# Benefit Summary (For groups 2 to 50)

## (Uniform Health Plan Benefits and Coverage Matrix)

### Blue Shield of California Life & Health Insurance Company

**Effective January 1, 2013**

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

### DEDUCTIBLE

<table>
<thead>
<tr>
<th>Description</th>
<th>Preferred Providers</th>
<th>Non-Preferred Providers</th>
</tr>
</thead>
<tbody>
<tr>
<td>Calendar Year Medical Deductible</td>
<td>$750 per Member</td>
<td>Not Covered</td>
</tr>
<tr>
<td>Calendar Year Brand Name Drug Deductible</td>
<td>$250 per Member</td>
<td>Charges for non-emergency services received from non-preferred providers do not count toward the calendar-year copayment maximum and continue to be the member's responsibility</td>
</tr>
<tr>
<td>Calendar Year Copayment Maximum</td>
<td>$4,000 per Member</td>
<td></td>
</tr>
</tbody>
</table>

### LIFETIME BENEFIT MAXIMUM

<table>
<thead>
<tr>
<th>Covered Services</th>
<th>Professional (Physician) Benefits</th>
<th>Preventive Health Benefits</th>
<th>Allergy Testing and Treatment Benefits</th>
<th>Outpatient Services (Facility Services)</th>
</tr>
</thead>
</table>

## Professional (Physician) Benefits

- Physician and specialist office visits (First 3 visits per Calendar Year are covered prior to meeting the deductible - subsequent visits are subject to the deductible)
- Subsequent physician and specialist office visits
- CT scans, MRIs, MRAs, PET scans, and cardiac diagnostic procedures utilizing nuclear medicine (prior authorization is required)
- Other outpatient X-ray, pathology and laboratory (Diagnostic testing by providers other than outpatient laboratory, pathology, and imaging departments of hospitals/facilities)

## Preventive Health Benefits

- Office visits (includes visits for allergy serum injections)
- Preventive Health Services (As required by applicable federal and California law.)

## Allergy Testing and Treatment Benefits

- Office visits (includes visits for allergy serum injections)

## Outpatient Services (Facility Services)

- Outpatient surgery performed at an Ambulatory Surgery Center
- Outpatient surgery in a hospital
- Outpatient Services for treatment of illness or injury and necessary supplies (Except as described under "Rehabilitation Benefits")
- CT scans, MRIs, MRAs, PET scans, and cardiac diagnostic procedures utilizing nuclear medicine performed in a hospital (prior authorization is required)
- Other outpatient X-ray, pathology and laboratory performed in a hospital
- Bariatric Surgery (prior authorization required by the Plan; medically necessary surgery for weight loss, for morbid obesity only)
# Hospitalization Services

## Hospital Benefits (Facility Services)
- **Inpatient Physician Services**: 30% / 50%
- **Inpatient non-Emergency Facility Services** (semi-private room and board, and medically necessary Services and supplies, including Subacute Care): $500 per admission + 30% / 50%
- **Bariatric Surgery** (prior authorization required by the Plan; medically necessary surgery for weight loss, for morbid obesity only): $500 per admission + 30% / 50%

## Skilled Nursing Facility Benefits
(Combined maximum of up to 60 prior authorized days per Calendar Year; semi-private accommodations)
- **Services by a free-standing Skilled Nursing Facility**: 30% / 30%
- **Skilled Nursing Unit of a Hospital**: 30% / 50%

## Emergency Health Coverage
- **Emergency room Services not resulting in admission** (Copayment does not apply if the member is directly admitted to the hospital for inpatient services): $100 per visit + 30% / 30%
- **Emergency room Services resulting in admission** (when the member is admitted directly from the ER): $500 per admission + 30% / 50%
- **Emergency room Physician Services**: 30% / 30%

## Ambulance Services
- **Emergency or authorized transport** (surface or air): 30% / 30%

## Prescription Drug Coverage
<table>
<thead>
<tr>
<th>Retail Prescriptions (up to a 30-day supply)</th>
<th>Participating Pharmacy</th>
<th>Non-Participating Pharmacy</th>
</tr>
</thead>
<tbody>
<tr>
<td>Contraceptive Drugs and Devices<strong>15</strong></td>
<td>No Charge</td>
<td>Not Covered</td>
</tr>
<tr>
<td>Formulary Generic Drugs</td>
<td>$15 per prescription</td>
<td>Not Covered</td>
</tr>
<tr>
<td>Formulary Brand Name Drugs</td>
<td>$30 or 30% of Blue Shield Life contracted rate, whichever is greater</td>
<td>Not Covered</td>
</tr>
<tr>
<td>Non-Formulary Brand Name Drugs</td>
<td>Not Covered</td>
<td>Not Covered</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Mail Service Prescriptions (up to a 90-day supply)</th>
<th>Participating Pharmacy</th>
<th>Non-Participating Pharmacy</th>
</tr>
</thead>
<tbody>
<tr>
<td>Contraceptive Drugs and Devices<strong>15</strong></td>
<td>No Charge</td>
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<td>Not Covered</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Specialty Pharmacies (up to a 30-day supply)</th>
<th>Participating Pharmacy</th>
<th>Non-Participating Pharmacy</th>
</tr>
</thead>
<tbody>
<tr>
<td>Specialty Drugs (May require prior authorization from Blue Shield Life Pharmacy Services. Specialty drugs are covered only when dispensed by select participating pharmacies in the Specialty Pharmacy Network. Drugs from non-participating pharmacies are not covered except in emergency and urgent situations. Mail service prescriptions are not covered. Member pays up to $200 copayment maximum per prescription):</td>
<td>30% per prescription</td>
<td>Not Covered</td>
</tr>
</tbody>
</table>

