Full PPO Combined Deductible 10-0
100/50
Benefit Summary (For groups of 51 and above)
(Uniform Health Plan Benefits and Coverage Matrix)

Blue Shield of California

Highlights: A description of the prescription drug coverage is provided separately

Effective January 1, 2015

<table>
<thead>
<tr>
<th></th>
<th>Participating Providers</th>
<th>Non-Participating Providers</th>
</tr>
</thead>
<tbody>
<tr>
<td>Calendar Year Medical Deductible</td>
<td>$0 per individual / $0 per family</td>
<td>$500 per individual / $1,000 per family</td>
</tr>
<tr>
<td>Calendar Year Out-of-Pocket Maximum</td>
<td>$500 per individual / $1,000 per family</td>
<td>$2,000 per individual / $4,000 per family</td>
</tr>
</tbody>
</table>

LIFETIME BENEFIT MAXIMUM

<table>
<thead>
<tr>
<th>Covered Services</th>
<th>Member Copayment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Professional Services</td>
<td>Participating Providers</td>
</tr>
<tr>
<td>Professional (Physician) Benefits</td>
<td>$10 per visit (Not subject to the Calendar-Year Deductible)</td>
</tr>
<tr>
<td>• Physician and specialist office visits</td>
<td>No Charge</td>
</tr>
<tr>
<td>• CT scans, MRIs, MRAs, PET scans, and cardiac diagnostic procedures utilizing nuclear medicine (prior authorization is required)</td>
<td>No Charge</td>
</tr>
<tr>
<td>• Other outpatient X-ray,pathology and laboratory (Diagnostic testing by providers other than outpatient laboratory, pathology, and imaging departments of hospitals/facilities)</td>
<td>$10 per visit</td>
</tr>
<tr>
<td>Allergy Testing and Treatment Benefits</td>
<td>No Charge</td>
</tr>
<tr>
<td>Preventive Health Benefits</td>
<td>No Charge</td>
</tr>
<tr>
<td>• Preventive Health Services (As required by applicable federal and California law.)</td>
<td>(Not subject to the Calendar-Year Deductible)</td>
</tr>
</tbody>
</table>

OUTPATIENT SERVICES

Hospital Benefits (Facility Services)

<table>
<thead>
<tr>
<th></th>
<th>Participating Providers</th>
<th>Non-Participating Providers</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Outpatient surgery performed at an Ambulatory Surgery Center</td>
<td>No Charge</td>
<td>50%</td>
</tr>
<tr>
<td>• Outpatient surgery in a hospital</td>
<td>No Charge</td>
<td>50%</td>
</tr>
<tr>
<td>• Outpatient Services for treatment of illness or injury and necessary supplies (Except as described under &quot;Rehabilitation Benefits&quot;)</td>
<td>No Charge</td>
<td>50%</td>
</tr>
<tr>
<td>• CT scans, MRIs, MRAs, PET scans, and cardiac diagnostic procedures utilizing nuclear medicine performed in a hospital (prior authorization is required)</td>
<td>$100 per visit</td>
<td>50%</td>
</tr>
<tr>
<td>• Other outpatient X-ray, pathology and laboratory performed in a hospital</td>
<td>$35 per visit</td>
<td>50%</td>
</tr>
<tr>
<td>• Bariatric Surgery (prior authorization required by the Plan; medically necessary surgery for weight loss, for morbid obesity only)</td>
<td>No Charge</td>
<td>50%</td>
</tr>
</tbody>
</table>

HOSPITALIZATION SERVICES

Hospital Benefits (Facility Services)

<table>
<thead>
<tr>
<th></th>
<th>Participating Providers</th>
<th>Non-Participating Providers</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Inpatient Physician Services</td>
<td>No Charge</td>
<td>50%</td>
</tr>
<tr>
<td>• Inpatient Non-emergency Facility Services (Semi-private room and board, and medically-necessary Services and supplies, including Subacute Care)</td>
<td>$100 per admission</td>
<td>50%</td>
</tr>
<tr>
<td>• Bariatric Surgery (prior authorization required by the Plan; medically necessary surgery for weight loss, for morbid obesity only)</td>
<td>$100 per admission</td>
<td>50%</td>
</tr>
</tbody>
</table>

Skilled Nursing Facility Benefits (Combined maximum of up to 100 prior authorized days per Calendar Year; semi-private accommodations)

