Blue Shield Medicare Supplement plans

Summary of benefits and provisions

Benefit Plans A, B, C, D, F, and K

Effective April 1, 2007

Download Application Click Here or Call 818-654-4548

Blue Shield of California Medicare Supplement plans

Please take a few minutes to review the information in this booklet.

Medicare Supplement coverage 5
Comparison chart of the 12 standard Medicare Supplement plans 6
Plan dues 7
Information about plan dues 14
Disclosures 14
Charts comparing Blue Shield's six Medicare Supplement plans
- Plan A 16
- Plan B 19
- Plan C 22
- Plan D 25
- Plan F 28
- Plan K 31

How the plans work – the rewards of choosing Blue Shield 34
Applying for coverage....46
Principal exclusions and limitations on benefits 50
Affordable dental plans for Medicare Supplement members 52
Important phone numbers....Back Cover

Applying for coverage is easy!

1. Fill out the enclosed application.

Refer to "Applying for coverage" on page 46 for application guidelines.

If you have any questions about enrolling, please contact your agent call
(818) 654-4548

2. Return the completed and signed application.

Be sure to check the information on the application carefully, keep the yellow copy of each page of the application for your files, and then mail the original application in the enclosed envelope. Please include the first payment with your application.

Cashing of your check or charging your credit card does not mean your application is approved. Blue Shield will refund your payment if your application is not approved. We will notify you of your effective date of coverage if your application is approved.

Medicare Supplement coverage

One of our Medicare Supplement plans is likely to be the right plan for you – and it's from the right company. After all, we've been in the healthcare business for more than 65 years. Blue Shield's Medicare Supplement plans offer you the freedom to choose any doctor, specialist, hospital, or other provider that accepts Medicare. In other words, *you're not limited to a network!*

Medicare Supplement coverage can only be sold in 12 standard plans plus two high-deductible plans. This chart compares the benefits included in each plan. Every company that offers Medicare Supplement plans must offer Plan A. Some plans may not be available in California.

Use the chart on the following page to compare benefits among all the Medicare Supplement plan options. Blue Shield offers Plans A, B, C, D, F, and K, shown in darker gray on the chart.

Blue Shield's Plans A, B, C, D, F, and K meet the requirements for Medicare Supplement plans established by the federal government, the state of California, and the National Association of Insurance Commissioners (NAIC).

For additional information concerning covered benefits, contact the Health Insurance Counseling and Advocacy Program (HICAP) or your agent. HICAP provides health insurance counseling for California senior citizens. Call the HICAP toll-free telephone number, (800) 434-0222, for a referral to your local HICAP office. HICAP is a service provided free of charge by the state of California.

Basic benefits included in all plans

On the chart on the following page, "Basic Benefits" includes coverage for:

Hospitalization

- Part A coinsurance plus coverage for 365 additional days after Medicare benefits end

Medical Expenses

- Part B coinsurance (generally half of Medicare-approved charges, except for Plan K which is 10 percent of Medicare-approved charges)

Blood

- First three pints of blood each year for Plans A, B, C, D, and F
- 50 percent coverage for first three pints of blood each year for Plan K

Comparison chart of the 12 standard Medicare Supplement plans

Category	Plan A	Plan B	Plan C	Plan D	Plan E	Plan F*	Plan G	Plan H	Plan I	Plan J*	Plan K	Plan L
Basic benefits	•	•	•	•	•	•	•	•	•	•	•	•
Skilled nursing coinsurance			•	•	•	•	•	•	•	•	50%	75%
Part A deductible		•	•	•	•	•	•	•	•	•	50%	75%
Part B deductible			•			•				•		
Part B excess						100%	80%		100%	100%		
Foreign travel emergency			•	•	•	•	•	•	•	•		
At-home recovery				•			•		•	•		
Preventive care					•					•		

* Plans F and J also have options called High-Deductible Plan F and High-Deductible Plan J. These high-deductible plans pay the same or offer the same benefits as Plans F and J after one has paid a calendar-year $1,860 deductible. Benefits from High-Deductible Plans F and J will not begin until out-of-pocket expenses reach $1,860. Out-of-pocket expenses for this deductible are expenses that would ordinarily be paid by the policy. These expenses include the Medicare deductibles for Part A and Part B, but do not include the plans' separate foreign travel emergency deductible. Neither of these high-deductible plans are offered by Blue Shield of California.

Note: Plans in the shaded columns are offered by Blue Shield of California.

Plan dues

Easy$Pay [1,3]

Easy$Pay[SM] is a simple, convenient way to pay your dues. Simply authorize Blue Shield to withdraw the monthly dues from your personal checking or savings account. By choosing this method, you will save $2 per month on your plan dues.

Two-party enrollment [1,3]

If you and your spouse or domestic partner are age 65 or older, apply together, and are accepted in the *same benefit plan type*, you may be able to save on your combined monthly dues if coverage is issued under one agreement[1]. Two-party rates are based on the age of the older party. For more information, please ask your Agent or Blue Shield representative for eligibility and details about our two-party enrollment feature.

Please note: If you are currently enrolled in a Medicare Supplement plan, you may transfer to a plan of equal or lesser value during an annual open-enrollment period, which begins every year on your birthday and lasts for 30 days. However, if you currently have a two-party agreement and change to a benefit plan that is different from your spouse or domestic partner, you will no longer be eligible for the two-party rate if your spouse does not change to the same plan.

Region 1

Los Angeles and Orange counties (except for ZIP codes 91711, 91759, 91765, 91766, 91767, 93535, 93544, 93563, and 93591)

Monthly plan dues – billed and to be paid in advance

Effective date 4/1/07

Single-party rates

Age range	A	B	C	D	F	K
65 to 66	$100	$ 118	$139	$123	$139	$ 64
67 to 69	104	123	145	129	145	73
70 to 74	136	161	190	168	190	89
75 to 79	177	209	247	219	248	130
80-plus	191	225	266	235	266	170
64 or younger[2]	514	607	717	635	718	236

Two-party rates[1, 3]

Age range	A	B	C	D	F
65 to 66	$ 194	$230	$272	$240	$272
67 to 69	202	240	284	252	284
70 to 74	247	297	355	311	355
75 to 79	329	393	469	413	471
80-plus	357	425	507	445	507
64 or younger[2]	N/A	N/A	N/A	N/A	N/A

Region 2

Riverside and San Bernardino counties and the following ZIP codes in Los Angeles County: 91711, 91759, 91765, 91766, 91767, 93535, 93544, 93563, and 93591

Monthly plan dues – billed and to be paid in advance

Effective date 4/1/07

Single-party rates

Age range	A	B	C	D	F	K
65 to 66	$ 96	$ 113	$134	$ 119	$134	$ 53
67 to 69	100	118	140	124	140	61
70 to 74	131	155	183	162	183	74
75 to 79	171	201	238	211	238	109
80-plus	183	216	256	226	256	142
64 or younger[2]	495	584	690	611	690	197

Two-party rates[1, 3]

Age range	A	B	C	D	F
65 to 66	$186	$220	$262	$232	$262
67 to 69	194	230	274	242	274
70 to 74	237	285	341	299	341
75 to 79	317	377	451	397	451
80-plus	341	407	487	427	487
64 or younger[2]	N/A	N/A	N/A	N/A	N/A

Region 3
San Diego County

Monthly plan dues – billed and to be paid in advance

Effective date 4/1/07

Single-party rates

Age range	A	B	C	D	F	K
65 to 66	$ 92	$108	$128	$ 113	$128	$ 52
67 to 69	96	113	133	118	134	59
70 to 74	125	148	175	155	175	72
75 to 79	163	192	227	201	227	106
80-plus	175	207	244	216	244	138
64 or younger[2]	472	557	658	583	659	192

