

Blue Shield Medicare Supplement plans

Summary of benefits and provisions

Benefit Plans A, B, C, D, F, G, J, and K
Effective January 1, 2009

Blue Shield of California Medicare Supplement plans

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

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Applying for coverage is easy!

1. Fill out the enclosed application.

Refer to “Applying for Coverage” on page 52 for application guidelines.

If you have any questions about enrolling, please contact your agent or call **(888) 713-0000** to speak with a Blue Shield representative.

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.

Our cashing 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. The following 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, G, J, and K, shown in darker gray on the chart.

Blue Shield's Plans A, B, C, D, F, G, J, 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.

Benefit chart of Medicare Supplement plans sold for effective dates on or after 1/1/09

This chart shows the benefits included in each of the standard Medicare Supplement plans. Blue Shield does not offer Plans E, High-Deductible F, H, I, High-Deductible J, and L for new enrollment. Every company must make Plan A available. Some plans may not be available in your state.

Basic benefits:

Hospitalization

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

Medical expenses

Part B coinsurance (generally 20% of Medicare-approved expenses) or copayments for hospital outpatient services. Plans K and L require the insured to pay a portion of Part B coinsurance or copayments.

Blood

First three pints of blood each year. Plans K and L require the insured to pay a portion of the coinsurance or copayments for the first three pints of blood.

Hospice:

Part A coinsurance.

Comparison chart of the 12 standard Medicare Supplement plans

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

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					•					•		
Calendar-year maximum copayment (copayments and coinsurance paid at 100% after maximum reached)											\$4,620	\$2,310

* 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 \$2,000 deductible. Benefits from High-Deductible Plans F and J will not begin until out-of-pocket expenses reach \$2,000. 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.

Plan dues

Opportunities for additional savings

NEW! Welcome to Medicare rate savings

New to Medicare? Then we want to welcome you! You can save \$10 each month for the first 12 months on your Medicare Supplement plan rates if you're new to Medicare Part B.¹

To qualify, you must be age 65 or older, and Blue Shield must receive your application within six months of the date you first enrolled for benefits under Medicare Part B. The savings will be in effect for the first 12 months of your plan dues.

The Welcome to Medicare Rate Savings is available for all Medicare Supplement plans that Blue Shield offers. And, you can also take advantage of our two-party rates and Easy\$PaySM method of payment for additional rate savings.

Easy\$Pay

Easy\$Pay 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.¹ Easy\$Pay savings are not available for automatic payment by credit card.

Two-party enrollment

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's, 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

The amounts listed are **before** any applicable Welcome to Medicare Rate Savings or Easy\$Pay savings are applied.

Effective date 9/1/08

Single-party rates

Age range	A	B	C	D	F	G	J	K
65 to 66	\$100	\$120	\$139	\$123	\$139	\$136	\$167	\$ 64
67 to 69	104	126	145	129	145	142	174	73
70 to 74	136	165	190	168	199	186	239	89
75 to 79	177	214	247	219	257	242	309	130
80-plus	202	246	286	255	287	279	344	170
64 or younger ²	514	620	717	635	718	703	862	307

Two-party rates¹

Age range	A	B	C	D	F	G	J
65 to 66	\$194	\$234	\$272	\$240	\$272	\$266	\$328
67 to 69	202	246	284	252	284	278	342
70 to 74	247	305	355	311	373	347	453
75 to 79	329	403	469	413	489	459	593
80-plus	379	467	547	485	549	533	663
64 or younger ²	N/A	N/A	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

The amounts listed are **before** any applicable Welcome to Medicare Rate Savings or Easy\$Pay savings are applied.

Effective date 9/1/08

Single-party rates

Age range	A	B	C	D	F	G	J	K
65 to 66	\$ 96	\$ 113	\$134	\$ 119	\$134	\$129	\$ 161	\$ 60
67 to 69	100	118	140	124	140	135	168	63
70 to 74	131	155	183	162	189	176	227	83
75 to 79	171	201	238	211	244	229	293	109
80-plus	191	233	271	241	271	264	326	142
64 or younger ²	495	584	690	611	690	665	828	256

Two-party rates¹

Age range	A	B	C	D	F	G	J
65 to 66	\$186	\$ 220	\$ 262	\$ 232	\$ 262	\$ 252	\$ 316
67 to 69	194	230	274	242	274	264	330
70 to 74	237	285	341	299	353	327	429
75 to 79	317	377	451	397	463	433	561
80-plus	357	441	517	457	517	503	627
64 or younger ²	N/A	N/A	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

The amounts listed are **before** any applicable Welcome to Medicare Rate Savings or Easy\$Pay savings are applied.

