay. Again, the small employer will provide premium information to enrollees at enrollment, so there is no reason to add this additional requirement.

Individual market coverage: For individual coverage, the proposed rule provides that SBC Forms should include standard rates and include the "why this matters" comment that the rates may change based on underwriting review of the application. Health plans will provide the rate to individuals as part of the enrollment process, so it is redundant to require insurers to provide enrollees with a new SBC when the individual receives an offer of coverage. Once the individual makes the purchase decision, the policy will include the premium information.

Recommendation: The requirement to provide premium information should be removed from the SBC documents. If not, the documents should simply tell enrollees to contact their employer for premium information. In the individual market, the document should simply say that premium information will be provided upon enrollment.

The SBC Forms should include an identifier indicating whether the health plan is for-profit or not-for-profit:

Consumers should be able to determine from the SBC Forms whether their health plan is investor-owned or nonprofit. Opinion surveys show that the public wants to know whether their health plan is for-profit or not-for-profit. Consumers believe this is an important distinguisher among health plans. This is because nonprofit status is often an important indicator of community benefit. For example, as part of its nonprofit mission, Blue Shield has pledged to limit its net income to 2 percent of revenue. This month, we announced that Blue Shield will return approximately $295 million to its customers and the community by December 31, 2011. Blue Shield first made its 2 percent pledge in

June and announced that it would return $180 million in October to offset net income earned above the 2 percent threshold in 2010. In addition, the company has contributed more than $125 million over the past four years to the Blue Shield of California Foundation which supports the safety-net in California.

Recommendation: The SBC Forms should include an indicator of whether the health plan is for-profit or not-for-profit. This minor addition will greatly increase transparency for consumers and provide information that consumers say is valuable to them in making a choice of health plans.

Conclusion:

Blue Shield of California remains committed to making health reform a success, and we look forward to working cooperatively on this and other issues to expand access to affordable health care. Our biggest concern for the success of the ACA is that many Americans will choose not to buy coverage because it costs too much. As the Administration crafts regulations to implement the ACA, it is essential that the impact of the regulations on the cost of coverage remain a priority.

Sincerely,

Andy Chasin
Associate General Counsel for Health Reform

ATTACHMENT A

Shield Spectrum PPO SM Plan, Zero Deductible

Benefit Summary (For groups 2 to 50)
(Uniform Health Plan Benefits and Coverage Matrix)

Blue Shield of California

Effective January 1, 2011

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

DEDUCTIBLES[1]	Preferred Providers[2]	Non-Preferred Providers[2]
Calendar-year Medical Deductibles	None	$500 per individual/$1,000 per family
Calendar-year Copayment Maximum[1] (Copayments for Preferred Providers accrue to both Preferred and Non-Preferred Provider Calendar-year Copayment Maximum amounts)	$2,000 per individual/$4,000 per family	$5,000 per individual/$10,000 per family
LIFETIME MAXIMUM	None	
Covered Services	**Member Copayment**	
PROFESSIONAL SERVICES		
Physician services		
• Physician and specialist office visits	$10/visit (Not subject to the Calendar-year Medical Deductible)	30%[1]
• Laboratory and X-rays	10%	30%
• Allergy testing or treatment	10%	30%
• Diagnostic testing	10%	30%
Preventive care		
• Annual routine physical exam, eye/ear screenings and immunizations	No charge (Not subject to the Calendar-year Medical Deductible)	Not covered
• Laboratory, including mammogram and Pap test screening or other FDA-approved cervical cancer screening tests (One per calendar-year)	No charge (Not subject to the Calendar-year Medical Deductible)	Not covered
Well-baby care		
• Office visits and consultations Includes: eye/ear screenings, immunizations, vaccinations	No charge (Not subject to the Calendar-year Medical Deductible)	Not covered
• Laboratory	No charge (Not subject to the Calendar-year Medical Deductible)	Not covered
OUTPATIENT SERVICES		
• Outpatient surgery performed in a participating ambulatory surgery center (ASC)[3]	10%	30%[4]
• Outpatient surgery in hospital/facility	10%	30%[4]
• Outpatient treatment and necessary supplies	10%	30%[1, 4]
• Bariatric surgery **(pre-authorization required; medically necessary surgery for weight loss, only for morbid obesity)**[5]	10%	30%[4]

Covered Services	Member Copayment	
HOSPITALIZATION SERVICES		
• Inpatient physician services (including pregnancy and maternity care)	10%	30%
• Semi-private room and board, medically necessary services and supplies	10%	30%[4]
• Bariatric surgery **(pre-authorization required; medically necessary surgery for weight loss, only for morbid obesity)**[5]	10%	30%[4]
Skilled nursing facility (SNF) services[6] (Combined maximum of up to 100 preauthorized days per calendar-year; semi-private accommodations)		
• Freestanding SNF	10%	10%
• Hospital SNF unit	10%	30%[4]
EMERGENCY HEALTH COVERAGE		
• Facility services (If ER services do not result in a direct admission the Calendar-Year Deductible does not apply)	$100/visit[1] + 10%	$100/visit[1] + 10%
• Facility services (Resulting in a direct admission)	10%	10%
• Emergency room physician visits	10%	10%
AMBULANCE SERVICES	10%	10%
PRESCRIPTION DRUG COVERAGE[1, 7, 8, 14] (Including oral contraceptives, diaphragms, and covered diabetic drugs and testing supplies)	**Participating Pharmacy**	**Non-Participating Pharmacy** Member pays 25% of allowed charge plus a copayment of:
• Calendar-Year Brand-Name Drug Deductible	None	
• Retail prescriptions (For up to a 30-day supply)		
Generic drugs	$10/prescription	$10/prescription
Formulary brand-name drugs	$25/prescription	$25/prescription
Non-formulary brand-name drugs	$50/prescription	$50/prescription
• Mail service prescriptions (For up to a 90-day supply)		
Generic drugs	$20/prescription	Not covered
Formulary brand-name drugs	$50/prescription	Not covered
Non-formulary brand-name drugs	$100/prescription	Not covered
• Specialty Pharmacies		
Specialty drugs (May require prior authorization from Blue Shield Pharmacy Services. Specialty drugs are covered only when dispensed by select participating pharmacies in the Specialty Pharmacy Network. Mail service prescriptions are not covered. Drugs from non-participating pharmacies are not covered except in emergency and urgent situations. **Member pays up to $100 copayment maximum per prescription**)	30%/prescription	Not covered
PROSTHETICS/ORTHOTICS	**Preferred Providers**[2]	**Non-Preferred Providers**[2]
• Prosthetic appliances and orthoses benefits (Equipment and devices only. Separate office visit copayment may apply)	10%	30%
DURABLE MEDICAL EQUIPMENT	50%	50%
MENTAL HEALTH SERVICES (PSYCHIATRIC)[9]	**MHSA Participating Providers**[2]	**MHSA Non-Participating Providers**[2]
• Inpatient hospital facility services	10%	30%[4]
• Outpatient visits for severe mental health conditions	$10/visit (Not subject to the Calendar-year Medical Deductible)	30%[1]
• Outpatient visits for non-severe mental health conditions (Up to 20 visits per calendar-year combined with outpatient chemical dependency visits)[10]	50%[1]	Not covered

Covered Services	Member Copayment	
CHEMICAL DEPENDENCY SERVICES (SUBSTANCE ABUSE)[9], PLEASE SEE FOOTNOTE 13		
• Inpatient services for medical acute detoxification	10%	30%[4]
• Outpatient visits (Up to 20 visits per calendar-year combined with outpatient non-severe mental health visits)[10]	50%[1]	Not covered
HOME HEALTH SERVICES	**Preferred Providers[2]**	**Non-Preferred Providers[2]**
• Home health (Maximum of 100 prior authorized visits per calendar-year)	10%	Not covered[11]
• Home infusion care (For specialty drugs see "Specialty Pharmacies.")	10%	Not covered[11]
OTHER		
Hospice		
• Routine home care	No charge	Not covered[11]
• Inpatient respite care	No charge	Not covered[11]
• 24 hour continuous home care	10%	Not covered[11]
• General inpatient care	10%	Not covered[11]
Alternative care[10]		
• Chiropractic services (Up to 12 visits per calendar-year)	10%	30%
• Acupuncture services (Up to 20 visits per calendar-year)	$25/visit	$25/visit plus charges above the allowable amount
Rehabilitative therapy services		
• Outpatient visits	10%	30%
Pregnancy and maternity care		
• Prenatal and postnatal professional (physician) services (For all necessary inpatient hospital services, see "Hospitalization Services.")	10%	30%
Family planning		
• Family planning counseling	10% (Not subject to the Calendar-year Medical Deductible)	Not covered
• Elective abortion[12], tubal ligation[12], vasectomy[12]	10%	Not covered
Diabetes care		
• Equipment, devices and non-testing supplies (For testing supplies, see "Prescription Drug Coverage.")	50%	50%
• Self-management training and education (If billed by your provider, you will also be responsible for the office visit copayment)	$10/visit	30%
Covered out-of-state benefits Benefits provided through 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.	See Applicable Benefit Line	See Applicable Benefit Line
Optional Benefits Optional dental, vision, or infertility benefit is available. If your employer purchased any of these benefits, a description of the benefit is provided separately.		