## Prosthetics/Orthotics
- **Prosthetic equipment and devices** (Separate office visit copay may apply): 30% / Not Covered
- **Orthotic equipment and devices** (Separate office visit copay may apply): 30% / Not Covered

## Durable Medical Equipment
- **Breast pump** (Not subject to the Calendar Year Medical Deductible): No Charge / Not Covered
- **Other Durable Medical Equipment**: 50% / Not Covered

## Mental Health Services (Psychiatric)**16**
- **Inpatient Hospital Services**: $500 per admission + 30% / 50%
- **Outpatient visits for severe mental health conditions** (First 3 visits per Calendar Year are covered prior to meeting the deductible; subsequent visits are subject to the deductible): $15 per visit - First 3 visits only / Not subject to the Calendar Year Medical Deductible
- **Subsequent outpatient visits for Severe Mental Health Conditions** (up to 20 visits per Calendar Year combined with outpatient chemical dependency visits): 30% / 50%
- **Outpatient visits for non-severe mental health conditions**: 30% / 50%
### CHEMICAL DEPENDENCY SERVICES (SUBSTANCE ABUSE)

Please see footnote 21

- Inpatient Hospital Services for medical acute detoxification
  - $500 per admission + 30% of the benefit is provided separately.
  - 50% of the benefit is provided separately.
- Outpatient visits (up to 20 visits per Calendar Year combined with outpatient non-severe mental health visits)
  - 50%1

### HOME HEALTH SERVICES

<table>
<thead>
<tr>
<th>Preferred Providers2</th>
<th>Non-Preferred Providers2</th>
</tr>
</thead>
<tbody>
<tr>
<td>Home health care agency Services9 (up to 100 prior authorized visits per Calendar Year)</td>
<td>30%</td>
</tr>
<tr>
<td>Home infusion/home intravenous injectable therapy and infusion nursing visits provided by a Home Infusion Agency</td>
<td>30%</td>
</tr>
</tbody>
</table>

### OTHER

#### Hospice Program Benefits
- Routine home care
  - No Charge
- Inpatient Respite Care
  - No Charge
- 24-hour Continuous Home Care
  - 30% Not Covered17
- General Inpatient care
  - 30% Not Covered17

#### Chiropractic Benefits9
- Chiropractic Services (up to 12 visits per Calendar Year; visit limit combines Outpatient chiropractic, Physical, Occupational, Respiratory, and Speech Therapy Services)
  - 30% Not Covered17

#### Acupuncture Benefits9
- Acupuncture
  - Not Covered Not Covered

#### Rehabilitation Benefits
- Office location (up to 12 visits per Calendar Year; visit limit combines Outpatient chiropractic, Physical, Occupational, Respiratory, and Speech Therapy Services)
  - 30% Not Covered17

#### Pregnancy and Maternity Care Benefits18
- Prenatal and postnatal Physician office visits
  - 30% Not Covered17

#### Family Planning Benefits
- Counseling and consulting5, 19
  - No Charge (Not subject to the Calendar Year Medical Deductible)
- Elective abortion20
  - 30% Not Covered17
- Tubal ligation20
  - No Charge (Not subject to the Calendar Year Medical Deductible)

#### Diabetes Care Benefits
- Devices, equipment, and non-testing supplies (for testing supplies see Outpatient Prescription Drug Benefits.)
  - 50% Not Covered
- Diabetes self-management training18 (If billed by your provider, you will also be responsible for the office visit copayment)
  - $15 per visit Not Covered

#### Care Outside of Plan Service Area

<table>
<thead>
<tr>
<th>Within US: BlueCard Program</th>
<th>See Applicable Benefit</th>
</tr>
</thead>
<tbody>
<tr>
<td>Outside of US: BlueCard Worldwide</td>
<td>See Applicable Benefit</td>
</tr>
</tbody>
</table>

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

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1. Deductible and copayments marked with this footnote do not accrue to calendar-year copayment maximum, except for the percentage copayment for the Outpatient Surgery in hospital/facility benefit which does accrue to the calendar-year copayment maximum. Copayments and charges for services not accruing to the member's calendar-year copayment maximum continue to be the member's responsibility after the calendar-year copayment maximum is reached. Deductible does not apply toward the calendar-year maximum. Please refer to the Certificate of Insurance and the Group Policy for exact terms and conditions of coverage.

