Active Choice® Plan 750

Benefit Summary (For groups of 51 and above)

Blue Shield of California
Life & Health Insurance Company

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

Highlights: $750 individual /
$1,500 family first dollar services amount

Effective January 1, 2012

The Active Choice Plan has three categories of benefit coverage.

Category One: Preventive Health Care, Outpatient Professional and Diagnostic

Category Two: Outpatient & Inpatient Surgery

Category Three: Outpatient Prescription Drugs

Benefits	Member Responsibility	
	Preferred Providers[1]	**Non-Preferred Providers[1]**
• Calendar Year Medical Deductible	$0 per Individual / $0 per Family	
• Calendar Year Copayment Maximum (For many covered services)	$3,000 per individual / $6,000 per family	$10,000 per individual / $20,000 per family
LIFETIME BENEFIT MAXIMUM	None	

Covered Services	First Dollar Services & Member Responsibility	
Category One: Outpatient Professional And Diagnostic[2]		
	Preferred Providers[1]	**Non-Preferred Providers[1]**
PREVENTIVE HEALTH SERVICES As recommended by the United States Preventive Services Task Force. (Preventive health services benefits are paid at 100% of the allowable amount and not subject to the first dollar services credit)		
• Preventive Health Services (see the description of Preventive Health Services in the definitions section of the Certificate of Insurance for more information)	No Charge	No Charge
PROFESSIONAL SERVICES		
Professional (Physician) Benefits • Physician and specialist office visits • Outpatient X-ray, pathology and laboratory • Diagnostic testing **Allergy Testing and Treatment Benefits** • Office visits (includes visits for allergy serum injections) **DURABLE MEDICAL EQUIPMENT** • Durable Medical Equipment **PROSTHETICS/ORTHOTICS** • Prosthetic equipment and devices • Orthotic equipment and devices **MENTAL HEALTH SERVICES (PSYCHIATRIC)[3]** • Outpatient Mental Health Services	The $750 individual or $1,500 family First Dollar Services covers any combination of covered outpatient professional and diagnostic services and supplies. Each insured family member has access to the entire amount of the family First Dollar Services. These services are paid at 100 percent of the allowable amount.[1] The member is responsible for all charges above the $750 individual or $1,500 family First Dollar Services amount until the member's maximum calendar year copayment amount has been reached.[2] Once the member's maximum calendar year copayment has been reached, many benefits will be paid at 100 percent of the allowable amount. The member's responsibility for charges over the allowable amount does not accrue to the calendar year copayment maximum. Outpatient chiropractic services are only covered under the $750 individual/ $1,500 family First Dollar Services amount. After the First Dollar Services limit is reached, these services are no longer covered until the next calendar year.	
OTHER **Chiropractic Benefits** • Chiropractic Services - provided by a chiropractor **Rehabilitation Benefits (Physical, Occupational and Respiratory Therapy)** • Office location **Speech Therapy Benefits** • Office location		

Pregnancy and Maternity Care Benefits

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

Family Planning Benefits

- Counseling and consulting
- Elective abortion[4]
- Tubal ligation[4]
- Vasectomy[4]

Diabetes Care Benefits

- Devices, equipment, and non-testing supplies
  (For testing supplies, see "Outpatient Prescription Drug Coverage Summary")
- Diabetes self-management training (If billed by your provider, you will also be responsible for the office visit copayment)

Covered Services	Member Coinsurance	
Category Two: Outpatient & Inpatient Surgery – including emergency care services		
OUTPATIENT SERVICES	**Preferred Providers[1]**	**Non-Preferred Providers[1]**
Hospital Benefits (Facility Services) The maximum allowed charges for non-emergency surgery and services performed in a non-participating Ambulatory Surgery Center or outpatient unit of a non-preferred hospital is $350 per day. Members are responsible for 40% of this $350 per day, plus all charges in excess of $350.		
• Outpatient surgery performed at an Ambulatory Surgery Center[5]	$250 per surgery + 20%	40%
• Outpatient surgery in a hospital	$400 per surgery + 20%	40%
• Outpatient Services for treatment of illness or injury and necessary supplies	20%	40%
• Bariatric Surgery (pre-authorization required; medically necessary surgery for weight loss, only for morbid obesity)[6]	$400 per surgery + 20%	40%
HOSPITALIZATION SERVICES		
Hospital Benefits (Facility Services)		
• Inpatient Physician Services , associated with inpatient or outpatient surgery and procedures (Including pregnancy and maternity care and services for medical acute detoxification)	20%	40%
• Inpatient Non-emergency Facility Services (Semi-private room and board, medically necessary services and supplies)	$500 per admission + 20%	40%[7]
• Bariatric Surgery (pre-authorization required; medically necessary surgery for weight loss, only for morbid obesity)[6]	$500 per admission + 20%	40%[7]
Skilled Nursing Facility Benefits[8] (Combined maximum of up to 100 preauthorized days per calendar year; semi-private accommodations)		
• Services by a free-standing Skilled Nursing Facility	20%	20%[8]
• Skilled Nursing Unit of a Hospital	20%	40%[7]
EMERGENCY HEALTH COVERAGE		
• Emergency room Services not resulting in admission (If ER services do not result in a direct admission the Calendar-Year Deductible does not apply)	$100 per visit + 20%	$100 per visit + 20%
• Emergency room Services resulting in admission (When the member is admitted directly from the ER)	$500 per admission + 20%	$500 per admission + 20%
• Emergency room Physician Services	20%	20%
AMBULANCE SERVICES		
• Emergency or authorized transport	20%	20%
MENTAL HEALTH SERVICES (PSYCHIATRIC)[3]	**MHSA Participating Providers[1]**	**MHSA Non-Participating Providers[1]**
• Inpatient Hospital Services	$500 per admission + 20%	40%[7]
CHEMICAL DEPENDENCY SERVICES (SUBSTANCE ABUSE)[9], Please see footnote 11		
• Chemical dependency and substance abuse services	Not Covered	Not Covered
HOME HEALTH SERVICES[10]	**Preferred Providers[1]**	**Non-Preferred Providers[1]**