1 Deductible and copayments marked with a (1) do not accrue to calendar-year copayment maximum, except for the percentage copayment for the Outpatient Surgery in hospital/facility benefit which does accrue to the calendar-year copayment maximum. Copayments and charges 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. Deductible does not apply toward the calendar-year maximum. Please refer to the *Evidence of Coverage* and the plan contract for exact terms and conditions of coverage.

2 Member is responsible for copayment in addition to any charges above allowable amounts. The copayment percentage indicated is a percentage of allowable amounts. Preferred providers accept Blue Shield'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 copayment plus any amount that exceeds Blue Shield's allowable amount. Charges above the allowable amount do not count toward the calendar-year deductible or copayment maximum.

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

4 The maximum allowed charge for non-emergency hospital services received from a non-plan provider-hospital is $600 per day. Members are responsible for 30 percent of this $600 per day, plus all charges in excess of $600.

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 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 *Evidence of Coverage* for further benefit details.

6 Services may require prior authorization by Blue Shield. When these services are prior authorized, members pay the preferred or participating provider level.

7 Please note that if you switch from another plan, your prescription drug deductible credit from the previous plan during the calendar year, if applicable, will not carry forward to your 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.

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

9 Mental health and chemical dependency services, other than medical acute detoxification, are accessed through Blue Shield Mental Health Service Administrator (MHSA) – using Blue Shield MHSA participating and non-participating providers. Only Blue Shield MHSA contracted providers are administered by the Blue Shield MHSA. Behavioral health services rendered by non-participating providers are administered by Blue Shield. Services for medical acute detoxification are accessed through Blue Shield using Blue Shield'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 *Evidence of Coverage* or plan contract.

10 All outpatient non-severe mental health, outpatient substance abuse, acupuncture and chiropractic visits accrue to the calendar-year visit maximum regardless of whether the plan deductible has been met.

11 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.

12 Copayment shown is for physician's services. If the procedure is performed in a facility setting (hospital or outpatient surgery center), an additional facility copayment may apply.

13 **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"*.**

14 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.

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

ATTACHMENT B

Blue Shield of California: Blue Groove **Policy Period: 1/1/2012 – 12/31/2012**
Summary of Coverage: What this Plan Covers & What it Costs **Coverage for:** <all contract types>| **Plan Type:** Blue Groove

This is not a policy. You can get the policy at **www.insurancecompany.com/PLAN1500** or by calling **1-800-XXX-XXXX.**
A policy has more detail about how to use the plan and what you and your insurer must do. It also has more detail about your coverage and costs.

Important Questions	Answers	Why this Matters:
What is the premium?	Please contact your employer for your share of the premium amount.	The **premium** is the amount paid for health insurance.
What is the overall deductible?	**$1,500** per member per calendar year for Basic Groove; **$0** per member per calendar year for Benefits from ACO Provider in Main Groove; **$1,500** per member per calendar year combined for preferred and non-preferred providers in Main Groove; **$0** per member per calendar year for Care+ Groove	You must pay all the costs up to the **deductible** amount before this health insurance plan begins to pay for covered services you use. Check your policy to see when the **deductible** starts over (usually, but not always, January 1st). See the chart starting on page 2 for how much you pay for covered services after you meet the **deductible**.
Are there other deductibles for specific services?	Yes; **$75** for brand name prescriptions per member per calendar year for Basic Groove and Main Groove; **$500** for facility services for ACO provider tier in Main Groove per member per calendar year.	You must pay all of the costs for these services up to the specific deductible amount before this plan begins to pay for these services.
Is there an out-of-pocket limit on my expenses?	Yes; **$7,000** per member per calendar year for Basic Groove preferred providers; **$10,000** per member per calendar year for Basic Groove non-preferred providers; **$1,500** per member per calendar year for Main Groove ACO providers; ; **$7,000** per member per calendar year for Main Groove preferred providers; **$10,000** per member per calendar year for Main Groove non-preferred providers; **$1,000** per member per calendar year for Care+ Groove	The **out-of-pocket limit** is the most you could pay during a policy period for your share of the cost of covered services. This limit helps you plan for health care expenses.
What is not included in the out-of-pocket limit?	Deductibles, premium, balance-billed charges, prescription drugs, and health care this plan does not cover.	Even though you pay these expenses, they don't count toward the **out-of-pocket limit**. So, a longer list of expenses means you have less coverage.

Questions: Call **1-800-XXX-XXXX** or visit us at **www.insurancecompany.com.**
If you aren't clear about any of the terms used in this form, see the Glossary at **www.insuranceterms.gov**.

Blue Shield of California: Blue Groove **Policy Period: 1/1/2012 – 12/31/2012**
Summary of Coverage: What this Plan Covers & What it Costs **Coverage for:** <all contract types>| **Plan Type:** Blue Groove

Important Questions	Answers	Why this Matters:
Is there an overall annual limit on what the insurer pays?	Yes; **$10,000** per member per calendar year combined for benefits under Main Groove preferred and non-preferred providers	This plan will pay for covered services only up to this limit during each policy period, even if your own need is greater. You're responsible for all expenses above this limit. The chart on page 2 describes *specific* coverage limits such as limits on the number of office visits.
Does this plan use a network of providers?	Yes, this plan uses Patient-Center Medical Home Providers for Care+ Groove; an ACO network for the first tier of coverage for Main Groove; as well as a Preferred Provider nework for both Basic Groove and Main Groove. You may use health care providers that aren't preferred providers for for both Main Groove and Basic Groove, but you may pay more. For a list of participating providers, see www.blueshieldca.com. *Exception statement about "Other Providers".* Please be aware that preferred providers will sometimes use non-preferred specialists.	If you use an **in-network** doctor or other health care provider, this plan will pay some or all of the costs of covered services. Plans use the term **in-network**, **preferred**, or **participating** for providers in their network.
Do I need a referral to see a specialist?	Yes. A written referral is may be needed to see a specialist for ACO provider plan benefits with Main Groove, and one is needed to so a specialist in Care+ Groove. An exception exists allowing for a woman to self-refer to an OB/GYN or family practice physician in her personal physician's medical group or IPA for OB/GYN services. You don't need a referral to see a specialist for preferred and non-preferred provider benefits in Basic Groove and Main Groove.	This plan will pay some or all of the costs to see a specialist but only if you have the plan's permission before you see the specialist for covered services.
Are there services this plan doesn't cover?	Yes.	Some of the services this plan doesn't cover are listed in the "Excluded Services & Other Covered Services" section.

Questions: Call 1-800-XXX-XXXX or visit us at **www.insurancecompany.com.**
If you aren't clear about any of the terms used in this form, see the Glossary at **www.insuranceterms.gov**.

Blue Shield of California: Blue Groove **Policy Period: 1/1/2012 – 12/31/2012**

Summary of Coverage: What this Plan Covers & What it Costs **Coverage for:** <all contract types>| **Plan Type:** Blue Groove

- **Co-payments** are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.
- **Co-insurance** is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. You pay this plus any deductible amounts you owe under this health insurance plan. For example, if the health plan's allowed amount for an overnight hospital stay is $1,000 and you've met your deductible, your co-insurance payment of 20% would be $200. If you haven't met any of the deductible and it's at least $1,000, you would pay the full cost of the hospital stay.
- The plan's payment for covered services is based on the **allowed amount**. If an **out-of-network provider** charges more than the allowed amount, you may have to pay the difference. For example, if an out-of-network hospital charges $1,500 for an overnight stay and the allowed amount is $1,000, you may have to pay the $500 difference. (This is called **balance billing**.)
- This plan may encourage you to use ACO, **Patient-centered medical home or preferred providers** by charging you lower deductibles, co-payments and co-insurance amounts.