Effective date 9/1/08

Single-party rates

Age range	A	B	C	D	F	G	J	K
65 to 66	\$ 92	\$108	\$128	\$ 113	\$128	\$122	\$154	\$ 57
67 to 69	96	113	133	118	134	128	161	59
70 to 74	125	148	175	155	181	167	217	78
75 to 79	163	192	227	201	233	217	280	106
80-plus	181	220	256	228	257	250	308	138
64 or younger ²	472	557	658	583	659	629	791	250

Two-party rates¹

Age range	A	B	C	D	F	G	J
65 to 66	\$ 178	\$ 210	\$ 250	\$ 220	\$ 250	\$ 238	\$ 302
67 to 69	186	220	260	230	262	250	316
70 to 74	225	271	325	285	337	309	409
75 to 79	301	359	429	377	441	409	535
80-plus	337	415	487	431	489	475	591
64 or younger ²	N/A	N/A	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

The amounts listed are **before** any applicable Welcome to Medicare Rate Savings or Easy\$Pay savings are applied.

Effective date 9/1/08

Single-party rates

Age range	A	B	C	D	F	G	J	K
65 to 66	\$ 96	\$ 113	\$134	\$ 119	\$134	\$128	\$ 161	\$ 60
67 to 69	100	118	140	124	140	134	168	64
70 to 74	131	155	183	162	189	175	227	82
75 to 79	171	201	238	211	244	227	293	115
80-plus	189	230	268	239	269	261	322	150
64 or younger ²	495	584	690	611	691	659	829	270

Two-party rates¹

Age range	A	B	C	D	F	G	J
65 to 66	\$186	\$ 220	\$ 262	\$ 232	\$ 262	\$ 250	\$ 316
67 to 69	194	230	274	242	274	262	330
70 to 74	237	285	341	299	353	325	429
75 to 79	317	377	451	397	463	429	561
80-plus	353	435	511	453	513	497	619
64 or younger ²	N/A	N/A	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

The amounts listed are **before** any applicable Welcome to Medicare Rate Savings or Easy\$Pay savings are applied.

Effective date 9/1/08

Single-party rates

Age range	A	B	C	D	F	G	J	K
65 to 66	\$ 85	\$103	\$ 118	\$105	\$ 119	\$ 117	\$143	\$ 54
67 to 69	89	108	124	110	124	122	149	62
70 to 74	116	141	162	146	168	160	202	76
75 to 79	151	183	210	190	217	208	260	111
80-plus	173	211	245	218	246	239	295	145
64 or younger ²	438	531	610	541	611	602	733	261

Two-party rates¹

Age range	A	B	C	D	F	G	J
65 to 66	\$164	\$ 200	\$ 230	\$ 204	\$ 232	\$ 228	\$ 280
67 to 69	172	210	242	214	242	238	292
70 to 74	207	257	299	267	311	295	379
75 to 79	277	341	395	355	409	391	495
80-plus	321	397	465	411	467	453	565
64 or younger ²	N/A	N/A	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

The amounts listed are **before** any applicable Welcome to Medicare Rate Savings or Easy\$Pay savings are applied.

Effective date 9/1/08

Single-party rates

Age range	A	B	C	D	F	G	J	K
65 to 66	\$ 85	\$ 101	\$ 119	\$ 105	\$ 119	\$ 117	\$ 143	\$ 55
67 to 69	89	107	124	110	124	122	149	59
70 to 74	117	138	163	144	169	159	203	75
75 to 79	152	183	211	187	218	207	262	105
80-plus	172	210	244	218	245	238	294	138
64 or younger ²	440	530	613	543	614	601	737	248

Two-party rates¹

Age range	A	B	C	D	F	G	J
65 to 66	\$ 164	\$ 196	\$ 232	\$ 204	\$ 232	\$ 228	\$ 280
67 to 69	172	208	242	214	242	238	292
70 to 74	209	251	301	263	313	293	381
75 to 79	279	341	397	349	411	389	499
80-plus	319	395	463	411	465	451	563
64 or younger ²	N/A	N/A	N/A	N/A	N/A	N/A	N/A

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.