<table>
<thead>
<tr>
<th></th>
<th>Participating Providers</th>
<th>Non-Participating Providers</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Services by a free-standing Skilled Nursing Facility</td>
<td>No Charge</td>
<td>No Charge</td>
</tr>
<tr>
<td>• Skilled Nursing Unit of a Hospital</td>
<td>No Charge</td>
<td>50%</td>
</tr>
</tbody>
</table>

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

- Emergency room Services not resulting in admission (The ER copayment does not apply if the member is directly admitted to the hospital for inpatient services)  
  $100 per visit  
  (Not subject to the Calendar-Year Deductible)

- Emergency room Services resulting in admission (when the member is admitted directly from the ER)  
  $100 per admission  
  (Not subject to the Calendar-Year Deductible)

- Emergency room Physician Services  
  No Charge

**AMBULANCE SERVICES**

- Emergency or authorized transport  
  No Charge

**PRESCRIPTION DRUG COVERAGE**

Outpatient Prescription Drug Benefits  
A description of your outpatient prescription drug coverage is provided separately. If you do not have the separate drug summary that goes with this benefit summary, please contact your benefits administrator or call the Customer Service number on your identification card.

**PROSTHETICS/ORTHOTICS**

- Prosthetic equipment and devices  (Separate office visit copay may apply)  
  No Charge  
  50%

- Orthotic equipment and devices  (Separate office visit copay may apply)  
  No Charge  
  50%

**DURABLE MEDICAL EQUIPMENT**

- Breast pump  
  No Charge  
  (Not subject to the Calendar-Year Deductible)

- Other Durable Medical Equipment  
  No Charge  
  50%

**MENTAL HEALTH AND SUBSTANCE ABUSE SERVICES**

- Inpatient Hospital Services  
  $100 per admission  
  50%*  
  MHSA Participating Providers

- Residential Care  
  $100 per admission  
  50%*  
  MHSA Participating Providers

- Inpatient Physician Services  
  No Charge  
  50%  
  MHSA Participating Providers

- Routine Outpatient Mental Health and Substance Abuse Services  
  (includes professional/physician visits)  
  $10 per visit  
  50%  
  (Not subject to the Calendar-Year Deductible)  
  MHSA Non-Participating Providers

- Non-Routine Outpatient Mental Health and Substance Abuse Services  
  (includes behavioral health treatment, electroconvulsive therapy, intensive outpatient programs, office-based opioid treatment, partial hospitalization programs, and transcranial magnetic stimulation. For partial hospitalization programs, a higher copayment and facility charges may apply per episode of care)  
  No Charge  
  50%  
  MHSA Non-Participating Providers

**HOME HEALTH SERVICES**

- Home health care agency Services  
  (up to 100 prior authorized visits per Calendar Year)  
  No Charge  
  Not Covered  
  Participating Providers  
  Not Covered  
  Non-Participating Providers

- Home infusion/home intravenous injectable therapy and infusion nursing visits provided by a Home Infusion Agency  
  No Charge  
  Not Covered  
  Participating Providers  
  Not Covered  
  Non-Participating Providers

**OTHER**

**Hospice Program Benefits**

- Routine home care  
  No Charge  
  Not Covered  
  Participating Providers  
  Not Covered  
  Non-Participating Providers

- Inpatient Respite Care  
  No Charge  
  Not Covered  
  Participating Providers  
  Not Covered  
  Non-Participating Providers

- 24-hour Continuous Home Care  
  No Charge  
  Not Covered  
  Participating Providers  
  Not Covered  
  Non-Participating Providers

- General Inpatient care  
  No Charge  
  Not Covered  
  Participating Providers  
  Not Covered  
  Non-Participating Providers

**Chiropractic Benefits**

- Chiropractic Services  
  (up to 12 visits per Calendar Year)  
  $25 per visit  
  50%  
  Participating Providers  
  Not Covered  
  Non-Participating Providers

**Acupuncture Benefits**

- Acupuncture Services  
  (up to 20 visits per Calendar Year)  
  $25 per visit  
  50%  
  Participating Providers  
  Not Covered  
  Non-Participating Providers

**Rehabilitation Benefits (Physical, Occupational and Respiratory Therapy)**

- Office location  
  $10 per visit  
  50%  
  Participating Providers  
  Not Covered  
  Non-Participating Providers

**Speech Therapy Benefits**

- Office Visit  
  $10 per visit  
  50%  
  Participating Providers  
  Not Covered  
  Non-Participating Providers