Common Medical Event	Services You May Need	Your cost if you use a							Limitations & Exceptions
		Basic Groove		Main Groove			Care+ Groove		
		Preferred Provider	Non-Preferred Provider	ACO Provider	Preferred Provider	Non-Preferred Provider	Patient - Centered Medical Home	Non-Preferred Provider	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$45 co-pay/ visit	50% co-insurance	$20 co-pay/ visit	$45 co-pay/ visit	50% coinsurance	$0	Not covered	Preferred provider co-pay is not subject to the calendar year deductible
	Specialist visit	$45 co-pay/ visit	50% co-insurance	$20 copay/ visit with referral; $30 co-pay/ visit with Access+ Specialist	$45 co-pay/ visit	50% coinsurance	$0	Not covered	Preferred provider co-pay is not subject to the calendar year deductible
	Other practitioner office visit	$0	Not covered	Not covered	$0	Not covered	Not covered	Not covered	----------none----------
	Preventive care/screening/immunization	$0	Not Covered	$0	Not covered	Not covered	$0	Not covered	----------none----------
If you have a test	Diagnostic test (x-ray, blood work)	$45 co-pay/ visit	50% coinsurance	$0	30% co-insurance	50% coinsurance	$0	Not covered	----------none----------
	Imaging (CT/PET scans, MRIs)	$100 co-pay/ visit plus 30%	50% co-insurance	$0	30% co-insurance	50% coinsurance	$0	Not covered	Prior authorization required

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Blue Shield of California: Blue Groove
Summary of Coverage: What this Plan Covers & What it Costs

Policy Period: 1/1/2012 – 12/31/2012
Coverage for: <all contract types>| **Plan Type:** Blue Groove

Common Medical Event	Services You May Need	Your cost if you use a							Limitations & Exceptions
		Basic Groove		Main Groove			Care+ Groove		
		Preferred Provider	Non-Preferred Provider	ACO Provider	Preferred Provider	Non-Preferred Provider	Patient - Centered Medical Home	Non-Preferred Provider	
If you need drugs to treat your illness or condition More information about drug coverage is at www.insurancecompany.com/prescriptions.	Generic drugs	$10 co-pay (retail); $15co-pay (mail order)	Not covered	$10 co-pay (retail); $15co-pay (mail order)		Not covered	$10 co-pay (retail); $15 co-pay (mail order) for non-selected chronic conditions; $5 co-pay (retail); $7.50 co-pay (mail order) for selected chronic conditions	Not covered	Covers up to a 30-day supply (retail prescriptions); up to a 90-day supply (mail order prescriptions)
	Preferred brand drugs	$40 co-pay (retail); $100 co-pay (mail order)	Not covered	$40 co-pay (retail); $100 co-pay (mail order)		Not covered	$40 co-pay (retail); $100 co-pay (mail order) for non-selected chronic conditions; $20 co-pay (retail); $50 co-pay (mail order)	Not covered	Covers up to a 30-day supply (retail prescriptions); up to a 90-day supply (mail order prescriptions) Selected formulary and non-formulary drugs require prior authorization. If generic drug equivalent is available, member

						for selected chronic conditions		pays the generic copay plus the difference in cost to Blue Shield between the generic and brand.
	Non-preferred brand drugs	$50 co-pay or 30% co-insurance up to $100 co-pay maximum / prescription (retail); $125 co-pay or 30% co-insurance up to $250 co-pay maximum / prescription (mail order);	Not covered	$30 co-pay or 30% co-insurance up to $100 co-pay maximum / prescription (retail); $75 co-pay or 30% co-insurance up to $250 co-pay maximum / prescription (mail order);	Not covered	$50 co-pay or 30% co-insurance up to $100 co-pay maximum / prescription (retail); $125 co-pay or 30% co-insurance up to $250 co-pay maximum / prescription (mail order) for non-selected chronic conditions; $45 co-pay or 25% co-insurance up to $80 co-pay maximum / prescription (retail); $100 co-pay	Not covered	Covers up to a 30-day supply (retail prescriptions); up to a 90-day supply (mail order prescriptions) Selected formulary and non-formulary drugs require prior authorization.

						or 25% co-insurance up to $200 co-pay maximum / prescription (mail order) for selected chronic conditions;		
	Specialty drugs (e.g., chemotherapy)	20% co-insurance up to $150 max	Not covered	20% co-insurance up to $150 max	Not covered	20% co-insurance up to $150 max	Not covered	Specialty-drugs are covered only when dispensed by select pharmacies in the Specialty Pharmacy Network unless Medically Necessary for a covered emergency

Blue Shield of California: Blue Groove **Policy Period: 1/1/2012 – 12/31/2012**

Summary of Coverage: What this Plan Covers & What it Costs **Coverage for:** <all contract types>| **Plan Type:** Blue Groove

Common Medical Event	Services You May Need	Your cost if you use a							Limitations & Exceptions
		Basic Groove		Main Groove			Care+ Groove		
		Preferred Provider	Non-Preferred Provider	ACO Provider	Preferred Provider	Non-Preferred Provider	Patient - Centered Medical Home	Non-Preferred Provider	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	30% co-insurance	50% co-insurance	$75 co-pay/ surgery at ambulatory surgery center; $150 co-pay/ surgery at hospital	30% co-insurance	50% co-insurance	$75 co-pay/ surgery at ambulatory surgery center; $150 co-pay/ surgery at hospital	Not covered	ACO Main Groove benefit subject to facility deductible
	Physician/surgeon fees	30% co-insurance	50% co-insurance	$0	30% co-insurance	50% co-insurance	$0	Not covered	----none-----
If you need immediate medical attention	Emergency room services	$100 co-pay/ visit + 30% co-insurance	$100 co-pay/ visit + 30% co-insurance	$100 co-pay/ visit	$100 co-pay/ visit	$100 co-pay/ visit	$100 co-pay/ visit	$100 co-pay/ visit	----none-----
	Emergency medical transportation	30% co-insurance	30% co-insurance	$50 co-pay	$50 co-pay	$50 co-pay	$0	$0	----none-----
	Urgent care	$45 co-pay/ visit	50% co-insurance	$20 co-pay/ visit	$45 co-pay/ visit	50% co-insurance	$0	Not covered	Not covered for ACO or patient-centered medical home benefits if care is not provided by or referred by your personal physician
If you have a hospital stay	Facility fee (e.g., hospital room)	30% co-insurance	50% co-insurance	$250 co-pay /admission	30% co-insurance	50% co-insurance	$250 co-pay /admission	Not covered	ACO Main Groove benefit subject to facility deductible
	Physician/surgeon fee	30% co-insurance	50% co-insurance	$0	30% co-insurance	50% co-insurance	$0	Not covered	----none-----

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Blue Shield of California: Blue Groove
Summary of Coverage: What this Plan Covers & What it Costs

Policy Period: 1/1/2012 – 12/31/2012
Coverage for: <all contract types>| **Plan Type:** Blue Groove

Common Medical Event	Services You May Need	Your cost if you use a							Limitations & Exceptions
		Basic Groove		Main Groove			Care+ Groove		
		Preferred Provider	Non-Preferred Provider	ACO Provider	Preferred Provider	Non-Preferred Provider	Patient - Centered Medical Home	Non-Preferred Provider	
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	$45 co-pay/ visit	50% co-insurance	$20 co-pay/ visit for MHSA provider		50% coinsurance	$0	Not covered	Preferred provider co-pay is not subject to the calendar year deductible
	Mental/Behavioral health inpatient services	30% co-insurance	50% co-insurance	$250 co-pay /admission		50% coinsurance	$250 co-pay /admission	Not covered	ACO Main Groove benefit subject to facility deductible
	Substance use disorder outpatient services	Not covered	Not covered	Not covered	Not covered	Not covered	Not covered	Not covered	----none-----
	Substance use disorder inpatient services	Not covered	Not covered	Not covered	Not covered	Not covered	Not covered	Not covered	----none-----
If you become pregnant	Prenatal and postnatal care	30% co-insurance	50% co-insurance	$0	30% co-insurance	50% co-insurance	$0	Not covered	----none-----
	Delivery and all inpatient services	30% co-insurance	50% co-insurance	$250 co-pay /admission	30% co-insurance	50% co-insurance	$250 co-pay /admission	Not covered	ACO Main Groove benefit subject to facility deductible

Questions: Call 1-800-XXX-XXXX or visit us at **www.insurancecompany.com.**
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Blue Shield of California: Blue Groove **Policy Period: 1/1/2012 – 12/31/2012**