Two-party rates[1, 3]

Age range	A	B	C	D	F
65 to 66	$178	$210	$250	$220	$250
67 to 69	186	220	260	230	262
70 to 74	225	271	325	285	325
75 to 79	301	359	429	377	429
80-plus	325	389	463	407	463
64 or younger[2]	N/A	N/A	N/A	N/A	N/A

Region 4

Ventura, Kern and Santa Barbara counties

Monthly Plan Dues – billed and to be paid in advance

Effective date 4/1/07

Single-party rates

Age range	A	B	C	D	F	K
65 to 66	$ 96	$ 113	$134	$ 119	$134	$ 56
67 to 69	100	118	140	124	140	64
70 to 74	131	155	183	162	183	78
75 to 79	171	201	238	211	238	115
80-plus	184	216	256	227	256	150
64 or younger[2]	495	584	690	611	691	208

Two-party rates[1, 3]

Age range	A	B	C	D	F
65 to 66	$186	$220	$262	$232	$262
67 to 69	194	230	274	242	274
70 to 74	237	285	341	299	341
75 to 79	317	377	451	397	451
80-plus	343	407	487	429	487
64 or younger[2]	N/A	N/A	N/A	N/A	N/A

Region 5

San Joaquin, Sonoma, and Stanislaus counties

Monthly plan dues – billed and to be paid in advance

Effective date 4/1/07

Single-party rates

Age range	A	B	C	D	F	K
65 to 66	$ 85	$100	$ 118	$105	$ 119	$ 54
67 to 69	89	105	124	110	124	62
70 to 74	116	137	162	143	162	76
75 to 79	151	178	210	186	211	111
80-plus	162	192	226	200	227	145
64 or younger[2]	438	517	610	541	611	201

Two-party rates[1, 3]

Age range	A	B	C	D	F
65 to 66	$164	$ 194	$230	$204	$232
67 to 69	172	204	242	214	242
70 to 74	207	249	299	261	299
75 to 79	277	331	395	347	397
80-plus	299	359	427	375	429
64 or younger[2]	N/A	N/A	N/A	N/A	N/A

Region 6

Counties: Alameda, Alpine, Amador, Butte, Calaveras, Colusa, Contra Costa, Del Norte, El Dorado, Fresno, Glenn, Humboldt, Imperial, Inyo, Kings, Lake, Lassen, Madera, Marin, Mariposa, Mendocino, Merced, Modoc, Mono, Monterey, Napa, Nevada, Placer, Plumas, Sacramento, San Benito, San Francisco, San Luis Obispo, San Mateo, Santa Clara, Santa Cruz, Shasta, Sierra, Siskiyou, Solano, Sutter, Tehama, Trinity, Tulare, Tuolumne, Yolo, and Yuba

Monthly Plan Dues – billed and to be paid in advance, effective date 4/1/07

Single-party rates

Age range	A	B	C	D	F	K
65 to 66	$ 85	$ 101	$ 119	$105	$ 119	$ 52
67 to 69	89	105	124	110	124	59
70 to 74	117	138	163	144	163	72
75 to 79	152	179	211	187	212	105
80-plus	163	192	227	201	228	138
64 or younger[2]	440	519	613	543	614	191

Two-party rates[1, 3]

Age range	A	B	C	D	F
65 to 66	$164	$ 196	$232	$204	$232
67 to 69	172	204	242	214	242
70 to 74	209	251	301	263	301
75 to 79	279	333	397	349	399
80-plus	301	359	429	377	431
64 or younger[2]	N/A	N/A	N/A	N/A	N/A

Value of health services

In 2006, the ratio of the value of health services provided to the amount Blue Shield collected in plan dues was 71.7 percent.

Information about plan dues

Blue Shield can only raise your plan dues if we raise the dues for all contracts like yours in California. Because plan dues are based on age, your dues will increase when you turn 67, 70, 75, and/or 80 years old (depending on your plan).

Disclosures

Use this outline to compare benefits and dues among policies.

Read your policy very carefully

This is only an outline describing the most important features of your Medicare Supplement plan contract. This is not the plan contract and only the actual contract provisions will control. You must read the contract itself to understand all of the rights and duties of both you and Blue Shield of California.

For information on whether you qualify for guaranteed acceptance into a Medicare Supplement plan (that is, whether you would be subject to underwriting), please refer to Blue Shield of California's *Guaranteed Acceptance Guide*, included in the Blue Shield of California Medicare Supplement Enrollment Kit. The Enrollment Kit contains this Summary of Benefits and Provisions, an application for enrollment, and the *Guaranteed Acceptance Guide*.

Right to return policy

If you find that you are not satisfied with your contract, you may return it to **Blue Shield of California, P.O. Box 7168, San Francisco, CA 94120.** If you send the contract back to us within 30 days after you receive it, we will treat the contract as if it had never been issued, and will return all of your payments.

Policy replacement

If you are replacing other health coverage, **DO NOT** cancel your existing health coverage until you have actually received your new contract from Blue Shield of California and are sure you want to keep it. If you are a member of a Medicare Advantage plan, your disenrollment date from the Medicare Advantage plan must be confirmed prior to final acceptance. Once your application has been accepted, Blue Shield will establish a coverage effective date for your Medicare Supplement plan.

Notice

- This contract may not fully cover all of your medical costs.
- Neither Blue Shield of California nor its agents are connected with Medicare.
- This Summary of Benefits does not give all the details of Medicare coverage. Contact your local Social Security office or consult the *Guide to Health Insurance for People with Medicare* for further details and limitations applicable to Medicare. In addition, Medicare produces a booklet titled *Medicare & You*, which you can obtain online at www.medicare.gov or by calling 1-800-MEDICARE.

Complete answers are very important

When you fill out the application for the new contract, be sure to answer truthfully and completely all questions about your medical and health history. The company may cancel your contract and refuse to pay any claims if you leave out or falsify important medical information.

Review the application carefully before you sign it. Be certain that all the information in each section has been properly recorded.

Plan A

Medicare (Part A) hospital services - per benefit period

Services	Medicare pays	Plan A pays	With Plan A you pay
Hospitalization[4] - Semi-private room and board, general nursing, subacute care, and miscellaneous services and supplies			
First 60 days	All but $992	-0-	$992 (Part A deductible)
61st through 90th day	All but $248 a day	$248 a day	-0-
91st day and after: while using 60 lifetime reserve days	All but $496 a day	$496 a day	-0-
Once lifetime reserve days are used			
• Additional 365 days	-0-	100% of Medicare eligible expenses	-0-[5]
• Beyond the additional 365 days	-0-	-0-	All costs
Skilled nursing facility/subacute care[4] – You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	-0-	-0-
21st through 100th day	All but $124 a day	-0-	Up to $124 a day
101st day and after	-0-	-0-	All costs
Blood			
First 3 pints	-0-	3 pints	-0-
Additional amounts	100%	-0-	-0-
Hospice care			
Available as long as your doctor certifies you are terminally ill and you elect to receive these services	All but very limited co-insurance for outpatient drugs and inpatient respite care	-0-	Balance