• Home health care agency Services (Maximum of 100 prior authorized visits per Calendar Year)	20%	Not Covered[10]
• Home infusion/home intravenous injectable therapy and infusion nursing visits provided by a Home Infusion Agency (See "Prescription Drug Coverage" for specialty drugs)	20%	Not Covered[10]
Hospice Program Benefits[10]		
• Routine home care	No Charge	Not Covered[10]
• Inpatient Respite Care	No Charge	Not Covered[10]
• 24-hour Continuous Home Care	20%	Not Covered[10]
• General Inpatient care	20%	Not Covered[10]
Care Outside of Plan Service Area		
• Within US: BlueCard Program	See Applicable Benefit	See Applicable Benefit
• Outside of US: BlueCard Worldwide	See Applicable Benefit	See Applicable Benefit

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

Optional Benefits Optional dental, vision, substance abuse treatment, infertility and hearing aid benefits are available. If your employer purchased any of these benefits, a description of the benefit is provided separately.

Covered Services	Member Coinsurance
Category Three: Outpatient Prescription Drugs	
PRESCRIPTION DRUG COVERAGE	A description of your outpatient prescription drug coverage is provided separately. If you do not have the separate drug summary that goes with this benefit summary, please contact your benefits administrator or call Customer Service at 800-200-3242.

1 Member is responsible for coinsurance or copayments in addition to any charges above the allowable amounts. Preferred providers accept Blue Shield of California Life & Health Insurance Company's (Blue Shield Life's) Allowable Amount as full payment for covered services. Non-preferred providers can charge more than these amounts. When members use Non-Preferred Providers, they must pay the applicable Coinsurance or Copayment plus any amount that exceeds Blue Shield Life's allowable amount. Charges above the allowable amount do not count toward the calendar year copayment maximum or First Dollar Services amounts. Mental health services are accessed through the Mental Health Service Administrator (MHSA) utilizing MHSA participating and MHSA non-participating providers. MHSA non-participating providers are not administered by the MHSA.

2 Copayments marked with a "1" do not accrue to the calendar-year copayment maximum and continue to be charged after they are reached. Coinsurance or copayments for services not accruing to the member's calendar-year copayment maximum and continue to be the member's responsibility after the calendar-year copayment maximum is reached. After the First Dollar Services amount is reached, covered First Dollar Services will accrue to the calendar-year copayment maximum.

3 Mental health services are accessed through the MHSA. For a listing of Severe Mental Illnesses, including Serious Emotional Disturbances of a Child, and other benefit details, please refer to the Certificate of Insurance or Group Policy.

4 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.

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

6 Bariatric surgery is covered when pre-authorized by Blue Shield. However, for members residing in Imperial, Kern, Los Angeles, Orange, Riverside, San Bernardino, San Diego, Santa Barbara and Ventura Counties ("Designated Counties"), bariatric surgery services are covered only when performed at designated contracting bariatric surgery facilities and by designated contracting surgeons; coverage is not available for bariatric services from any other preferred provider and there is no coverage for bariatric services from non-preferred Providers. In addition, if prior authorized by Blue Shield Life and Health, a member in a Designated County who is required to travel more than 50 miles to a designated bariatric surgery facility will be eligible for limited reimbursement for specified travel expenses for the member and one companion. Refer to the Certificate of Insurance for further benefit details.

7 The maximum allowed charges for non-emergency hospital services received from a Non-Preferred Hospital are $600 per day. Members are responsible for 40% of this $600 per day, plus all charges in excess of $600.

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

9 Inpatient services for acute detoxification are covered under the medical benefit; see hospitalization services for benefit details. Services for medical acute detoxification are accessed through Blue Shield Life using Blue Shield Life's preferred providers or non-preferred providers.

10 Out of network home health care, home infusion and hospice services are not covered unless pre-authorized. When these services are pre-authorized, the member pays the Preferred Provider Copayment.

11 **Optional 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."**

Plan designs may be modified to ensure compliance with state and federal requirements.
A16286 (1/12)