Value of health services

In 2007, the ratio of the value of health services provided to the amount Blue Shield collected in plan dues was 65.9%.

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 the *Guaranteed Acceptance Guide*, included in the Blue Shield Medicare Supplement plan 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 ³ – Semi-private room and board, general nursing, subacute care, and miscellaneous services and supplies			
First 60 days	All but \$1,068	-0-	\$1,068 (Part A deductible)
61 st through 90 th day	All but \$267 a day	\$267 a day	-0-
91 st day and after: while using 60 lifetime reserve days	All but \$534 a day	\$534 a day	-0-
Once lifetime reserve days are used			
• Additional 365 days	-0-	100% of Medicare-eligible expenses	-0 ⁴ -
• Beyond the additional 365 days	-0-	-0-	All costs
Skilled nursing facility/subacute care ³ – 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-
21 st through 100 th day	All but \$133.50 a day	-0-	Up to \$133.50 a day
101 st 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 coinsurance 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 \$135 of Medicare-approved amounts ⁵	-0-	-0-	\$135 (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 \$135 of Medicare-approved amounts ⁵	-0-	-0-	\$135 (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 \$135 of Medicare-approved amounts ⁵	-0-	-0-	\$135 (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 United States			
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
Hospitalization³ – Semi-private room and board, general nursing, subacute care, and miscellaneous services and supplies			
First 60 days	All but \$1,068	\$1,068 (Part A deductible)	-0-
61 st through 90 th day	All but \$267 a day	\$267 a day	-0-
91 st day and after: While using 60 lifetime reserve days	All but \$534 a day	\$534 a day	-0-
Once lifetime reserve days are used • Additional 365 days	-0-	100% of Medicare-eligible expenses	-0 ⁴ -
• Beyond the additional 365 days	-0-	-0-	All costs
Skilled nursing facility/subacute care³ – 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-
21 st through 100 th day	All but \$133.50 a day	-0-	Up to \$133.50 a day
101 st 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 coinsurance 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 \$135 of Medicare-approved amounts ⁵	-0-	-0-	\$135 (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 \$135 of Medicare-approved amounts ⁵	-0-	-0-	\$135 (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 \$135 of Medicare-approved amounts ⁵	-0-	-0-	\$135 (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 United States			
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
Hospitalization³ – Semi-private room and board, general nursing, subacute care, and miscellaneous services and supplies			
First 60 days	All but \$1,068	\$1,068 (Part A deductible)	-0-
61 st through 90 th day	All but \$267 a day	\$267 a day	-0-
91 st day and after: While using 60 lifetime reserve days	All but \$534 a day	\$534 a day	-0-
Once lifetime reserve days are used • Additional 365 days	-0-	100% of Medicare-eligible expenses	-0 ⁴ -
• Beyond the additional 365 days	-0-	-0-	All costs
Skilled nursing facility/subacute care³ – 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-
21 st through 100 th days	All but \$133.50 a day	Up to \$133.50 a day	-0-
101 st 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 coinsurance 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 \$135 of Medicare-approved amounts ⁵	-0-	\$135 (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 \$135 of Medicare-approved amounts ⁵	-0-	\$135 (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 \$135 of Medicare-approved amounts ⁵	-0-	\$135 (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 United States			
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 D