Plan A

Medicare (Part B) medical services – per calendar year

Services	Medicare pays	Plan A pays	With Plan A you pay
Medical expenses – In or out of the hospital and outpatient treatment, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment			
First $131 of Medicare-approved amounts[6]	-0-	-0-	$131 (Part B deductible)
Remainder of Medicare-approved amounts	Generally 80%	Generally 20%	-0-
Part B excess charges (above Medicare approved amounts)	-0-	-0-	All costs
Blood			
First 3 pints	-0-	100%	-0-
Next $131 of Medicare-approved amounts[6]	-0-	-0-	$131 (Part B deductible)
Remainder of Medicare-approved amounts	80%	20%	-0-
Clinical laboratory services			
Blood tests for diagnostic services	100%	-0-	-0-

Plan A

Medicare (Parts A and B) medical services – per calendar year

Services	Medicare pays	Plan A pays	With Plan A you pay
Home health care (Medicare-approved services)			
Medically necessary skilled care services and medical supplies	100%	-0-	-0-
Durable medical equipment: First $131 of Medicare-approved amounts[6]	-0-	-0-	$131 (Part B deductible)
Remainder of Medicare-approved amounts	80%	20%	-0-
At-home recovery services (not covered by Medicare) Home care certified by your doctor, for personal care during recovery from an injury or sickness for which Medicare approved a home care treatment plan			
Benefit for each visit	-0-	-0-	All costs
Number of visits covered (must be received within 8 weeks of last Medicare-approved visit)	-0-	-0-	All costs
Calendar-year maximum	-0-	-0-	All costs

Other benefits – not covered by medicare

Services	Medicare pays	Plan A pays	With Plan A you pay
Foreign travel (not covered by Medicare) Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA			
First $250 each calendar year	-0-	-0-	All costs
Remainder of charges	-0-	-0-	All costs

Plan B

Medicare (Part A) hospital services – per benefit period

Services	Medicare pays	Plan B pays	With Plan B you pay
Hospitalization[4] – Semi-private room and board, general nursing, subacute care and miscellaneous services and supplies			
First 60 days	All but $992	$992 (Part A deductible)	-0-
61st through 90th day	All but $248 a day	$248 a day	-0-
91st day and after: While using 60 lifetime reserve days	All but $496 a day	$496 a day	-0-
Once lifetime reserve days are used			
Additional 365 days	-0-	100% of Medicare eligible expenses	-0-[5]
Beyond the additional 365 days	-0-	-0-	All costs
Skilled nursing facility/subacute care[4] – You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	-0-	-0-
21st through 100th day	All but $124 a day	-0-	Up to $124 a day
101st day and after	-0-	-0-	All costs
Blood			
First 3 pints	-0-	3 pints	-0-
Additional amounts	100%	-0-	-0-
Hospice care			
Available as long as your doctor certifies you are terminally ill, and you elect to receive these services	All but very limited co-insurance for outpatient drugs and inpatient respite care	-0-	Balance

Plan B

Medicare (Part B) medical services – per calendar year

Services	Medicare pays	Plan B pays	With Plan B you pay
Medical expenses – In or out of the hospital and outpatient treatment, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment			
First $131 of Medicare approved amounts[6]	-0-	-0-	$131 (Part B deductible)
Remainder of Medicare-approved amounts	Generally 80%	Generally 20%	-0-
Part B excess charges (above-Medicare approved amounts)	-0-	-0-	All costs
Blood			
First 3 pints	-0-	100%	-0-
Next $131 of Medicare-approved amounts[6]	-0-	-0-	$131 (Part B deductible)
Remainder of Medicare-approved amounts	80%	20%	-0-
Clinical laboratory services			
Blood tests for diagnostic services	100%	-0-	-0-

Plan B

Medicare (Parts A and B) medical services – per calendar year

Services	Medicare pays	Plan B pays	With Plan B you pay
Home health care (Medicare-approved services)			
Medically necessary skilled care services and medical supplies	100%	-0-	-0-
Durable medical equipment First $131 of Medicare-approved amounts[6]	-0-	-0-	$131 (Part B deductible)
Remainder of Medicare-approved amounts	80%	20%	-0-
At-home recovery services (not covered by Medicare) Home care certified by your doctor, for personal care during recovery from an injury or sickness for which Medicare approved a home care treatment plan			
Benefit for each visit	-0-	-0-	All costs
Number of visits covered (must be received within 8 weeks of last Medicare-approved visit)	-0-	-0-	All costs
Calendar year maximum	-0-	-0-	All costs

Other benefits – not covered by Medicare

Services	Medicare pays	Plan B pays	With Plan B you pay
Foreign travel (not covered by Medicare) Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA			
First $250 each calendar year	-0-	-0-	All costs
Remainder of charges	-0-	-0-	All costs

Plan C

Medicare (Part A) hospital services – per benefit period

Services	Medicare pays	Plan C pays	With Plan C you pay
Hospitalization[4] - Semi-private room and board, general nursing, subacute care, and miscellaneous services and supplies			
First 60 days	All but $992	$992 (Part A deductible)	-0-
61st through 90th day	All but $248 a day	$248 a day	-0-
91st day and after: While using 60 lifetime reserve days	All but $496 a day	$496 a day	-0-
Once lifetime reserve days are used			
Additional 365 days	-0-	100% of Medicare eligible expenses	-0-[5]
Beyond the additional 365 days	-0-	-0-	All costs
Skilled nursing facility/subacute care[4] – You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	-0-	-0-
21st through 100th days	All but $124 a day	Up to $124 a day	-0-
101st day and after	-0-	-0-	All costs
Blood			
First 3 pints	-0-	3 pints	-0-
Additional amounts	100%	-0-	-0-
Hospice care			
Available as long as your doctor certifies you are terminally ill and you elect to receive these services	All but very limited co-insurance for outpatient drugs and inpatient respite care	-0-	Balance

Plan C

Medicare (Part B) medical services – per calendar year

Services	Medicare pays	Plan C pays	With Plan C you pay
Medical expenses – In or out of the hospital and outpatient treatment, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment			
First $131 of Medicare approved amounts [6]	-0-	$131 (Part B deductible)	-0-
Remainder of Medicare-approved amounts	Generally 80%	Generally 20%	-0-
Part B excess charges (above Medicare-approved amounts)	-0-	-0-	All costs
Blood			
First 3 pints	-0-	100%	-0-
Next $131 of Medicare-approved amounts [6]	-0-	$131 (Part B deductible)	-0-
Remainder of Medicare-approved amounts	80%	20%	-0-
Clinical laboratory services			
Blood tests for diagnostic services	100%	-0-	-0-

Plan C

Medicare (Parts A and B) medical services – per calendar year

Services	Medicare pays	Plan C pays	With Plan C you pay
Home health care (Medicare-approved services)			
Medically necessary skilled care services and medical supplies	100%	-0-	-0-
Durable medical equipment First $131 of Medicare-approved amounts[6]	-0-	$131 (Part B deductible)	-0-
Remainder of Medicare-approved amounts	80%	20%	-0-
At-home recovery services (not covered by Medicare) Home care certified by your doctor, for personal care during recovery from an injury or sickness for which Medicare approved a home care treatment plan			
Benefit for each visit	-0-	-0-	All costs
Number of visits covered (must be received within 8 weeks of last Medicare-approved visit)	-0-	-0-	All costs
Calendar-year maximum	-0-	-0-	All costs

Other benefits – not covered by Medicare

Services	Medicare pays	Plan C pays	With plan C you pay
Foreign travel (Not covered by Medicare) Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA			
First $250 each calendar year	-0-	-0-	$250
Remainder of charges	-0-	80% to a lifetime maximum benefit of $50,000	20% and amounts over the $50,000 lifetime maximum