Summary of Coverage: What this Plan Covers & What it Costs **Coverage for:** <all contract types>| **Plan Type:** Blue Groove

Common Medical Event	Services You May Need	Your cost if you use a							Limitations & Exceptions
		Basic Groove		Main Groove			Care+ Groove		
		Preferred Provider	Non-Preferred Provider	ACO Provider	Preferred Provider	Non-Preferred Provider	Patient - Centered Medical Home	Non-Preferred Provider	
If you have a recovery or other special health need	Home health care	30% co-insurance	Not covered	$20 co-pay/ visit	30% co-insurance	Not covered	$0	Not covered	Limited to 100 visits per calendar year
	Rehabilitation services	$45 co-pay/ visit	50% co-insurance	$20 co-pay/ visit	$45 co-pay/ visit	50% co-insurance	$0	Not covered	----none-----
	Habilitation services	$45 co-pay/ visit	50% co-insurance	$20 co-pay/ visit	$45 co-pay/ visit	50% co-insurance	$0	Not covered	Up to 30 visits per year combined for Main Groove preferred and non-preferred provider
	Skilled nursing care	30% co-insurance	30% co-insurance at free-standing skilled nursing facility; 50% co-insurance at skilled nursing unit of a hospital	$100 co-pay / day	30% co-insurance	30% co-insurance at free-standing skilled nursing facility; 50% co-insurance at skilled nursing unit of a hospital	$100 co-pay / day	Not covered	Requires prior-authorization; limited to 100 days per calendar year
	Durable medical equipment	50% co-insurance	50% co-insurance	50% co-insurance	50% co-insurance	50% co-insurance	$0 for osteo-arthritis devices; 20% for other DME	Not covered	----none-----
	Hospital service	30% co-insurance	50% co-insurance	$250 co-pay /admission	30% co-insurance	50% co-insurance	$250 co-pay /admission	Not covered	ACO Main Groove benefit subject to

Questions: Call **1-800-XXX-XXXX** or visit us at **www.insurancecompany.com.**

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									facility deductible
Common Medical Event	**Services You May Need**	**Your cost if you use a**							**Limitations & Exceptions**
		Basic Groove		**Main Groove**			**Care+ Groove**		
		Preferred Provider	**Non-Preferred Provider**	**ACO Provider**	**Preferred Provider**	**Non-Preferred Provider**	**Patient - Centered Medical Home**	**Non-Preferred Provider**	
If your child needs dental or eye care	Eye exam	Not covered	Not covered	Not covered	Not covered	Not covered	Not covered	Not covered	----none-----
	Glasses	Not covered	Not covered	Not covered	Not covered	Not covered	Not covered	Not covered	----none-----
	Dental check-up	Not covered	Not covered	Not covered	Not covered	Not covered	Not covered	Not covered	----none-----

Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy for others.)

- Non-emergency care when traveling outside the U.S.
- Cosmetic surgery
- Dental care
- Eye glasses
- Long-term care
- Private-duty nursing
- Routine eye care
- Acupuncture
- Substance abuse treament
- Routine foot care
- Routine hearing test
- Weight loss programs
- Hearing aids

Other Covered Services (This isn't a complete list. Check your policy for other covered services and your costs for these services.)

- Bariatric surgery
- Infertility treatments (diagnosis and treatment of causes)

Your Rights to Continue Coverage:

You can keep this insurance as long as you pay your premium unless one or more of the following happens:

- you commit fraud
- the insurer stops offering services in the state
- you move outside the coverage area

Questions: Call 1-800-XXX-XXXX or visit us at **www.insurancecompany.com.**
If you aren't clear about any of the terms used in this form, see the Glossary at **www.insuranceterms.gov.**

Your Grievance and Appeals Rights:

- A **grievance** is a complaint you have about your health insurer or plan. You have the right to file a written complaint to express your
- dissatisfaction or denial of coverage for claims under this health insurance. Call **1-800-XXX-XXXX** or visit **www. Xxxxxxxxxxxxx.com**.
- An **appeal** is a request for your health insurer or plan to review a decision or a grievance again. For more information on the appeals process, call

your state office of health insurance customer assistance at: **1-800-XXX-XXXX** or visit **www. Xxxxxxxxxxxxx.gov**.

To see examples of how this plan might cover costs for a sample medical situation, see the next page.

Questions: Call **1-800-XXX-XXXX** or visit us at **www.insurancecompany.com.**
If you aren't clear about any of the terms used in this form, see the Glossary at **www.insuranceterms.gov**.

ATTACHMENT C

This is not a policy. You can get the policy at **www.insurancecompany.com/PLAN1500** or by calling **1-800-XXX-XXXX**.
A policy has more detail about how to use the plan and what you and your insurer must do. It also has more detail about your coverage and costs.

Important Questions	Answers	Why this Matters:
What is the premium?	Please contact your employer for your share of the premium amount.	The **premium** is the amount paid for health insurance.
What is the overall deductible?	**$0**	See chart starting on page 2 for other costs for services this plan covers
Are there other deductibles for specific services?	Yes; **$250** for brand name prescriptions per member per calendar year. There are no other deductibles.	You must pay all of the costs for these services up to the specific deductible amount before this plan begins to pay for these services.
Is there an out-of-pocket limit on my expenses?	Yes; **$5,000** for preferred providers per individual per calendar year; **$10,000** for preferred providers per family per calendar year; **$10,000** for non-preferred providers per individual per calendar year; **$20,000** for non-preferred providers per family per calendar year; Other limits apply – see the chart that starts on page 2.	The **out-of-pocket limit** is the most you could pay during a policy period for your share of the cost of covered services. This limit helps you plan for health care expenses.
What is not included in the out-of-pocket limit?	Deductibles, premium, balance-billed charges, prescription drugs, and health care this plan does not cover.	Even though you pay these expenses, they don't count toward the **out-of-pocket limit**. So, a longer list of expenses means you have less coverage.

Questions: Call **1-800-XXX-XXXX** or visit us at **www.insurancecompany.com.**
If you aren't clear about any of the terms used in this form, see the Glossary at **www.insuranceterms.gov**.

Important Questions	Answers	Why this Matters:
Is there an overall annual limit on what the insurer pays?	No	The chart starting on page 2 describes any limits on what the insurer will pay for specific covered services, such as office visits.
Does this plan use a network of providers?	Yes. For a list of preferred providers, see www.blueshieldca.com. *Exception statement about "Other Providers".* Please be aware that preferred providers will sometimes use non-preferred specialists.	If you use an **in-network** doctor or other health care provider, this plan will pay some or all of the costs of covered services. Plans use the term **in-network**, **preferred**, or **participating** for providers in their network.
Do I need a referral to see a specialist?	No. You don't need a referral to see a specialist.	You can see the **specialist** you choose without permission from this plan.
Are there services this plan doesn't cover?	Yes.	Some of the services this plan doesn't cover are listed in the "Excluded Services & Other Covered Services" section.

- **Co-payments** are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.
- **Co-insurance** is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. You pay this plus any deductible amounts you owe under this health insurance plan. For example, if the health plan's allowed amount for an overnight hospital stay is $1,000 and you've met your deductible, your co-insurance payment of 20% would be $200. If you haven't met any of the deductible and it's at least $1,000, you would pay the full cost of the hospital stay.
- The plan's payment for covered services is based on the **allowed amount**. If an **out-of-network provider** charges more than the allowed amount, you may have to pay the difference. For example, if an out-of-network hospital charges $1,500 for an overnight stay and the allowed amount is $1,000, you may have to pay the $500 difference. (This is called **balance billing**.)
- This plan may encourage you to use Level I HMO Plan or Level II Preferred **providers** by charging you lower deductibles, co-payments and co-insurance amounts.

Common Medical Event	Services You May Need	Your cost if you use a Preferred Providers	Your cost if you use a Non-Preferred Providers	Limitations & Exceptions
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$0 while First Dollar Service amounts are available; 100% co-insurance thereafter until calendar year out-of-pocket limit is reached; Thereafter, $0 up to allowable amount		This plan has $750 individual or $1,500 family First Dollar Services that 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.
	Specialist visit			
	Other practitioner office visit	$0 while First Dollar Service amounts are available; Not covered thereafter for chiropractors		
	Preventive care/screening/immunization	$0	$0	---none---
If you have a test	Diagnostic test (x-ray, blood work)	$0 while First Dollar Service amounts are available; 100% co-insurance thereafter until calendar year out-of-pocket limit is reached; Thereafter, $0 up to allowable amount		This plan has $750 individual or $1,500 family First Dollar Services that 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.
	Imaging (CT/PET scans, MRIs)			

Questions: Call 1-800-XXX-XXXX or visit us at www.insurancecompany.com.
If you aren't clear about any of the terms used in this form, see the Glossary at www.insuranceterms.gov.