Medicare (Part A) hospital services – per benefit period

Services	Medicare pays	Plan D pays	With Plan D you pay
Hospitalization³ – Semi-private room and board, general nursing, subacute care, and miscellaneous services and supplies			
First 60 days	All but \$1,068	\$1,068 (Part A deductible)	-0-
61 st through 90 th day	All but \$267 a day	\$267 a day	-0-
91 st day and after: While using 60 lifetime reserve days	All but \$534 a day	\$534 a day	-0-
Once lifetime reserve days are used • Additional 365 days	-0-	100% of Medicare-eligible expenses	-0 ⁴ -
• Beyond the additional 365 days	-0-	-0-	All costs
Skilled nursing facility/subacute care³ – 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-
21 st through 100 th day	All but \$133.50 a day	Up to \$133.50 a day	-0-
101 st 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 coinsurance 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 \$135 of Medicare-approved amounts ⁵	-0-	-0-	\$135 (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 \$135 of Medicare-approved amounts ⁵	-0-	-0-	\$135 (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 \$135 of Medicare-approved amounts ⁵	-0-	-0-	\$135 (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 D pays	With plan D you pay
Foreign travel (not covered by Medicare) Medically necessary emergency care services beginning during the first 60 days of each trip outside the United States			
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
Hospitalization³ – Semi-private room and board, general nursing, subacute care, and miscellaneous services and supplies			
First 60 days	All but \$1,068	\$1,068 (Part A deductible)	-0-
61 st through 90 th day	All but \$267 a day	\$267 a day	-0-
91 st day and after: While using 60 lifetime reserve days	All but \$534 a day	\$534 a day	-0-
Once lifetime reserve days are used • Additional 365 days	-0-	100% of Medicare-eligible expenses	-0 ⁴ -
• Beyond the additional 365 days	-0-	-0-	All costs
Skilled nursing facility/subacute care³ – 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-
21 st through 100 th day	All but \$133.50 a day	Up to \$133.50 a day	-0-
101 st 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 coinsurance 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 \$135 of Medicare-approved amounts ⁵	-0-	\$135 (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 \$135 of Medicare-approved amounts ⁵	-0-	\$135 (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 \$135 of Medicare-approved amounts ⁵	-0-	\$135 (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 F pays	With plan F you pay
Foreign travel (not covered by Medicare) Medically necessary emergency care services beginning during the first 60 days of each trip outside the United States			
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 G

Medicare (Part A) hospital services – per benefit period

Services	Medicare pays	Plan G pays	With Plan G you pay
Hospitalization³ – Semi-private room and board, general nursing, subacute care, and miscellaneous services and supplies			
First 60 days	All but \$1,068	\$1,068 (Part A deductible)	-0-
61 st through 90 th day	All but \$267 a day	\$267 a day	-0-
91 st day and after: While using 60 lifetime reserve days	All but \$534 a day	\$534 a day	-0-
Once lifetime reserve days are used • Additional 365 days	-0-	100% of Medicare-eligible expenses	-0 ⁴ -
• Beyond the additional 365 days	-0-	-0-	All costs
Skilled nursing facility/subacute care³ – You must meet Medicare's requirements, including having been in a hospital for at least 3 days and having entered a Medicare-approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	-0-	-0-
21 st through 100 th day	All but \$133.50 a day	Up to \$133.50 a day	-0-
101 st 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 coinsurance for outpatient drugs and inpatient respite care	-0-	Balance

Plan G

Medicare (Part B) medical services – per calendar year

Services	Medicare pays	Plan G pays	With Plan G 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 \$135 of Medicare-approved amounts ⁵	-0-	-0-	\$135 (Part B deductible)
Remainder of Medicare-approved amounts	Generally 80%	Generally 20%	-0-
Part B excess charges (above Medicare-approved amounts)	-0-	Generally 80%	Generally 20%
Blood			
First 3 pints	-0-	100%	-0-
Next \$135 of Medicare-approved amounts ⁵	-0-	-0-	\$135 (Part B deductible)
Remainder of Medicare-approved amounts	80%	20%	-0-
Clinical laboratory services			
Blood tests for diagnostic services	100%	-0-	-0-

Plan G

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

Services	Medicare pays	Plan G pays	With Plan G you pay
Home health care (Medicare-approved services)			
Medically necessary skilled care services and medical supplies	100%	-0-	-0-
Durable medical equipment: First \$135 of Medicare-approved amounts ⁵	-0-	-0-	\$135 (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 per 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 G pays	With plan G you pay
Foreign travel (not covered by Medicare) Medically necessary emergency care services beginning during the first 60 days of each trip outside the United States			
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 J