Plan D

Medicare (Part A) hospital services – per benefit period

Services	Medicare pays	Plan D pays	With Plan D you pay
Hospitalization[4] – Semi-private room and board, general nursing, subacute care, and miscellaneous services and supplies			
First 60 days	All but $992	$992 (Part A deductible)	-0-
61st through 90th day	All but $248 a day	$248 a day	-0-
91st day and after: While using 60 lifetime reserve days	All but $496 a day	$496 a day	-0-
Once lifetime reserve days are used			
Additional 365 days	-0-	100% of Medicare-eligible expenses	-0-[5]
Beyond the additional 365 days	-0-	-0-	All costs
Skilled nursing facility/subacute care[4] – You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	-0-	-0-
21st through 100th day	All but $124 a day	Up to $124 a day	-0-
101st day and after	-0-	-0-	All costs
Blood			
First 3 pints	-0-	3 pints	-0-
Additional amounts	100%	-0-	-0-
Hospice care			
Available as long as your doctor certifies you are terminally ill and you elect to receive these services	All but very limited co-insurance for outpatient drugs and inpatient respite care	-0-	Balance

Plan D

Medicare (Part B) medical services – per calendar year

Services	Medicare pays	Plan D pays	With Plan D you pay
Medical expenses – In or out of the hospital and outpatient treatment, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment			
First $131 of Medicare-approved amounts[6]	-0-	-0-	$131 (Part B deductible)
Remainder of Medicare-approved amounts	Generally 80%	Generally 20%	-0-
Part B excess charges (above Medicare-approved amounts)	-0-	-0-	All costs
Blood			
First 3 pints	-0-	100%	-0-
Next $131 of Medicare-approved amounts[6]	-0-	-0-	$131 (Part B deductible)
Remainder of Medicare-approved amounts	80%	20%	-0-
Clinical laboratory services			
Blood tests for diagnostic services	100%	-0-	-0-

Plan D

Medicare (Parts A and B) medical services – per calendar year

Services	Medicare pays	Plan D pays	With Plan D you pay
Home health care (Medicare Approved Services)			
Medically necessary skilled care services and medical supplies	100%	-0-	-0-
Durable medical equipment First $131 of Medicare approved amounts[6]	-0-	-0-	$131 (Part B deductible)
Remainder of Medicare approved amounts	80%	20%	-0-
At-home recovery services (Not covered by Medicare) Home care certified by your doctor, for personal care during recovery from an injury or sickness for which Medicare approved a home care treatment plan			
Benefit for each visit	-0-	Actual charges to $40 a visit	Balance
Number of visits covered (must be received within 8 weeks of last Medicare approved visit)	-0-	Up to the number of Medicare approved visits, not to exceed 7 each week	Balance
Calendar year maximum	-0-	$1,600	Balance

Other benefits – not covered by Medicare

Services	Medicare pays	Plan C pays	With plan C you pay
Foreign travel (Not covered by Medicare) Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA			
First $250 each calendar year	-0-	-0-	All costs
Remainder of charges	-0-	80% to a lifetime maximum benefit of $50,000	20% and amounts over the $50,000 lifetime maximum

Plan F

Medicare (Part A) hospital services – per benefit period

Services	Medicare pays	Plan F pays	With Plan F you pay
Hospitalization[4] – Semi-private room and board, general nursing, subacute care and miscellaneous services and supplies			
First 60 days	All but $992	$992 (Part A deductible)	-0-
61st through 90th day	All but $248 a day	$248 a day	-0-
91st day and after: While using 60 lifetime reserve days	All but $496 a day	$496 a day	-0-
Once lifetime reserve days are used			
Additional 365 days	-0-	100% of Medicare eligible expenses	-0-[5]
Beyond the additional 365 days	-0-	-0-	All costs
Skilled nursing facility/subacute care[4] – You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	-0-	-0-
21st through 100th day	All but $124 a day	Up to $124 a day	-0-
101st day and after	-0-	-0-	All costs
Blood			
First 3 pints	-0-	3 pints	-0-
Additional amounts	100%	-0-	-0-
Hospice care			
Available as long as your doctor certifies you are terminally ill, and you elect to receive these services	All but very limited co-insurance for outpatient drugs and inpatient respite care	-0-	Balance

Plan F

Medicare (Part B) medical services – per calendar year

Services	Medicare pays	Plan F pays	With Plan F you pay
Medical expenses - In or out of the hospital and outpatient treatment, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment			
First $131 of Medicare approved amounts[6]	-0-	$131 (Part B deductible)	-0-
Remainder of Medicare-approved amounts	Generally 80%	Generally 20%	-0-
Part B excess charges (above Medicare-approved amounts)	-0-	100%	-0-
Blood			
First 3 pints	-0-	100%	-0-
Next $131 of Medicare-approved amounts[6]	-0-	$131 (Part B deductible)	-0-
Remainder of Medicare-approved amounts	80%	20%	-0-
Clinical laboratory services			
Blood tests for diagnostic services	100%	-0-	-0-

Plan F

Medicare (Parts A and B) medical services – per calendar year

Services	Medicare pays	Plan F pays	With Plan F you pay
Home health care (Medicare-approved services)			
Medically necessary skilled care services and medical supplies	100%	-0-	-0-
Durable medical equipment First $131 of Medicare approved amounts[6]	-0-	$131 (Part B deductible)	-0-
Remainder of Medicare approved amounts	80%	20%	-0-
At-home recovery services (not covered by Medicare) Home care certified by your doctor, for personal care during recovery from an injury or sickness for which Medicare approved a home care treatment plan			
Benefit for each visit	-0-	-0-	All costs
Number of visits covered (must be received within 8 weeks of last Medicare-approved visit)	-0-	-0-	All costs
Calendar year maximum	-0-	-0-	All costs

Other benefits – not covered by Medicare

Services	Medicare pays	Plan C pays	With plan C you pay
Foreign travel (not covered by Medicare) Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA			
First $250 each calendar year	-0-	-0-	$250
Remainder of charges	-0-	80% to a lifetime maximum benefit of $50,000	20% and amounts over the $50,000 lifetime maximum

Plan K

Medicare (Part A) hospital services – per benefit period

The annual out-of-pocket limitation for Plan K is $4,140.

You will pay half the cost-sharing of some covered services until you reach the annual out-of-pocket limit of $4,140 each calendar year. Once you reach the annual limit, the plan pays 100 percent of your Medicare copayment and coinsurance for the rest of the calendar year. This limit, however, does not include charges from your provider that exceed Medicare-approved amounts, referred to as "excess charges," and you will be responsible for paying this difference in the amount charged by your provider and the amount paid by Medicare for the item or service.

Services	Medicare pays	Plan K pays	With Plan K you pay
Hospitalization[4] – Semi-private room and board, general nursing, subacute care, and miscellaneous services and supplies			
First 60 days	All but $992	$496 (50%)	$496 (50% of Part A deductible)
61st through 90th day	All but $248 a day	$248 a day	-0-
91st day and after: While using 60 lifetime reserve days	All but $496 a day	$496 a day	-0-
Once lifetime reserve days are used			
Additional 365 days	-0-	100% of Medicare eligible expenses	-0-[5]
Beyond the additional 365 days	-0-	-0-	All costs
Skilled nursing facility/subacute care[4] – You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	-0-	-0-
21st through 100th day	All but $124 a day	Up to $62 a day (50%)	Up to $62 a day (50%)
101st day and after	-0-	-0-	All costs
Blood			
First 3 pints	-0-	50%	50%
Additional amounts	100%	-0-	-0-
Hospice care			
Available as long as your doctor certifies you are terminally ill and you elect to receive these services	All but very limited co-insurance for outpatient drugs and inpatient respite care	50% (of coinsurance or copay-ments)	50% (of coinsurance or copay-ments)

Plan K

Medicare (Part B) medical services – per calendar year

The annual out-of-pocket limitation for Plan K is $4,140.