Common Medical Event	Services You May Need	Your cost if you use a		Limitations & Exceptions
		Preferred Providers	Non-Preferred Providers	
If you need drugs to treat your illness or condition More information about drug coverage is at www.insurancecompany.com/prescriptions.	Generic drugs	$10 co-pay (retail); $20 co-pay (mail order)	$10 co-pay + 25% coinsurance of billed amount (retail)	Covers up to a 30-day supply (retail prescriptions); up to a 90-day supply (mail order prescriptions)
	Preferred brand drugs	$20 co-pay (retail); $40 co-pay (mail order)	$20 co-pay + 25% coinsurance of billed amount (retail)	Covers up to a 30-day supply (retail prescriptions); up to a 90-day supply (mail order prescriptions) Selected formulary and non-formulary drugs require prior authorization. If generic drug equivalent is available, member pays the generic copay plus the difference in cost to Blue Shield between the generic and brand.
	Non-preferred brand drugs	$35 co-pay (retail); $70 co-pay (mail order)	$35 co-pay + 25% coinsurance of billed amount (retail)	Covers up to a 30-day supply (retail prescriptions); up to a 90-day supply (mail order prescriptions) Selected formulary and non-formulary drugs require prior authorization.
	Specialty drugs (e.g., chemotherapy)	20% co-insurance up to $100 co-pay maximum / prescription	Not covered	Specialty-drugs are covered only when dispensed by select pharmacies in the Specialty Pharmacy Network unless Medically Necessary for a covered emergency

Common Medical Event	Services You May Need	Your cost if you use a Preferred Providers	Your cost if you use a Non-Preferred Providers	Limitations & Exceptions
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	$250 co-pay/ surgery + 30% coinsurance at ambulatory surgery center; $400 co-pay/ surgery + 30% coinsurance at hospital	50% co-insurance	----------none----------
	Physician/surgeon fees	30% coinsurance	50% co-insurance	----------none----------
If you need immediate medical attention	Emergency room services	$100 co-pay/ surgery + 30% coinsurance	$100 co-pay/ surgery + 30% coinsurance	----------none----------
	Emergency medical transportation	30% coinsurance	30% coinsurance	----------none----------
	Urgent care	$0 while First Dollar Service amounts are available; 100% co-insurance thereafter until calendar year out-of-pocket limit is reached; Thereafter, $0 up to allowable amount		This plan has $750 individual or $1,500 family First Dollar Services that 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.
If you have a hospital stay	Facility fee (e.g., hospital room)	$500 co-pay/ admission + 30% coinsurance	50% co-insurance	----------none----------
	Physician/surgeon fee	30% coinsurance	50% co-insurance	----------none----------

Common Medical Event	Services You May Need	Your cost if you use a Preferred Providers	Your cost if you use a Non-Preferred Providers	Limitations & Exceptions
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	$0 while First Dollar Service amounts are available; 100% co-insurance thereafter until calendar year out-of-pocket limit is reached; Thereafter, $0 up to allowable amount		This plan has $750 individual or $1,500 family First Dollar Services that 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.
	Mental/Behavioral health inpatient services	$500 co-pay/ admission + 30% coinsurance	50% co-insurance	----------none----------
	Substance use disorder outpatient services	Not covered	Not covered	----------none----------
	Substance use disorder inpatient services	Not covered	Not covered	----------none----------
If you become pregnant	Prenatal and postnatal care	$0 while First Dollar Service amounts are available; 100% co-insurance thereafter until calendar year out-of-pocket limit is reached; Thereafter, $0 up to allowable amount		This plan has $750 individual or $1,500 family First Dollar Services that 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.
	Delivery and all inpatient services	$500 co-pay/ admission + 30% coinsurance	50% co-insurance	----------none----------

Common Medical Event	Services You May Need	Your cost if you use a Preferred Providers	Your cost if you use a Non-Preferred Providers	Limitations & Exceptions
If you have a recovery or other special health need	Home health care	30% co-insurance	Not covered	100 visit limit / calendar year. Prior authorization required
	Rehabilitation services	$0 while First Dollar Service amounts are available; 100% co-insurance thereafter until calendar year out-of-pocket limit is reached; Thereafter, $0 up to allowable amount		This plan has $750 individual or $1,500 family First Dollar Services that 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.
	Habilitation services			
	Skilled nursing care	30% co-insurance	30% co-insurance at free-standing skilled nursing facility; 50% co-insurance at skilled nursing unit of a hospital	Requires prior-authorization; limited to 100 days per calendar year
	Durable medical equipment	$0 while First Dollar Service amounts are available; 100% co-insurance thereafter until calendar year out-of-pocket limit is reached; Thereafter, $0 up to allowable amount		This plan has $750 individual or $1,500 family First Dollar Services that 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.
	Hospital service	$500 co-pay/ admission + 30% coinsurance	50% co-insurance	----------none----------

Questions: Call 1-800-XXX-XXXX or visit us at **www.insurancecompany.com.**
If you aren't clear about any of the terms used in this form, see the Glossary at **www.insuranceterms.gov**.

Common Medical Event	Services You May Need	Your cost if you use a Preferred Providers	Your cost if you use a Non-Preferred Providers	Limitations & Exceptions
If your child needs dental or eye care	Eye exam	Not Covered	Not Covered	----------none----------
	Glasses	Not Covered	Not Covered	----------none----------
	Dental check-up	Not Covered	Not Covered	----------none----------

Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy for others.)

- Non-emergency care when traveling outside the U.S.
- Cosmetic surgery
- Dental care
- Eye glasses
- Long-term care
- Private-duty nursing
- Routine eye care
- Acupuncture
- Substance abuse treament
- Routine foot care
- Routine hearing test
- Weight loss programs
- Hearing aids

Other Covered Services (This isn't a complete list. Check your policy for other covered services and your costs for these services.)

- Bariatric surgery
- Infertility treatments (diagnosis and treatment of causes)

Your Rights to Continue Coverage:

You can keep this insurance as long as you pay your premium unless one or more of the following happens:

- you commit fraud
- the insurer stops offering services in the state
- you move outside the coverage area

Questions: Call 1-800-XXX-XXXX or visit us at www.insurancecompany.com.
If you aren't clear about any of the terms used in this form, see the Glossary at www.insuranceterms.gov.

Your Grievance and Appeals Rights:

- A **grievance** is a complaint you have about your health insurer or plan. You have the right to file a written complaint to express your
- dissatisfaction or denial of coverage for claims under this health insurance. Call 1-800-XXX-XXXX or visit www. Xxxxxxxxxxxxxx.com.
- An **appeal** is a request for your health insurer or plan to review a decision or a grievance again. For more information on the appeals process, call

your state office of health insurance customer assistance at: 1-800-XXX-XXXX or visit www. Xxxxxxxxxxxxxx.gov.

To see examples of how this plan might cover costs for a sample medical situation, see the next page.

ATTACHMENT D

This is not a policy. You can get the policy at www.insurancecompany.com/PLAN1500 or by calling 1-800-XXX-XXXX.
A policy has more detail about how to use the plan and what you and your insurer must do. It also has more detail about your coverage and costs.

Important Questions	Answers	Why this Matters:
What is the premium?	Please contact your employer for your share of the premium amount.	The **premium** is the amount paid for health insurance.
What is the overall deductible?	**$0** for Level I HMO plan providers **$500** for Level II preferred provider and Level III non-preferred providers per individual per calendar year **$1,000** for Level II preferred provider and Level III non-preferred providers per family per calendar year	You must pay all the costs up to the **deductible** amount before this health insurance plan begins to pay for covered services you use. Check your policy to see when the **deductible** starts over (usually, but not always, January 1st). See the chart starting on page 2 for how much you pay for covered services after you meet the **deductible**.
Are there other deductibles for specific services?	Yes; **$250** for brand name prescriptions per member per calendar year. There are no other deductibles.	You must pay all of the costs for these services up to the specific deductible amount before this plan begins to pay for these services.
Is there an out-of-pocket limit on my expenses?	Yes; **$1,500** for Level I HMO plan providers per individual per calendar year **$4,500** for Level I HMO plan providers per family per calendar year **$3,000** for Level II preferred providers per individual per calendar	The **out-of-pocket limit** is the most you could pay during a policy period for your share of the cost of covered services. This limit helps you plan for health care expenses.