Medicare (Part A) hospital services – per benefit period

Services	Medicare pays	Plan J pays	With Plan J you pay
Hospitalization³ – Semi-private room and board, general nursing, subacute care, and miscellaneous services and supplies			
First 60 days	All but \$1,068	\$1,068 (Part A deductible)	-0-
61 st through 90 th day	All but \$267 a day	\$267 a day	-0-
91 st day and after: While using 60 lifetime reserve days	All but \$534 a day	\$534 a day	-0-
Once lifetime reserve days are used • Additional 365 days	-0-	100% of Medicare-eligible expenses	-0 ⁴ -
• Beyond the additional 365 days	-0-	-0-	All costs
Skilled nursing facility/subacute care³ – You must meet Medicare's requirements, including having been in a hospital for at least 3 days and having entered a Medicare-approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	-0-	-0-
21 st through 100 th day	All but \$133.50 a day	Up to \$133.50 a day	-0-
101 st 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 coinsurance for outpatient drugs and inpatient respite care	-0-	Balance

Plan J

Medicare (Part B) medical services – per calendar year

Services	Medicare pays	Plan J pays	With Plan J 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, and durable medical equipment			
First \$135 of Medicare-approved amounts ⁵	-0-	\$135 (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 \$135 of Medicare-approved amounts ⁵	-0-	\$135 (Part B deductible)	-0-
Remainder of Medicare-approved amounts	80%	20%	-0-
Clinical laboratory services			
Blood tests for diagnostic services	100%	-0-	-0-

Plan J

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

Services	Medicare pays	Plan J pays	With Plan J you pay
Home health care (Medicare-approved services)			
Medically necessary skilled care services and medical supplies	100%	-0-	-0-
Durable medical equipment: First \$135 of Medicare-approved amounts ⁵	-0-	\$135 (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-	Actual charges to \$40 per 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 J pays	With plan J you pay
Foreign travel (not covered by Medicare) Medically necessary emergency care services beginning during the first 60 days of each trip outside the United States			
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
Non-Medicare covered preventive care			
Routine check-ups and screening tests	\$0	Up to \$120 per calendar year	All costs after \$120

Plan K

Medicare (Part A) hospital services – per benefit period

The calendar-year maximum copayment for Plan K is \$4,620.

You will pay half the cost-sharing of some covered services until you reach the calendar-year maximum copayment of \$4,620 each calendar year. Once you reach the calendar-year maximum, the plan pays 100% of your Medicare copayment and coinsurance for the rest of the calendar year. This maximum, 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
Hospitalization³ – Semi-private room and board, general nursing, subacute care, and miscellaneous services and supplies			
First 60 days	All but \$1,068	\$534 (50%)	\$534 (50% of Part A deductible)
61 st through 90 th day	All but \$267 a day	\$267 a day	-0-
91 st day and after: While using 60 lifetime reserve days	All but \$534 a day	\$534 a day	-0-
Once lifetime reserve days are used • Additional 365 days	-0-	100% of Medicare-eligible expenses	-0 ⁴ -
• Beyond the additional 365 days	-0-	-0-	All costs
Skilled nursing facility/subacute care³ – You must meet Medicare's requirements, including having been in a hospital for at least 3 days and having entered a Medicare-approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	-0-	-0-
21 st through 100 th day	All but \$133.50 a day	Up to \$66.75 a day (50%)	Up to \$66.75 a day (50%)
101 st 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 copayments)	50% (of coinsurance or copayments)

Plan K

Medicare (Part B) medical services – per calendar year

The calendar-year maximum copayment for Plan K is \$4,620.

You will pay half the cost-sharing of some covered services until you reach the calendar-year maximum copayment of \$4,620 each calendar year. Once you reach the calendar-year maximum, the plan pays 100% of your Medicare copayment and coinsurance for the rest of the calendar year. This maximum, 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 \$135 of Medicare-approved amounts ⁵	-0-	-0-	\$135 (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 \$135 of Medicare-approved amounts ⁵	-0-	-0-	\$135 (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 the calendar-year maximum copayment of \$4,620.

Plan K

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

The calendar-year maximum copayment for Plan K is \$4,620.

You will pay half the cost-sharing of some covered services until you reach the calendar-year maximum copayment of \$4,620 each calendar year. Once you reach the calendar-year maximum, the plan pays 100% of your Medicare copayment and coinsurance for the rest of the calendar year. This maximum, 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 \$135 of Medicare-approved amounts ⁵	-0-	-0-	\$135 (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 United States			
First \$250 each calendar-year	-0-	-0-	All costs
Remainder of charges	-0-	-0-	All costs

NOTE: The preceding pages are only an outline describing the most important features of our Medicare Supplement plans. Complete information about the plans' benefits, limitations, and exclusions can be found in our 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** or **(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.