You will pay half the cost-sharing of some covered services until you reach the annual out-of-pocket limit of $4,140 each calendar year. Once you reach the annual limit, the plan pays 100 percent of your Medicare copayment and coinsurance for the rest of the calendar year. This limit, however, does not include charges from your provider that exceed Medicare-approved amounts, referred to as "excess charges," and you will be responsible for paying this difference in the amount charged by your provider and the amount paid by Medicare for the item or service.

Services	Medicare pays	Plan K pays	With Plan K you pay
Medical expenses In or out of the hospital and outpatient treatment, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment			
First $131 of Medicare approved amounts[6]	-0-	-0-	$131 (Part B deductible)
Medicare approved preventive services after Part B deductible is met	Generally 80%	Generally 20%	-0-
Remainder of Medicare-approved amounts	Generally 80%	Generally 10%	Generally 10%
Part B excess charges (above Medicare-approved amounts)	-0-	-0-	ALL COSTS*
Blood			
First 3 pints	-0-	50%	50%
First $131 of Medicare-approved amounts[6]	-0-	-0-	$131 (Part B deductible)
Remainder of Medicare-approved Amounts	80%	10%	10%
Clinical laboratory services			
Blood tests for diagnostic services	100%	-0-	-0-

*Excess charges do not count toward annual out-of-pocket limit of $4,140.

Plan K

Medicare (Part A and B) medical services – per calendar year

The annual out-of-pocket limitation for Plan K is $4,140.

You will pay half the cost-sharing of some covered services until you reach the annual out-of-pocket limit of $4,140 each calendar year. Once you reach the annual limit, the plan pays 100 percent of your Medicare copayment and coinsurance for the rest of the calendar year. This limit, however, does not include charges from your provider that exceed Medicare-approved amounts, referred to as "excess charges," and you will be responsible for paying this difference in the amount charged by your provider and the amount paid by Medicare for the item or service.

Services	Medicare pays	Plan K pays	With Plan K you pay
Home health care (Medicare-approved services)			
Medically necessary skilled care services and medical supplies	100%	-0-	-0-
Durable medical equipment First $131 of Medicare approved amounts[6]	-0-	-0-	$131 (Part B deductible)
Remainder of Medicare approved amounts	80%	10%	10%
At-home recovery services (Not covered by Medicare) Home care certified by your doctor, for personal care during recovery from an injury or sickness for which Medicare approved a home care treatment plan			
Benefit for each visit	-0-	-0-	All costs
Number of visits covered (must be received within 8 weeks of last Medicare-approved visit)	-0-	-0-	All costs
Calendar year maximum	-0-	-0-	All costs

Other benefits – not covered by Medicare

Services	Medicare pays	Plan K pays	With Plan K you pay
Foreign travel (not covered by Medicare) Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA			
First $250 each calendar year	-0-	-0-	All costs
Remainder of charges	-0-	-0-	All costs

The rewards of choosing Blue Shield

More than 65 years of serving Californians

Blue Shield of California is a not-for-profit health plan whose mission since 1939 has been to provide Californians with access to quality care at an affordable price. We are dedicated to understanding your unique needs and offer several types of health plans designed to meet those needs. Blue Shield serves more than two million members, covered by individual and employer group plans, throughout California.

Why consider a Blue Shield Supplement plan?

Healthcare costs continue to soar, so it makes good sense to supplement Original Medicare with a plan from Blue Shield. Why? Because although Medicare helps pay many of your healthcare bills, Medicare deductibles and copayments can quickly and easily add up to thousands of dollars a year. Our Medicare Supplement plans are designed to cover a portion of the hospital, medical and surgical services that are not covered by Medicare.

Blue Shield of California offers you a choice of six Medicare Supplement plans: A, B, C, D, F, and K. All six plans pay most of the Medicare copayments, and Plans B, C, D, and F offer additional benefits, paying most of the Medicare deductibles.

NOTE: The preceding pages are only an outline describing the most important features of your Medicare Supplement plan contract. Complete information about the plans' benefits, limitations, and exclusions can be found in Blue Shield's Medicare Supplement Plan *Evidence of Coverage and Health Service Agreement* (Service Agreement). The Service Agreement will be your plan contract if you become a Blue Shield member.

Please read the Service Agreement completely. You have the right to receive a copy of the Service Agreement before you enroll, and we will be happy to provide you with a copy upon request. To request a copy, or if you have questions or need additional information, please call Blue Shield Customer Service at **(800) 248-2341**, TDD for hearing impaired: **(800) 241-1823.** If you have special healthcare needs, be sure to carefully read the sections of both this summary and the Service Agreement that are relevant to you before you apply for coverage.

Our Medicare Supplement benefits are subject to the deductible and copayment provisions of Plans A, B, C, D, F, and K, which may be in addition to the deductible and copayments required by Medicare. Blue Shield benefits may also be subject to other limitations set forth in the Service Agreement.

How Medicare Supplement plans work

Medicare pays the Medicare-approved amount first, then your Medicare Supplement plan pays all or part of the balance, depending on which plan you choose. For example, let's assume you have already met your yearly Medicare Part B deductible ($131) and the physician charge is $2,000 for a Medicare-covered service. The following example shows how Medicare Supplement plans work:

The total cost of your physician's service is:	$2,000
The Medicare-approved amount is:	$1,800
Generally, Medicare pays 80% of the approved amount:	– $1,440
Medicare Supplement plans pay up to the remaining 20%:	Up to $360

If you enroll in Plans A, B, C, or, D:

You pay nothing for Medicare-approved physician services, as long as your physician agrees to provide service and accept Medicare assignment charges for the services provided. This means you don't have to worry about bills for excess charges. If your physician does not accept Medicare assignment, however, you must pay the difference between the total amount and the Medicare-approved amount. Currently, physicians who don't accept Medicare assignment cannot bill for more than 115 percent of Medicare-approved charges. In this example, since the physician charged more than the Medicare approved amount, you would pay $200 ($2,000 - $1,800).

If you enroll in Plan K:

You will pay half the cost-sharing of some covered services until you reach the annual out-of-pocket limit of $4,140 each calendar year. Once you reach the annual limit, the plan pays 100 percent of your Medicare copayment and coinsurance for the rest of the calendar year. This limit, however, does not include charges from your provider that exceed Medicare approved amounts, referred to as "excess charges," and you will be responsible for paying this difference in the amount charged by your provider and the amount paid by Medicare for the item or service.

If you enroll in Plan F:

You pay nothing for Medicare approved physician services, even if your physician does not accept Medicare assignment. These plans pay the difference (if any) between the amount charged by your physician and the Medicare approved amount, regardless of whether your physician accepts Medicare assignment.

Your choice of physicians and hospitals

You can choose any licensed physician, provider, or medical facility that accepts Medicare, whenever and wherever you need care for illness or injury within the United States.

Providers are paid by Blue Shield only for the covered services they render to plan members. Providers receive no financial incentives or bonuses from Blue Shield.