Questions: Call 1-800-XXX-XXXX or visit us at www.insurancecompany.com.
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	year **$9,000** for Level II preferred providers per family per calendar year **$5,000** for Level III non-preferred providers per individual per calendar year **$15,000** for Level III non-preferred providers per family per calendar year Other limits apply – see the chart that starts on page 2.	
Important Questions	**Answers**	**Why this Matters:**
What is not included in the out-of-pocket limit?	Deductibles, premium, balance-billed charges, prescription drugs, and health care this plan does not cover.	Even though you pay these expenses, they don't count toward the **out-of-pocket limit**. So, a longer list of expenses means you have less coverage.
Is there an overall annual limit on what the insurer pays?	No	The chart starting on page 2 describes any limits on what the insurer will pay for specific covered services, such as office visits.
Does this plan use a network of providers?	Yes, this plan uses our HMO provider network for Level I benefits and preferred providers for Level II benefits. You may use health care providers that aren't preferred providers for Level III benefits, but you may pay more. For a list of HMO and preferred providers, see www.blueshieldca.com.	If you use an **in-network** doctor or other health care provider, this plan will pay some or all of the costs of covered services. Plans use the term **in-network**, **preferred**, or **participating** for providers in their network.

	Exception statement about "Other Providers". Please be aware that preferred providers will sometimes use non-preferred specialists.	
Important Questions	**Answers**	**Why this Matters:**
Do I need a referral to see a specialist?	Yes. A written referral is needed to see a specialist for Level I HMO plan benefits. An exception exists allowing for a woman to self-refer to an OB/GYN or family practice physician in her personal physician's medical group or IPA for OB/GYN services. You don't need a referral to see a specialist for Level II or Level III benefits.	This plan will pay some or all of the costs to see a specialist but only if you have the plan's permission before you see the specialist for covered services.
Are there services this plan doesn't cover?	Yes.	Some of the services this plan doesn't cover are listed in the "Excluded Services & Other Covered Services" section.

- **Co-payments** are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.
- **Co-insurance** is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. You pay this plus any deductible amounts you owe under this health insurance plan. For example, if the health plan's allowed amount for an overnight hospital stay is $1,000 and you've met your deductible, your co-insurance payment of 20% would be $200. If you haven't met any of the deductible and it's at least $1,000, you would pay the full cost of the hospital stay.
- The plan's payment for covered services is based on the **allowed amount**. If an **out-of-network provider** charges more than the allowed amount, you may have to pay the difference. For example, if an out-of-network hospital charges $1,500 for an overnight stay and the allowed amount is $1,000, you may have to pay the $500 difference. (This is called **balance billing**.)
- This plan may encourage you to use Level I HMO Plan or Level II Preferred **providers** by charging you lower deductibles, co-payments and co-insurance amounts.

Common Medical Event	Services You May Need	Your cost if you use a			Limitations & Exceptions
		Level I: HMO Plan Providers	Level II: Preferred Providers	Level III: Non-Preferred Providers	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$10 co-pay /visit	20% coinsurance	40% coinsurance	----------none----------
	Specialist visit	$10 co-pay /visit	20% coinsurance	40% coinsurance	----------none----------
	Other practitioner office visit	$10 co-pay /visit for chiropractor	20% coinsurance for chiropractor	40% coinsurance for chiropractor	LEVEL II and III BENEFITS: Limit to 12 visits for outpatient Physical Therapy and Chiropractic Services per Member per calendar year.
	Preventive care/screening/immunization	$0	Not Covered	Not Covered	----------none----------
If you have a test	Diagnostic test (x-ray, blood work)	$0	20% coinsurance	40% coinsurance	----------none----------
	Imaging (CT/PET scans, MRIs)	$0	20% coinsurance	40% coinsurance	----------none----------

Questions: Call **1-800-XXX-XXXX** or visit us at **www.insurancecompany.com.**
If you aren't clear about any of the terms used in this form, see the Glossary at **www.insuranceterms.gov**.

Common Medical Event	Services You May Need	Your cost if you use a			Limitations & Exceptions
		Level I: HMO Plan Providers	Level II: Preferred Providers	Level III: Non-Preferred Providers	
If you need drugs to treat your illness or condition More information about drug coverage is at www.insurancecompany.com/prescriptions.	Generic drugs	$10 co-pay (retail); $20 co-pay (mail order)		Not covered	Covers up to a 30-day supply (retail prescriptions); up to a 90-day supply (mail order prescriptions)
	Preferred brand drugs	$20 co-pay (retail); $40 co-pay (mail order)		Not covered	Covers up to a 30-day supply (retail prescriptions); up to a 90-day supply (mail order prescriptions) Selected formulary and non-formulary drugs require prior authorization. If generic drug equivalent is available, member pays the generic copay plus the difference in cost to Blue Shield between the generic and brand.
	Non-preferred brand drugs	$35 co-pay (retail); $70 co-pay (mail order)		Not covered	Covers up to a 30-day supply (retail prescriptions); up to a 90-day supply (mail order prescriptions) Selected formulary and non-formulary drugs require prior authorization.
	Specialty drugs (e.g., chemotherapy)	20% co-insurance up to $100 co-pay maximum / prescription		Not covered	Specialty-drugs are covered only when dispensed by select pharmacies in the Specialty Pharmacy Network unless Medically

				Necessary for a covered emergency
Common Medical Event	**Services You May Need**	**Your cost if you use a**		**Limitations & Exceptions**
		Level I: HMO Plan Providers	**Level II: Preferred Providers**	**Level III: Non-Preferred Providers**
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	$100 co-pay/ surgery at ambulatory surgery center; $150 co-pay/ surgery at hospital	20% co-insurance	40% co-insurance	----------none----------
	Physician/surgeon fees	$0	20% co-insurance	40% co-insurance	----------none----------
If you need immediate medical attention	Emergency room services	$100 co-pay/ visit	$100 co-pay/ visit	$100 co-pay/ visit	----------none----------
	Emergency medical transportation	$100 co-pay	20% co-insurance	20% co-insurance	----------none----------
	Urgent care	$10 co-pay/ visit	20% co-insurance	40% co-insurance	Not covered for Level I HMO benefits if care is not provided by or referred by your personal physician
If you have a hospital stay	Facility fee (e.g., hospital room)	$200 co-pay/ admission	20% co-insurance	40% co-insurance	----------none----------
	Physician/surgeon fee	$0	20% co-insurance	40% co-insurance	----------none----------
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	$10 co-pay/ visit	N/A	40% co-insurance	Level I Benefits accessed through MHSA Participating Providers
	Mental/Behavioral health inpatient services	$200 co-pay/ admission	20% co-insurance	40% co-insurance	----------none----------
	Substance use disorder outpatient services	Not Covered	Not Covered	Not Covered	----------none----------

Common Medical Event	Services You May Need	Your cost if you use a Level I: HMO Plan Providers	Level II: Preferred Providers	Level III: Non-Preferred Providers	Limitations & Exceptions
	Substance use disorder inpatient services	Not Covered	Not Covered	Not Covered	----------none----------
If you become pregnant	Prenatal and postnatal care	$0	20% co-insurance	40% co-insurance	----------none----------
	Delivery and all inpatient services	$200 co-pay/ admission	20% co-insurance	40% co-insurance	----------none----------
If you have a recovery or other special health need	Home health care	$10 co-pay/ visit	20% co-insurance	20% co-insurance	Level III benefits require prior-authorization
	Rehabilitation services	$10 co-pay /visit	20% coinsurance	40% coinsurance	LEVEL II and III BENEFITS: Limit to 12 visits for outpatient Physical Therapy and Chiropractic Services per Member per calendar year.
	Habilitation services	<<don't know what this is??>>			
	Skilled nursing care	$0	20% co-insurance	20% co-insurance at free-standing skilled nursing facility; 40% co-insurance at skilled nursing unit of a hospital	Requires prior-authorization; limited to 100 days per calendar year
	Durable medical equipment	50% coinsurance	50% coinsurance	50% coinsurance	Level II & III benefits require prior-authorization
	Hospital service	$200 co-pay/	20% co-	40% co-	----------none----------

Common Medical Event	Services You May Need	admission	insurance	insurance	Limitations & Exceptions
		Your cost if you use a			
		Level I: HMO Plan Providers	Level II: Preferred Providers	Level III: Non-Preferred Providers	
If your child needs dental or eye care	Eye exam	Not Covered	Not Covered	Not Covered	----------none----------
	Glasses	Not Covered	Not Covered	Not Covered	----------none----------
	Dental check-up	Not Covered	Not Covered	Not Covered	----------none----------

Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy for others.)