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 (\$135), 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 "excess charges," which are 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% 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 F or J:

You pay nothing for Medicare-approved physician services even if your physician does not accept Medicare assignment, because Plans F and J include coverage for 100% of excess charges. Plans F and J cover the difference, or the "excess charges" (if any) between the amount charged by your physician and the Medicare-approved amount. In this example, the Medicare Supplement plan would pay \$360 if the provider accepts assignment, and \$560 if the provider does not accept assignment. You pay \$0 in either scenario, because the plan pays both the 20% and any applicable excess charges.

If you enroll in Plan G:

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. If your physician does not accept Medicare assignment, however, Plan G pays 80% of the “excess charges” (the difference between the total amount and the Medicare-approved amount) and you pay 20% of the excess charges. Currently, physicians who don’t accept Medicare assignment cannot bill for more than 115% of Medicare-approved charges. In this example, since the physician charged more than the Medicare-approved amount, Plan G pays \$160.00, and you pay \$40 (20% of the difference between \$2,000 and \$1,800).

If you enroll in Plan K:

You pay \$180 for Medicare-approved physician services if your physician accepts assignment, which represents half of the cost sharing until you reach the calendar-year maximum copayment of \$4,620. In this example, Plan K pays 50% of the remaining 20% that Medicare does not cover (50% of \$360 is \$180). Once you reach the calendar-year maximum, the plan pays 100% of your Medicare copayment and coinsurance for the rest of the calendar year.

You pay \$380 for Medicare-approved physician services if your physician does not accept assignment because you are responsible for any “excess charges.” In this example, Plan K pays 50% of the remaining 20% that Medicare does not cover, so you pay (50% of \$360 = \$180), plus the excess charges (\$200). The calendar-year maximum copayment of \$4,620 does not include excess charges for physicians who do not accept assignment, and you will be responsible for paying the difference in the amount charged by your provider and the amount paid by Medicare for the item or service.

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 2 million members, covered by individual and employer group plans, throughout California.

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

Our Medicare Supplement benefits are subject to the deductible and copayment provisions of Plans A, B, C, D, F, G, J, 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.

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.

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, F, G, and J 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% 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.

NurseHelp 24/7SM

Blue Shield gives you round-the-clock access to a registered nurse. These 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.

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

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 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 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. PST 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. PST on 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 you 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 representative 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 has established a grievance procedure for receiving, resolving, and tracking subscribers’ grievances with us.

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.

Expedited decision process

Blue Shield 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. We will 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 “Expedited decision process” above for more information on this 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-Kowles 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 a 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

Applying for coverage

If you are 65 or older

You may apply to enroll in any of Blue Shield's Medicare Supplement plans (A, B, C, D, F, G, J, or K) if:

- You are a resident of the state of California.
- You are enrolled in Medicare Parts A and B, Title 18, Public Law 89-97, at the time you apply.

If you are 64 or younger

You may be able to enroll in a Blue Shield Medicare Supplement plan (A, B, C, D, F, G, J, or K) under the following conditions:

- You are a resident of the state of California.
- You are enrolled in Medicare Parts A and B, Title 18, Public Law 89-97, at the time you apply.
- You qualify for guaranteed acceptance in a Blue Shield of California Medicare Supplement plan according to Blue Shield's guidelines.
- You do not have end-stage renal disease.

If you qualify for guaranteed acceptance into a Blue Shield Medicare Supplement plan, you will not be required to complete a health statement. If you do *not* qualify for guaranteed acceptance, you will need to complete a health statement and be subject to underwriting.

To qualify for guaranteed acceptance, you must meet certain, specific criteria as outlined in Blue Shield's *Guaranteed Acceptance Guide*. For additional information about qualifying for guaranteed acceptance in a Blue Shield Medicare Supplement plan, please call your agent, or call Blue Shield at **(888) 713-0000**. You may also contact the California Health Insurance Counseling and Advocacy Program (HICAP) for guidance. HICAP provides insurance counseling for California senior citizens. Call HICAP toll-free at **(800) 434-0222** for a referral to your local HICAP office. HICAP is a service provided free of charge by the state of California.