Additional monthly savings

Blue Shield of California offers two opportunities for additional savings[3] on your plan dues:

- Easy$Pay℠ – If you choose to use our Easy$Pay method of automatic monthly deductions from your checking or savings account, you will save $2 per month on your plan dues. Details of how Easy$Pay works appear on page 46. Easy$Pay savings do not apply for Plan K.
- Two-party enrollment – If you and your spouse or domestic partner are age 65 or older, apply together, and are accepted for coverage under one agreement in the ***same benefit plan type***, you may be able to save on your combined monthly dues. Two-party rates are based on the age of the older party. For more information, please ask your Blue Shield representative for details about our two-party enrollment feature. Two-party rates are not available with Plan K.

Automatic claims procedures

Whenever you receive Medicare-covered services within California, there's rarely a need to file a claim. Your doctor will submit a claim to Medicare for the services you receive, and Medicare will, in turn, bill Blue Shield.

Blue Shield will pay the benefits directly to you, the physician or the hospital, depending on which party covered the cost of services when they were delivered. We will also send you an Explanation of Benefits form showing what we've paid and what, if anything, you owe.

All claims must be received within one year after the month of the date of service.

Worldwide coverage

Blue Shield's Plans C, D, and F go with you when you travel, even though Medicare benefits are available only when you are in the United States, its territories or possessions.

When you are outside the United States, these Blue Shield plans pay 80 percent of billed charges for Medicare-covered expenses for medically necessary emergency care, as long as care begins during the first 60 days of the trip outside the United States. This benefit is subject to a $250 calendar-year deductible and a $50,000 lifetime maximum benefit.

Lifepath Resources

Blue Shield is dedicated to helping you maintain good health and, if you become ill, to helping you get better. So, if life presents you with health-related challenges, turn to our *Lifepath* Resources℠ for access, choices, and support. We understand there are many paths to health, and the following programs and services are available to assist you in managing your health and well-being – all at no additional charge.

Lifepath Nurses

Blue Shield gives you round-the-clock access to a registered nurse. Our *Lifepath*℠ nurses will listen to your situation and direct you toward a healthy solution, any time, day or night. These knowledgeable, caring nurses are trained to help you:

- Understand your situation and which treatment options are available, as well as the risks and outcomes of each
- Make healthcare decisions and evaluate healthcare services
- Adopt healthier habits toward living life to the fullest

In addition, our audio library has a wide variety of health-related topics to help you.

Nurse Chat

You can speak with an experienced registered nurse one-on-one via Nurse Chat, an Internet instant messaging service. This secure online chat service offers you immediate general health information and research assistance. Nurse Chat nurses can also refer you to appropriate articles on **blueshieldca.com** and other relevant resources.

Chart Your Course Diabetes Management Program

Sometimes it's easy to forget the tests and services you need when you have a chronic illness. *Chart Your Course*, our program to help you manage diabetes, offers such tools as:

- Reminders for tests and other needed services, such as blood glucose levels and an annual eye exam
- Facts to help you understand the role of medications in diabetes
- Information about the care recommended by the American Diabetes Association

Guided imagery audiotapes and CDs

When you're about to have surgery, guided imagery can help reduce your anxiety level before the procedure and possibly help speed your recovery. Guided-imagery audiotapes and CDs are available to Blue Shield members facing surgery.

Lifepath Information

Sometimes all you need is information. Our *Lifepath*SM Information Series offers you many ways to learn – in print, in person, on video, and online:

- Our **Information & Assistance** team can help you sort through the variety of choices you face whenever you need help.
- A wealth of resources and support is available at **blueshieldca.com**. Our award-winning Web site has easy-to-use features, including **Ask the Pharmacist**, where you can e-mail a question to a pharmacist from the University of California, San Francisco and receive a private answer within two business days. At **blueshieldca.com**, you can file claims, download claims forms, and contact Customer Service representatives. You can also get detailed benefit information, including eligibility and covered services, as well as links to health-related information from Healthwise. If you don't have Internet access at home, you may be able to go online at your local library.
- ***Better Living*** is our newsletter for Medicare beneficiaries. It's packed with news related to your health plan and Medicare, as well as articles on improving your health and well-being, gardening, cooking tips and recipes, and many other lifestyle topics.

Lifepath Decision Guide

When you or a loved one experiences a significant health event, you want every available resource to help you understand what is happening, and to guide you as you make

important healthcare choices. Our *Lifepath* Decision Guide[SM] offers you access to expert information, tools and support online:

- Our **Hospital Comparison Tool** helps you choose a hospital that is best suited to your needs. You can compare hospitals in your area on many criteria, including the volume of particular procedures performed, and relative quality, safety, and price.
- When you're newly diagnosed with a serious or complicated health condition, use our **Treatment Options Tool**, with its powerful databases of expert information from such highly trusted sources as the American Cancer Society and the American Heart Association. Learn about treatment successes, risks, and potential side effects to help you decide which course of action is right for you.
- Our **Online Pharmacy Tool** helps you learn more about prescription and over-the-counter drugs. You can e-mail your questions directly to pharmacists at the University of California, San Francisco, and refill maintenance prescriptions through mail service.

Lifepath Decision Guide is available anytime, day or night, at **blueshieldca.com**.

Conditions of coverage

Termination of benefits

Your Service Agreement will not be terminated by Blue Shield for any cause except those outlined in your Service Agreement. These include:

1. You are no longer enrolled in Parts A and B of Medicare
2. False representation or concealment of material facts when applying for coverage or after enrollment
3. Fraud or deception in use of plan services or knowingly permitting such fraud or deception by another
4. Failing or refusing to provide access to documents and other information that was provided in the application for coverage
5. Abusive or disruptive behavior
6. Non-payment of dues

If Blue Shield does not receive your payment by the 15th day after it is due, we will send a "Prospective Notice of Termination" to your last address of record. This notice will inform you that if payment is not received within 15 days from the date of the Prospective Notice of Termination, coverage will be terminated as of 12:01 a.m. Pacific Time on the 16th day following the date of the Prospective Notice of Termination. At that time we will send you a "Notice Confirming Termination of Coverage."

Blue Shield may terminate coverage for non-payment of dues retroactively, up to 60 days from the date of mailing the Notice Confirming Termination of Coverage.

If you wish to terminate the Service Agreement, you are required to give Blue Shield 30 days' written notice. Should Blue Shield have plan dues for any period after the date of termination, such dues will be returned to you within 30 days. Coverage terminates at 12:01 a.m. Pacific Time of the 31st day following your request for termination.

The plan is not responsible for any services received after termination unless the subscriber is totally disabled at the time of termination. See your Service Agreement for a description of extension of benefits for disability.

Cancellation

Your coverage cannot be canceled for any reason other than those conditions specified above under "Termination of benefits."

Reinstatement of benefits

If you receive a "Notice Confirming Termination of Coverage," Blue Shield will allow a subscriber two coverage reinstatements per rolling 12-month period, if the amounts owed are paid within 15 days of the date the Notice of Termination of Coverage is mailed to you.

If your request for reinstatement and payment of all outstanding amounts is not received within the required 15 days, you must fill out an application and re-apply for coverage. Members who re-apply for coverage following termination may be subject to medical underwriting. Call your agent or **(888) 713-0000** to request an application. Your coverage will begin on the day the application is approved by Blue Shield.

Renewal provision

Your Blue Shield health coverage is "guaranteed renewable" (it may not be canceled by Blue Shield) and will remain in effect as long as your dues are paid in advance, except under the conditions listed above under "Termination of benefits" and as outlined in your Service Agreement. Blue Shield may modify or amend the Service Agreement by giving you at least 30 days' prior written notice.

Appeal of an underwriting decision

If you would like to appeal an underwriting decision, contact Customer Service at **(800) 248-2341**.