2. Member is responsible for copayment in addition to any charges above allowable amounts. The coinsurance included is a percentage of allowable amounts. Preferred providers accept Blue Shield of California Life & Health Insurance Company's (Blue Shield Life) allowable amount as full payment for covered services. Non-preferred providers can charge more than these amounts. When members use non-preferred providers, they must pay the applicable copayment plus any amount that exceeds Blue Shield Life's allowable amount. Charges above the allowable amount do not count toward the calendar-year deductible or copayment maximum.

3. For subsequent physician office visits, the member is responsible for 100% of the Allowable Amount up to the calendar-year medical deductible for Preferred Providers or MHSA Participating Providers office visits, and for Non-Preferred Providers or MHSA Non-Participating Providers office visits the member is responsible for billed charges (charges in excess of the Allowable Amount do not count towards the calendar-year medical deductible or out-of-pocket maximum). Once the calendar-year deductible has been met, the member is responsible for 30% of the Allowable Amount for Preferred Providers or MHSA Participating Providers office visits up to the calendar-year out-of-pocket maximum and for Non-Preferred Providers or MHSA Non-Participating Providers office visits the member is responsible for 50% of the Allowable Amount and any charges above the Allowable Amount. After the out-of-pocket maximum has been met, Blue Shield pays for 100% of the Allowable Amount for Preferred Providers or MHSA Participating Providers office visits.

4. Participating non Hospital based ("freestanding") outpatient X-ray, pathology and laboratory facilities centers may not be available in all areas. Regardless of their availability, you can obtain outpatient X-ray, pathology and laboratory services from a hospital or an ambulatory surgery center affiliated with a hospital, with payment according to your health plan's hospital services benefits.
Specialty Drugs are specific Drugs used to treat complex or chronic conditions which usually require close monitoring such as multiple sclerosis, hepatitis, rheumatoid arthritis, cancers, and other conditions that are difficult to treat with traditional therapies. Specialty Drugs are listed in the Blue Shield Outpatient Drug Formulary.

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

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 preferred provider and there is no coverage for bariatric services from non-preferred 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 Certificate of Insurance for further benefit details.

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.

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

If the member or physician requests a brand name drug when a generic drug equivalent is available, the member is responsible for the difference in cost between the brand name drug and its generic drug equivalent, in addition to the generic drug copayment.

Specialty Drugs are specific Drugs used to treat complex or chronic conditions which usually require close monitoring such as multiple sclerosis, hepatitis, rheumatoid arthritis, cancers, and other conditions that are difficult to treat with traditional therapies. Specialty Drugs are listed in the Blue Shield Outpatient Drug Formulary.

Specialty Drugs may be self-administered in the home by injection by the patient or family member (subcutaneously or intramuscularly), by inhalation, orally or topically. Specialty Drugs must be considered safe for self-administration by Blue Shield’s Pharmacy & Therapeutics Committee, be obtained from a Blue Shield Specialty Pharmacy and may require prior authorization for Medical Necessity by Blue Shield. Infused or Intravenous (IV) medications are not included as Specialty Drugs.

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

This plan’s prescription drug coverage provides less coverage on average than the standard benefit set by the federal government for Medicare Part D (also called non-creditable coverage). It is important to know that generally you may only enroll in a Medicare Part D plan from October 15th through December 7th of each year. If you do not enroll in a Medicare Part D plan when you are first eligible to join, you may be subject to a late enrollment penalty in addition to your Part D premium when you enroll at a later date. For more information about your current plan’s prescription drug coverage, call Customer Service at 1-888-239-6469, Monday through Thursday, 8 a.m. to 5 p.m. or Friday, 9 a.m. to 5 p.m. The hearing impaired may call the TTY number at 1-888-239-6482.

Contraceptive Drugs and Devices covered under the outpatient prescription drug benefits will no longer require a copayment and will not be subject to the calendar-year brand-name drug deductible. However, if a brand-name contraceptive is requested when a generic equivalent is available, the member will still be responsible for paying the difference between the cost to the Plan for the brand-name contraceptive and its generic drug equivalent. In addition, select contraceptives may need prior authorization to be covered without a copayment.

Mental health and chemical dependency services, other than medical acute detoxification, are accessed through Blue Shield Life’s Mental Health Service Administrator (MHSA) - using Blue Shield Life MHSA participating and non-participating providers. Only Blue Shield Life MHSA-contracted providers are administered by the Blue Shield Life MHSA. Behavioral health services rendered by non-participating providers are administered by Blue Shield Life. Services for medical acute detoxification are accessed through Blue Shield Life using Blue Shield Life’s preferred providers or non-preferred providers. For a listing of severe mental illnesses, including serious emotional disturbances of a child, and other benefit details, please refer to the Certificate of Insurance or the group policy.

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

If billed by your provider, you will also be responsible for an office visit copayment or coinsurance. In addition, the office visit will count towards the first three visits.

Includes insertion of IUD as well as injectable contraceptives for women.

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. Non-preferred facilities are not covered under this benefit.

Optional inpatient substance abuse treatment benefits are available. If your employer purchased these benefits, a description of the benefit is attached hereto as “Additional Substance Abuse Treatment Benefits”.

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

Pending Regulatory Approval