**Pregnancy and Maternity Care Benefits**

- Prenatal and postnatal Physician office visits  
  (For inpatient hospital services, see “Hospitalization Services”)  
  No Charge  
  50%  
  Participating Providers  
  Not Covered  
  Non-Participating Providers

- Abortion services  
  (Facility charges may apply - see “Hospital Benefits (Facility Services)”)  
  No Charge  
  50%  
  Participating Providers  
  Not Covered  
  Non-Participating Providers
Family Planning Benefits

- Counseling and consulting
  - None
  - Not covered
  - (Not subject to the calendar-year deductible)

- Tubal ligation
  - No charge
  - Not covered
  - (Not subject to the calendar-year deductible)

- Vasectomy
  - No charge
  - Not covered
  - (Not subject to the calendar-year deductible)

Diabetes Care Benefits

- Devices, equipment, and non-testing supplies (for testing supplies see outpatient prescription drug benefits)
  - No charge
  - 50%

- Diabetes self-management training
  - $10 per visit
  - 50%
  - (Not subject to the calendar-year deductible)

Care Outside of Plan Service Area (Benefits provided through the BlueCard®
Program for out-of-state emergency and non-emergency care are provided at the participating level of the local Blue Plan allowable amount when you use a Blue Cross/Blue Shield provider)

- Within US: BlueCard Program
  - See applicable benefit

- Outside of US: BlueCard Worldwide
  - See applicable benefit

Optional Benefits Optional dental, vision, infertility and hearing aid benefits are available.

If your employer purchased any of these benefits, a description of the benefit is provided separately.

1. Unless otherwise specified, copayments/coinsurance are calculated based on allowable amounts. Participating providers agree to accept Blue Shield's allowable amount plus the plan's and any applicable member's payment as full payment for covered services. Non-participating providers can charge more than these amounts. When members use non-participating providers, they must pay the applicable deductibles, copayments or coinsurance plus any amount that exceeds Blue Shield's allowable amount. Charges above the allowable amount do not count toward the calendar-year deductible or out-of-pocket maximum.

2. Participating non Hospital based ("free-standing") laboratory or radiology centers may not be available in all areas. Laboratory and radiology Services may also be obtained from a Hospital or from a laboratory and radiology center that is affiliated with a Hospital, and paid according to the benefit under your health plan's Hospital Benefits.

3. Participating Ambulatory Surgery Centers may not be available in all areas. Outpatient surgery Services may also be obtained from a Hospital or from an ambulatory surgery center that is affiliated with a Hospital, and paid according to the benefit under your health plan's Hospital Benefits.

4. The maximum allowed charges for non-emergency surgery and services performed in a non-participating Ambulatory Surgery Center or outpatient unit of a non-participating hospital is $350 per day. Members are responsible for 50% of this $350 per day, plus all charges in excess of $350.

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

6. The maximum allowed charges for non-emergency hospital services received from a non-participating hospital is $600 per day. Members are responsible for 50% of this $600 per day, plus all charges in excess of $600.

7. For plans with a calendar-year medical deductible amount, services with a day or visit limit accrue to the calendar-year day or visit limit maximum regardless of whether the plan medical deductible has been met.

8. Services may require prior authorization by the Plan. When services are prior authorized, members pay the participating provider amount.

9. Mental Health and Substance Abuse services are accessed through Blue Shield's Mental Health Service Administrator (MHSA) - using Blue Shield's MHSA participating and non-participating providers. Only Mental Health and Substance Abuse services rendered by Blue Shield MHSA participating providers are administered by the Blue Shield MHSA. Mental Health and Substance Abuse services rendered by non-participating providers are administered by Blue Shield.

10. Inpatient services for acute detoxification are covered under the medical benefit; see the Hospital Benefits (Facility Services) section of the Evidence of Coverage for benefit details. Services for acute medical detoxification are accessed through Blue Shield using Blue Shield's participating providers or non-participating providers.

11. Out of network home health care, home infusion and hospice Services are not covered unless pre-authorized. When these services are pre-authorized, the member pays the participating provider copayment.

12. Includes insertion of IUD, as well as injectable and implantable contraceptives for women.

13. Copayment shown is for physician's services. If the procedure is performed in a facility setting (hospital or outpatient surgery center), an additional facility copayment may apply. Services from non-participating providers and non-participating facilities are not covered under this benefit.

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

A20303 (1/15)