If you have questions about a service, a provider, your benefits, how to use your plan or any matter other than underwriting decisions, you should use the following grievance procedure.

Grievance process

Blue Shield of California has established a grievance procedure for receiving, resolving, and tracking Subscribers' grievances with Blue Shield of California.

Our Customer Service Department

If you, as a subscriber, have a question about services, providers, benefits, how to use this plan, or concerns regarding the quality of care or access to care that you have experienced, you may call Blue Shield's Customer Service Department at **(800) 248-2341**. If you are hearing impaired, call Blue Shield's toll-free TDD number, **(800) 241-1823**. A Customer Service representative can answer many of your questions over the telephone.

Note: Blue Shield of California has established a procedure for our subscribers to request an expedited decision. You, your physician, or your representative may request an expedited decision when the routine decision-making process might seriously jeopardize your life or health, or when you are experiencing severe pain. Blue Shield shall make a decision and notify you and your physician within 72 hours following receipt of the request. An expedited decision may involve admissions, continued stay, or other healthcare services. If you would like additional information regarding the expedited decision process, or if you believe your particular situation qualifies for an expedited decision, please contact our Customer Service Department.

Blue Shield may refer inquiries or grievances to a local medical society, hospitalization utilization review committee, peer review committee of the California Medical Association or a medical specialty society, or other appropriate peer-review committee for an opinion to assist in the resolution of these matters.

You may contact the Customer Service Department by telephone, letter, or online to request review of an initial determination concerning a claim or service. Subscribers may contact the plan at **(800) 248-2341**. If the telephone inquiry to Customer Service does not resolve the question or issue to your satisfaction, you may request a grievance at that time, which the Customer Service representative will initiate on your behalf.

You, your designated representative, or a provider may also initiate a grievance on your behalf by

submitting a letter or a completed "grievance form." You may request this form from Customer Service at the address noted below. You may also submit the grievance online by visiting our Web site, **blueshieldca.com**.

Blue Shield of California
Customer Service Appeals and Grievance
P.O. Box 5588
El Dorado Hills, CA 95762-0011

Blue Shield will acknowledge receipt of a grievance within five (5) calendar days.

The grievance system allows you to file grievances for at least 180 days following any incident or action that is the subject of your dissatisfaction. Grievances are resolved within 30 days. Refer to the "NOTE" above for information on the expedited decision process.

External independent medical review

The following independent medical review does not apply to services that are not covered based on a Medicare coverage determination.

If your grievance involves a claim or services for which coverage was denied by Blue Shield in whole or in part on the grounds that the service is not medically necessary or is experimental/investigational (including the external review available under the Friedman-Knowles Experimental Treatment Act for 1996), you may choose to make a request to the Department of Managed Health Care to have the matter submitted to an independent agency for external review in accordance with California law. You normally must first submit a grievance to Blue Shield and wait for at least 30 days before you request external review; however, if your matter would qualify for an expedited decision as described above, or involves a determination that the requested service is experimental/investigational, you may immediately request an external review following receipt of notice of denial. You may initiate this review by completing an application for external review, a copy of which can be obtained by contacting Customer Service. The Department of Managed Health Care will review the application, and, if the request qualifies for external review, will select an external review agency and have your records submitted to a qualified specialist for an independent determination of whether the care is medically necessary. You may choose to submit additional records to the external review agency for review. There is no cost to you for this external review. You and your physician will receive copies of the opinions of the external review agency. The decision of the external review agency is binding on

Blue Shield; if the external reviewer determines that the service is medically necessary, Blue Shield will promptly arrange for the service to be provided or the claim in dispute to be paid. This external review process is in addition to any other procedures or remedies available to you and is completely voluntary on your part; you are not obligated to request external review. However, failure to participate in external review may cause you to give up any statutory right to pursue legal action against Blue Shield regarding the disputed service. For more information regarding the external review process, or to request an application form, please contact Customer Service.

California Department of Managed Health Care Review

The California Department of Managed Health Care is responsible for regulating healthcare service plans. If you have a grievance against your health plan you should first telephone your health plan at **(800) 248-2341** and use your health plan's grievance process before contacting the Department. Utilizing this grievance procedure does not prohibit any potential legal rights or remedies that may be available to you. If you need help with a grievance involving an emergency, a grievance that has not been satisfactorily resolved by your health plan, or a grievance that has remained unresolved for more than 30 days, you may call the Department for assistance. You may also be eligible for an Independent Medical Review (IMR). If you are eligible for an IMR, the IMR process will provide an impartial review of medical decisions made by a health plan related to the medical necessity of a proposed service or treatment, coverage decisions for treatments that are experimental or investigational in nature, and payment disputes for emergency or urgent medical services. The Department also has a toll-free telephone number **(888) HMO-2219** and a TDD line **(888) 877-5378** for the hearing- and speech-impaired. The Department's Web site www.hmohelp.ca.gov, has complaint forms, IMR application forms, and instructions online. In the event that Blue Shield should cancel or refuse to renew your enrollment, and you feel that such action was due to reasons of health or utilization of benefits, you may request a review by the Department of Managed Health Care Director.

Acts of third parties

If a subscriber is injured through the act or omission of another person (a "third party"), Blue Shield shall, with respect to services required as a result of that injury, provide the benefits of the plan, and have an equitable right to restitution or other available remedy to recover the reasonable costs of the services provided to the covered person paid by Blue Shield on a fee-for-service basis.

The covered person is required to:

1. Notify Blue Shield in writing of any actual or potential claim or legal action which such covered person anticipates bringing or has brought against the third party arising from the alleged acts or omissions causing the injury or illness, not later than 30 days after submitting or filing a claim or legal action against the third party;
2. Agree to fully cooperate with Blue Shield to execute any forms or documents needed to assist them in exercising their equitable right to restitution or other available remedies; and
3. Provide Blue Shield with a lien, in the amount of reasonable costs of benefits provided, calculated in accordance with California Civil Code section 3040. The lien may be filed with the third party, the third party's agent or attorney, or the court, unless otherwise prohibited by law.

A covered person's failure to comply with 1. through 3.), above, shall not in any way act as a waiver, release, or relinquishment of the rights of Blue Shield.

Utilization review process

The utilization review process does not apply to services that are not covered based on a Medicare coverage determination.
State law requires that health plans disclose to plan members and health plan providers the process used to authorize or deny healthcare services under the plan.

Blue Shield has documented this process ("Utilization Review"), as required under Section 1363.5 of the California Health and Safety Code. To request a copy of this document, call our Customer Service Department toll-free at **(800) 248-2341**.

Plan interpretation

Blue Shield shall have the power and discretionary authority to construe and interpret the provisions of the Service Agreement, to determine the benefits of the Service Agreement, and determine eligibility to receive benefits under the Service Agreement. Blue Shield shall exercise this authority for the benefit of all subscribers entitled to receive benefits under the Service Agreement.

Confidentiality of personal and health information

Blue Shield of California protects the confidentiality of your personal health information, including your medical records, claims, and personal information. We will not disclose your personal health information without your authorization, except as permitted by law.

A statement describing Blue Shield's policies and procedures for preserving the confidentiality of medical records is available, and we will furnish it to you upon request. To request a copy of this statement, you may call the Customer Service Department at **(800) 248-2341** or print a copy from **blueshieldca.com**.