How to apply

You may apply by completing the application and returning it in the enclosed envelope. Enclose the first payment with your application. Blue Shield will refund your payment if your application is not approved. If your application is approved, Blue Shield will send you a bill indicating the date your next payment is due.

Effective date of coverage

You can expect to receive notice of approval or declination within approximately two weeks after Blue Shield receives your application. Your coverage will be effective at 12:01 a.m. PST on your effective date.

Switching from another plan to a Blue Shield of California Medicare Supplement plan

If you have a Medicare Advantage or Medicare Advantage Prescription Drug Plan

Most Medicare Supplement plans duplicate the coverage provided by Medicare Advantage plans. Federal law prohibits Medicare Supplement plans from enrolling anyone who is still enrolled in a Medicare Advantage plan if the Medicare Supplement coverage would duplicate the coverage provided by the Medicare Advantage plan.

It works like this: Members of Medicare Advantage plans agree to access services under the terms of that plan and from the providers who contract with that plan, rather than accessing services under the Original Medicare program. Medicare Advantage plans contract with the government and receive funds under that contract to provide this coverage to their members. Consequently, enrollees of Medicare Advantage plans do not have access to coverage under Original Medicare.

Medicare Supplement plans generally provide coverage only for the portion of a claim that is left over after Original Medicare has paid its share. Since Original Medicare generally does not pay for services provided to a Medicare Advantage enrollee, Medicare Supplement plans won't pay toward the claim either. And, since Original Medicare generally won't pay if a Medicare Advantage plan member receives services outside their Medicare Advantage plan's network, the member is usually financially responsible for the full cost of those services.

If you are currently a member of a Medicare Advantage plan, and you decide to join a Blue Shield of California Medicare Supplement plan, it is in your best interest to choose one of the options listed below to disenroll from the Medicare Advantage plan.

This will help ensure that your current Medicare Advantage coverage is terminated and that your Original Medicare coverage, which works in conjunction with Medicare Supplement coverage, is in place. For that reason, we will work with you to coordinate the effective date of any Medicare Supplement coverage we approve with the date you disenroll from your current Medicare Advantage plan.

Option 1

Go directly to your Social Security office and disenroll there. If you choose this option, ask for a copy of the disenrollment form, and please fax or mail it to Blue Shield (see below).

Option 2

Call the Centers for Medicare and Medicaid Services (CMS), the federal agency that administers Medicare, and ask to be disenrolled from your current Medicare Advantage plan. You can reach the agency at **1-800-MEDICARE**. CMS will either mail or fax you confirmation of termination from your Medicare Advantage plan. Please forward that termination confirmation to Blue Shield via mail or fax (see below).

Option 3

Submit a written request to your current Medicare Advantage plan, and ask to be disenrolled. You can do this one of two ways:

- Call your Medicare Advantage plan and ask for a disenrollment form to be sent to you, then complete and return the form to your Medicare Advantage plan. Keep a copy for your records.
- Send your Medicare Advantage plan a letter, which includes your name and member ID number, requesting disenrollment. Keep a photocopy of your letter for your records.

Your disenrollment request will be processed the same month it's received, with an effective date the first of the following month. We will be happy to accept a verbal confirmation from your health plan that you have disenrolled from their plan – just have them call us.

Phone: **(800) 248-2341**

TTY: **(800) 241-1823**

Fax: **(209) 367-6391**

Mailing address:

Blue Shield of California
P.O. Box 3008
Lodi, CA 95241-1912

If you have other health coverage

Federal law prohibits you from being enrolled in both a Medicare Supplement plan and a Medicare Advantage plan. State laws prevent Blue Shield from enrolling you in a Medicare Supplement plan if you already have coverage, such as an existing Medicare Supplement or employer group plan, that the new plan would duplicate.

To help ensure that this doesn't happen, we will coordinate your effective date of coverage under your new Blue Shield of California Medicare Supplement plan to coincide with disenrollment from your previous health plan.

First, we will notify you of your acceptance in a Blue Shield Medicare Supplement plan. Then you can cancel your other coverage. You may either let us know as soon as you've disenrolled, or we will contact you to confirm that you have disenrolled. Please refer to the Notice Regarding Replacement form, which is included with this Summary of Benefits.