- Non-emergency care when traveling outside the U.S.
- Cosmetic surgery
- Dental care
- Eye glasses
- Long-term care
- Private-duty nursing
- Routine eye care
- Acupuncture
- Substance abuse treament
- Routine foot care
- Routine hearing test
- Weight loss programs
- Hearing aids

Other Covered Services (This isn't a complete list. Check your policy for other covered services and your costs for these services.)

- Bariatric surgery
- Infertility treatments (diagnosis and treatment of causes)

Your Rights to Continue Coverage:

You can keep this insurance as long as you pay your premium unless one or more of the following happens:

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- An **appeal** is a request for your health insurer or plan to review a decision or a grievance again. For more information on the appeals process, call

your state office of health insurance customer assistance at: **1-800-XXX-XXXX** or visit **www. Xxxxxxxxxxxxxx.gov.**

To see examples of how this plan might cover costs for a sample medical situation, see the next page.

Questions: Call **1-800-XXX-XXXX** or visit us at **www.insurancecompany.com.**
If you aren't clear about any of the terms used in this form, see the Glossary at **www.insuranceterms.gov.**

ATTACHMENT E

LOCAL ACCESS+ HMO RATING REGION DEFINITIONS
Effective July 2011

Rating Region	County
I	Kern except zip codes: 93205-93206, 93220, 93222, 93224-93226, 93238, 93240, 93243, 93249, 93251-93252, 93255, 93268, 93283, 93285, 93287, 93501-93502, 93504-93505, 93516, 93518-93519, 93524, 93560, 93596. San Luis Obispo, Yolo.
II	Sacramento except zip codes: 95632, 95638-95639, 95641, 95671, 95680, 95683, 95690, 95693, 95798-95799. Santa Clara.
III	Santa Cruz.
IV	San Mateo except zip codes: 94018-94021, 94028, 94037-94038, 94060, 94074, 94303.
V	San Bernardino except zip codes: 91759, 92252, 92256, 92267-92268, 92277-92278, 92284-92286, 92304-92305, 92309-92310, 92314-92315, 92317, 92321-92323, 92325-92327, 92332-92333, 92338, 92341-92342, 92347, 92352, 92356, 92358, 92364-92366, 92368, 92372, 92378, 92382, 92385-92386, 92391, 92395, 92397-92398, 92407, 93523, 93558, 93562, 93592.
VI	Los Angeles zip codes: 90247-90251, 90260-90261, 90274-90275, 90501-90510, 90601-90610, 90637-90640, 90650-90652, 90660-90662, 90670-90671, 90701-90703, 90706-90707, 90710-90717, 90723, 90731-90734, 90744-90749, 90755, 90801-90810, 90813-90815, 90822, 90831-90835, 90840, 90842, 90844, 90846-90848, 90853, 90895, 90899, 91001, 91003, 91006-91012, 91016-91017, 91020-91021, 91023-91025, 91030-91031, 91040-91043, 91046, 91066, 91077, 91101-91110, 91114-91118, 91121, 91123-91126, 91129, 91182, 91184-91185, 91188-91189, 91199, 91201-91210, 91214, 91221-91222, 91224-91226, 91501-91508, 91510, 91521-91523, 91526, 91702, 91706, 91711, 91714-91716, 91722-91724, 91731-91735, 91740-91741, 91744-91750, 91754-91756, 91765-91773, 91775-91776, 91778, 91780, 91788-91793, 91795, 91797, 91801-91804, 91896, 91899, 93563.
VII	San Diego except zip codes: 91905-91906, 91934, 91963, 91980, 91987, 92004, 92036, 92066, 92086.
VIII	Orange except zip codes: 92603, 92607, 92609-92610, 92618-92619, 92624, 92629-92630, 92637, 92651-92654, 92656-92657, 92662, 92672-92679, 92688, 92690-92694, 92698. Ventura except zip codes: 91307, 91358-91362, 91377, 93020-93021, 93040, 93042, 93062-93065, 93094, 93099.
IX	Los Angeles except the zip codes in Rating Region VI and except the zip codes: 90263-90265, 90290, 90704, 91301-91302, 91307, 91361, 91372, 91376, 93510, 93532, 93534-93536, 93539, 93543-93544, 93550-93553, 93584, 93586, 93590-93591, 93599. Riverside except the zip codes: 92225-92226, 92239, 92247-92248, 92275, 92530-92532, 92536, 92539, 92543-92546, 92548, 92562-92564, 92567, 92581-92587, 92589-92593, 92595-92596.

Region VII
Risk Adjustment Factor 0.90

Age	Employee	Empl and Spouse or Dmstc Prtnr	Empl and Dependent	Empl and Family
Access+ HMO® Plan 40*				
0 to 29	251	610	595	922
30 to 39	292	643	639	1008
40 to 49	351	797	656	1086
50 to 54	449	928	699	1250
55 to 59	585	1230	825	1427
60 to 64	759	1448	1001	1719
65+	1007	2002	1286	2339
65+**	567	1562	846	1899
Access+ HMO® Plan 25*				
0 to 29	276	663	649	1004
30 to 39	319	701	699	1093
40 to 49	383	863	711	1180
50 to 54	490	1007	758	1355
55 to 59	635	1336	899	1547
60 to 64	823	1572	1089	1866
65+	1093	2172	1395	2542
65+**	615	1694	918	2064
Access+ HMO® Plan 30*				
0 to 29	290	693	677	1052
30 to 39	333	734	729	1140
40 to 49	402	904	742	1230
50 to 54	510	1053	792	1418
55 to 59	664	1393	937	1616
60 to 64	861	1641	1135	1947
65+	1140	2268	1453	2654
65+**	642	1771	955	2156
Access+ HMO® Plan 20 Value*				
0 to 29	305	734	717	1114
30 to 39	354	774	771	1209
40 to 49	425	956	787	1305
50 to 54	543	1116	837	1502
55 to 59	702	1477	993	1709
60 to 64	913	1737	1204	2064
65+	1209	2403	1542	2810
65+**	679	1872	1012	2280

Age	Employee	Empl and Spouse or Dmstc Prtnr	Empl and Dependent	Empl and Family
Access+ HMO® Plan 20*				
0 to 29	303	738	722	1120
30 to 39	356	783	778	1217
40 to 49	424	963	795	1314
50 to 54	542	1121	844	1514
55 to 59	707	1488	1003	1720
60 to 64	918	1754	1210	2079
65+	1217	2425	1551	2828
65+**	684	1892	1018	2295
Access+ HMO® Plan 15*				
0 to 29	333	797	785	1215
30 to 39	386	849	846	1321
40 to 49	462	1046	859	1424
50 to 54	592	1217	917	1639
55 to 59	765	1613	1086	1871
60 to 64	996	1902	1315	2256
65+	1320	2628	1684	3067
65+**	745	2052	1109	2492
Access+ HMO® Plan 10*				
0 to 29	345	830	815	1262
30 to 39	400	882	877	1375
40 to 49	483	1090	900	1486
50 to 54	616	1268	954	1710
55 to 59	800	1679	1133	1945
60 to 64	1037	1980	1370	2345
65+	1375	2733	1755	3193
65+**	771	2129	1151	2589
Access+ HMO® Plan 5*				
0 to 29	401	955	937	1449
30 to 39	461	1010	1006	1576
40 to 49	550	1247	1029	1707
50 to 54	706	1452	1092	1959
55 to 59	917	1929	1301	2232
60 to 64	1192	2274	1573	2699
65+	1576	3141	2014	3666
65+**	888	2452	1325	2978

*The employer must be located and all enrolled employees and family members must live or work in an approved Blue Shield of California HMO/POS service area in order to be eligible to purchase HMO/POS health plans.

**These rates apply when Medicare is the primary payer. Contact your local sales representative for more information.

Regions may vary by product. The "Small Group Rating Region Definitions" chart located near the front of this booklet identifies the counties located in each region.