If you are concerned that Blue Shield may have violated your confidentiality/privacy rights, or you disagree with a decision we made about access to your personal and health information, you may contact us at:

Correspondence address:
Blue Shield of California Privacy Official
P.O. Box 272540
Chico, CA 95927-2540

Toll-free telephone:
(888) 266-8080

E-mail Address:
BlueShieldCa_Privacy@BlueShieldca.com

Principal exclusions and limitations on benefits

Please Note:

Blue Shield Medicare Supplement plans do not cover custodial care in any institution, including a skilled nursing facility. Custodial care includes such services as help with walking, getting in and out of bed, eating, dressing, bathing, and taking medicine.

Unless exceptions to the following exclusions are specifically made in the *Evidence of Coverage and Health Service Agreement* (Service Agreement) for your plan, no benefits are provided for:

- Services related to hospitalization or confinement in a health facility, including a skilled nursing facility, primarily for custodial, maintenance or domiciliary care, rest, or to control or change a patient's environment, such as custodial or intermediate nursing home care;
- Services and supplies which are not medically necessary as defined in the Service Agreement;
- Dental care and treatment, dental surgery, and dental appliances;
- Physical examinations, except for a one-time physical exam within six months of your first coverage under Medicare Part B (for members whose Part B coverage begins on or after January 1, 2005, and who have not already taken advantage of this exception in another plan or through Medicare Advantage);
- Routine immunizations;
- Cosmetic surgery;
- Routine foot care;
- Examinations for and the cost of eyeglasses and hearing aids;
- Services for or incident to vocational, educational, recreational, art, dance, or music therapy; and unless (and then only to the extent) medically necessary as an adjunct to medical treatment of an underlying medical condition and prescribed by the attending physician, and recognized by Medicare, weight-control programs, or exercise programs;
- Services for transgender or gender dysphoria conditions, including but not limited to, intersex surgery (transsexual operations), or any related services, or any resulting medical complications, except as medically necessary;
- Services performed in a hospital by house officers, residents, interns, or others in training;
- Blood and plasma, except for the first three (3) pints each calendar year;

- Acupuncture;
- Services for which you are not legally obligated to pay, or services for which no charge is made to you;
- Services not payable by Medicare except as provided in the Service Agreement; or
- Services not specifically listed as benefits.

See the Grievance Process section on page 38 for information on filing a grievance, your right to seek assistance from the Department of Managed Health Care, and your right to independent medical review.

Affordable dental plans for Medicare Supplement members

Taking care of your teeth can help you look and feel better. From cleanings to crowns, dental coverage is one of the best ways to protect against serious dental conditions and high costs related to care.

Make the choice, make it Blue Shield

Effective April 1, 2007

Good reasons to enroll

- Access to one of the largest nationwide dental PPO provider networks[9]
- Practice preventive dental health while avoiding costly expenses
- Get the most of your annual basic, preventive, and diagnostic, care such as teeth cleaning, X-rays, and fillings subject to annual benefit maximum
- Pay a smaller portion of the cost of care when you use the Blue Shield dental network
- Benefit from a wide range of services, including endodontics, periodontics, oral surgery, and prosthetics[1]
- Sign up for Easy$Pay and have your dues paid automatically

Get covered

When you consider it, you can't afford to be without dental coverage. Select a dental plan along with your health plan from Blue Shield. You'll get coverage from a trusted company that knows your dental coverage needs.

Affordable rates	Dental PPO 1500	Dental PPO 1000
Monthly Dues		
Individual	$39	$31
Two-party***	$78	$62

***** For two-party contract holders only**

If you are enrolled in a Medicare Supplement plan with a two-party contract, you may enjoy the convenience of a single-bill and lower rates for you and your spouse/domestic partner. Keep the same convenience when you choose your dental plan by matching your dental plan enrollment with your Medicare Supplement enrollment. You and your spouse/domestic partner need to select the same dental PPO plan to continue to receive one bill that may include the lower Medicare Supplement rates bundled with your dental rates.

Your two-party contract will be split into individual Medicare Supplement plan contracts if only one of you chooses dental or if you want different dental PPO plans. As separate contract holders each of you will receive your own bill and will no longer be eligible for the two-party discount.

Healthier smile, healthier you

Become a member today!

Sign up for a Blue Shield dental plan by selecting a Blue Shield plan on the enclosed Medicare Supplement application, or calling our Dental Member Services representatives at (888) 679-8928.

Conditions of Coverage

Dental PPO benefits are separate from the medical benefits of Blue Shield's health plans. Except for the following, the general provisions and exclusions of the health plan apply:

- Dental benefits aren't subject to health plan deductible requirements.
- The Blue Shield dental PPO plans are underwritten by Blue Shield of California and administered by Dental Benefit Providers of California Inc.
- If your dental coverage is cancelled for any reason (by you or by Blue Shield), you may apply for reinstatement, but you will have to wait 12 months to reapply.
- If your health plan coverage is terminated or cancelled, your dental coverage is terminated, as well.

To find a dentist, or see if your dentist is in our network, visit **blueshieldca.com.** Click *Find a Provider,* choose *Guest*, then select the *Dental Only* option, and click the link to *Dentists and Dental Specialists.*

Dental PPO

With the Blue Shield Dental PPO, you have the freedom to choose any dentist, but your out-of-pocket costs for covered services are lowest when you receive care from network dental providers.

	Dental PPO 1500		Dental PPO 1000	
	Network dentist	Non-network dentist[2]	Network dentist	Non-network dentist[2]
Deductible	$50/person		$75/person	
Calendar-year maximum	$1,500 ($1,000 may be used for non-network dentists)		$1,000 ($750 may be used for non-network dentists)	
Diagnostic and preventive care (not subject to plan deductibles with network dentists; includes routine oral exams, X-rays, and cleanings)	100%	80%	100%	50%
Basic services (includes anesthesia, emergency treatment to relieve pain, restorative dentistry, sealants, and space maintainers)	80%	70%	50%	50%
Major services[1] 12-month waiting period (includes crown buildups, crowns, prosthetics, inlays, onlays, jackets, posts and cores, and veneers)	50%	50%	50%	50%

This chart is only a summary. For a complete list of the benefits, exclusions and limitations of either dental plan, please refer to the *Dental Evidence of Coverage/Health Service Agreement*.

FOOTNOTES

1. Two-party rates are not available with Plan K.
2. If you are 64 or younger and do not have end-stage renal disease, you may apply for Blue Shield of California Medicare Supplement coverage as described in Blue Shield's Guaranteed Acceptance Guide. Blue Shield of California does not offer coverage if you are 64 or younger unless you qualify for guaranteed acceptance. Two-party rates are not available to those 64 or younger.
3. Savings due to increased efficiencies from administering Medicare Supplement plans under this program/service are passed on to the subscriber. Two-party rates and Easy$Pay discounts do not apply to Plan K.
4. A benefit period begins on the first day you receive service as an inpatient in a hospital, and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.
5. **Notice**: When your Medicare Part A hospital benefits are exhausted, Blue Shield of California will pay whatever amount Medicare would have paid, for up to an additional 365 days as provided in the plan's "core benefits." During this time, the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.
6. Once you have been billed $131 of Medicare approved amounts for covered services, your Part B deductible will have been met for the calendar year.
7. Dental PPO members have a 12-month waiting period for major restorative services and procedures (such as crowns), and removable fixed prosthetics.
8. The coinsurance percentage indicated is a percentage of allowed amounts that we pay to providers. Non-network providers can charge more than our allowable amount. When members use non-network providers, they must pay the applicable copayment/coinsurance plus any amount that exceeds our allowable amount. Charges in excess of the allowable amount do not count toward the calendar-year deductible or copayment maximum.
9. Dental providers in California are contracted through Dental Benefit Providers of California. Dental providers outside California are contracted through Dental Benefit Providers Inc.