Retroactive coverage

If you apply and are approved for coverage under Blue Shield's guaranteed acceptance guidelines, and are either (1) 65 or older and have received Medicare Part B within the previous six months, or (2) you are eligible by reason of disability and have received or were notified of your eligibility to receive Medicare Part B within the previous six months, you may request that your effective date coincide with the date you received Medicare Part B. Once you pay plan dues for the period elapsed since the month of your birthday, you will receive retroactive coverage.

Payment procedures

Billing options

Once you have enrolled in a Blue Shield Medicare Supplement plan, you have several options for plan dues payment.

1. Easy\$Pay: Pay your plan dues with Blue Shield's quick and convenient Easy\$Pay program, an automatic electronic transfer on the first or fifteenth of the month from your checking or savings account. There's no check to write and no postage to pay. A record of your payment is included on your bank statement. **Remember, if you choose this option, you're able to trim \$2 off your dues each month!** (This savings does not apply to Plan K.)

An Easy\$Pay authorization form, with more details, is included with this Summary of Benefits for your consideration.

2. Payment by credit card: Your payment amount is automatically charged to the Visa or MasterCard you designate.

An authorization form with more details is included with this Summary of Benefits.

3. Quarterly billing: Blue Shield will bill you once every three months.

4. Monthly billing: Blue Shield will send you a bill each month.

With Options 3 and 4, the bill will tell you the date your payment is due.

The dues you pay or the benefits you receive may change during the year. In either case, Blue Shield will always let you know at least 30 days in advance.

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;
- 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 47 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.

FOOTNOTES

1. 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 savings do not apply to Plan K. Welcome to Medicare Rate Savings applies to all plans Blue Shield offers.
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. 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.
4. 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.
5. Once you have been billed \$135 of Medicare-approved amounts for covered services, your Part B deductible will have been met for the calendar year.

Important phone numbers

If you are applying for a Blue Shield Medicare Supplement plan and need more information to help you make your decision, call your broker/agent or the Blue Shield sales office in your area:

Northern California

Fresno
5250 N. Palm Ave., Suite 120
Fresno, CA 93704
(800) 779-1906, (559) 440-4000
Fax: (559) 436-0371

Sacramento
11249 Gold Country Blvd., Suite 160
Gold River, CA 95670
(800) 304-2583, (916) 851-3400
Fax: (916) 851-3450

San Francisco
50 Beale St., 20th Floor
San Francisco, CA 94105
(415) 229-5272
Fax: (415) 229-6230

San Jose
1735 Technology Drive
Bldg. 4, Suite 100
San Jose, CA 95110
(877) 455-6115, (408) 452-6900
Fax: (408) 452-6910

Walnut Creek
2175 N. California Blvd., Suite 250
Walnut Creek, CA 94596
(925) 927-7400
Fax: (925) 927-7410

HICAP

(800) 434-0222

The Health Insurance Counseling and Advocacy Program, or HICAP, provides free health insurance counseling for California senior citizens.

Blue Shield Medicare Supplement Customer Service

(800) 248-2341, TDD: (800) 241-1823

8 a.m. to 5 p.m. Monday to Thursday, 9 a.m. to 5 p.m. Friday, excluding holidays

Blue Shield of California Medicare Plans

Regional Sales Office

6300 Canoga Ave.

Woodland Hills, CA 91367-2555

Southern California

El Segundo
100 N. Sepulveda Blvd.
El Segundo, CA 90245
(800) 499-3899, (310) 744-2580
Fax: (310) 744-2894

Ontario
3401 Centre Lake Drive, Suite 400
Ontario, CA 91761
(800) 628-6501, (909) 974-5200
Fax: (909) 974-5220

Costa Mesa
555 Anton Blvd., 8th Floor
Costa Mesa, CA 92626
(714) 428-4800
Fax: (714) 428-4949

San Diego
2275 Rio Bonito Way, Suite 250
San Diego, CA 92108
(619) 686-4200
Fax: (619) 686-4250

Santa Barbara/Ventura
1933 Cliff Drive, Suite 11
Santa Barbara, CA 93109
(888) 697-0000, (805) 883-2000
Fax: (805) 883-2019

Woodland Hills
6300 Canoga Avenue, 13th Floor
Woodland Hills, CA 91367
(818) 598-8000
Fax: (818) 228-5249