Region VII
Risk Adjustment Factor 0.90

Age	Employee	Empl and Spouse or Dmstc Prtnr	Empl and Dependent	Empl and Family
Local Access+ HMO® Plan 40*				
0 to 29	235	573	559	867
30 to 39	275	604	601	947
40 to 49	330	749	616	1021
50 to 54	422	873	657	1175
55 to 59	550	1156	775	1341
60 to 64	713	1361	941	1616
65+	946	1882	1208	2198
65+**	532	1468	794	1784
Local Access+ HMO® Plan 25*				
0 to 29	260	623	610	945
30 to 39	300	659	657	1027
40 to 49	360	810	668	1109
50 to 54	461	946	712	1273
55 to 59	596	1256	846	1454
60 to 64	774	1477	1023	1755
65+	1027	2041	1312	2390
65+**	577	1591	862	1940
Local Access+ HMO® Plan 30*				
0 to 29	273	651	637	989
30 to 39	313	690	685	1071
40 to 49	378	850	698	1156
50 to 54	479	990	744	1333
55 to 59	624	1309	882	1519
60 to 64	810	1543	1067	1830
65+	1071	2133	1366	2494
65+**	603	1665	898	2026
Local Access+ HMO® Plan 20 Value*				
0 to 29	287	690	674	1046
30 to 39	333	728	724	1136
40 to 49	400	899	739	1226
50 to 54	511	1049	787	1411
55 to 59	659	1389	934	1606
60 to 64	858	1633	1131	1941
65+	1136	2259	1449	2642
65+**	639	1762	953	2145

Age	Employee	Empl and Spouse or Dmstc Prtnr	Empl and Dependent	Empl and Family
Local Access+ HMO® Plan 20*				
0 to 29	285	693	679	1053
30 to 39	334	737	731	1144
40 to 49	399	906	747	1235
50 to 54	510	1053	793	1423
55 to 59	665	1399	943	1617
60 to 64	864	1648	1137	1954
65+	1144	2279	1458	2658
65+**	643	1778	957	2157
Local Access+ HMO® Plan 15*				
0 to 29	313	749	738	1142
30 to 39	362	798	795	1242
40 to 49	434	983	808	1339
50 to 54	557	1144	862	1541
55 to 59	720	1516	1021	1758
60 to 64	936	1788	1236	2121
65+	1241	2470	1584	2883
65+**	700	1929	1043	2342
Local Access+ HMO® Plan 10*				
0 to 29	324	781	766	1187
30 to 39	376	828	825	1292
40 to 49	454	1025	846	1397
50 to 54	579	1192	896	1607
55 to 59	752	1578	1065	1828
60 to 64	975	1862	1288	2205
65+	1292	2569	1649	3001
65+**	725	2002	1082	2434
Local Access+ HMO® Plan 5*				
0 to 29	377	898	882	1362
30 to 39	433	950	945	1482
40 to 49	517	1172	967	1604
50 to 54	664	1365	1026	1841
55 to 59	862	1813	1223	2098
60 to 64	1121	2137	1478	2537
65+	1482	2952	1893	3447
65+**	835	2305	1246	2799

*Local Access+ HMO plans can only be offered to employers and their employees who reside or work in a Local Access+ HMO service area. Local Access+ HMO products are only available in designated counties: portions of Orange, Los Angeles, San Diego, San Bernardino, Riverside, San Mateo, Sacramento, Kern, and Ventura counties, as well as in all of San Luis Obispo, Santa Clara, Santa Cruz, and Yolo counties. Please review the Benefit Summary Guide for detailed information regarding the Local Access+ HMO service area. Local Access+ HMO products are offered as standalone, Dual Choice, as part of our Suite Deal package and with PlanSelect. Local Access+ HMO plans may not be offered alongside any Blue Shield full network HMO or POS product (except Access Baja HMO).

**These rates apply when Medicare is the primary payer. Contact your local sales representative for more information.

Regions may vary by product. The "Small Group Rating Region Definitions" chart located near the front of this booklet identifies the counties located in each region.

Region VII
Risk Adjustment Factor 0.90

Age	Employee	Empl and Spouse or Dmstc Prtnr	Empl and Dependent	Empl and Family
Added Advantage POS(SM) Plan*				
0 to 29	367	883	862	1338
30 to 39	425	932	927	1455
40 to 49	510	1154	948	1575
50 to 54	654	1340	1010	1808
55 to 59	846	1780	1198	2061
60 to 64	1098	2099	1449	2488
65+	1454	2897	1857	3385
65+**	816	2259	1219	2747

*The employer must be located and all enrolled employees and family members must live or work in an approved Blue Shield of California HMO/POS service area in order to be eligible to purchase HMO/POS health plans.

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Regions may vary by product. The "Small Group Rating Region Definitions" chart located near the front of this booklet identifies the counties located in each region.

Region VII
Risk Adjustment Factor 0.90

Age	Employee	Empl and Spouse or Dmstc Prtnr	Empl and Dependent	Empl and Family
Base PPO 50*				
0 to 29	138	376	316	486
30 to 39	170	415	351	563
40 to 49	234	478	360	612
50 to 54	312	642	428	725
55 to 59	386	800	504	888
60 to 64	502	1003	619	1115
65+	619	1380	739	1450
65+**	298	1060	419	1130
Base PPO 40*				
0 to 29	155	421	354	545
30 to 39	189	465	394	630
40 to 49	261	536	403	685
50 to 54	348	719	479	810
55 to 59	432	895	563	993
60 to 64	562	1124	693	1248
65+	693	1545	828	1624
65+**	334	1186	469	1265
Base PPO 30*				
0 to 29	177	480	405	622
30 to 39	217	531	450	720
40 to 49	298	612	459	783
50 to 54	398	821	548	927
55 to 59	493	1023	643	1135
60 to 64	642	1284	792	1426
65+	792	1765	945	1854
65+**	382	1355	535	1444
Shield Spectrum PPO(SM) Plan 2000 Value*				
0 to 29	118	320	268	415
30 to 39	143	351	297	478
40 to 49	198	409	306	522
50 to 54	265	545	365	615
55 to 59	329	677	428	754
60 to 64	426	853	527	951
65+	528	1172	628	1233
65+**	252	896	351	957

Age	Employee	Empl and Spouse or Dmstc Prtnr	Empl and Dependent	Empl and Family
Shield Spectrum PPO(SM) Plan 1500 Value*				
0 to 29	152	414	344	533
30 to 39	182	454	384	617
40 to 49	256	527	395	674
50 to 54	342	704	470	795
55 to 59	423	876	551	973
60 to 64	549	1101	679	1224
65+	683	1514	808	1592
65+**	325	1157	450	1234
Shield Spectrum PPO(SM) Plan 1000 Value*				
0 to 29	189	518	429	668
30 to 39	228	569	479	771
40 to 49	323	657	492	839
50 to 54	429	881	590	996
55 to 59	529	1097	687	1216
60 to 64	690	1375	851	1529
65+	849	1894	1015	1988
65+**	407	1452	573	1546
Shield Spectrum PPO(SM) Plan 3000* [1]				
0 to 29	209	567	468	731
30 to 39	248	624	524	842
40 to 49	353	716	540	919
50 to 54	466	963	645	1088
55 to 59	579	1201	751	1332
60 to 64	756	1504	929	1673
65+	927	2070	1107	2171
65+**	445	1587	625	1689
Shield Spectrum PPO(SM) Plan 750 Value*				
0 to 29	210	576	477	741
30 to 39	253	630	533	856
40 to 49	357	729	549	936
50 to 54	472	979	654	1103
55 to 59	587	1218	761	1351
60 to 64	762	1524	945	1698
65+	945	2099	1125	2204
65+**	451	1606	631	1710

*Underwritten by Blue Shield of California Life & Health Insurance Company. The following plans are pending regulatory approval: Base PPO 50, PPO 40, PPO 30; Shield Spectrum PPO Plan 2000 Value, Plan 1500 Value, Plan 1000 Value, Plan 750 Value; Shield Savings 2000/4000, Shield Savings 1800/3600.

**These rates apply when Medicare is the primary payer. Contact your local sales representative for more information.

[1]The Shield Savings(SM) 2250/4500, Shield Savings(SM) 1800/3600 (both HSA-compatible) and the Shield Spectrum PPO Plan 3000 are the only Blue Shield plans, offered by either Blue Shield of California or Blue Shield of California Life & Health Insurance Company, that may be used with any form of an employer-sponsored wrap plan. Underwriting criteria prohibits pairing its other health plans with a wrap plan at any time, with the exception of a Health Savings Account (HSA) or employee-funded general purpose Flexible Spending Account (FSA).

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