### Benefit Summary

**Blue Shield of California**

**Effective October 1, 2012**

<table>
<thead>
<tr>
<th>Covered Services</th>
<th>Preferred Providers</th>
<th>Non-Preferred Providers</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Professional (Physician) Benefits</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Physician and specialist office visits</td>
<td>$10 per visit&lt;sup&gt;2,14&lt;/sup&gt;</td>
<td>50%&lt;sup&gt;2&lt;/sup&gt;</td>
</tr>
<tr>
<td>• CT scans, MRIs, MRAs, PET scans, and cardiac diagnostic procedures utilizing nuclear medicine&lt;sup&gt;6&lt;/sup&gt; (prior authorization is required)</td>
<td>10%&lt;sup&gt;2&lt;/sup&gt;</td>
<td>50%&lt;sup&gt;2&lt;/sup&gt;</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)&lt;sup&gt;3&lt;/sup&gt;</td>
<td>10%&lt;sup&gt;2&lt;/sup&gt;</td>
<td>50%&lt;sup&gt;2&lt;/sup&gt;</td>
</tr>
<tr>
<td><strong>Allergy Testing and Treatment Benefits</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Office visits (includes visits for allergy serum injections)</td>
<td>10%&lt;sup&gt;2&lt;/sup&gt;</td>
<td>50%&lt;sup&gt;2&lt;/sup&gt;</td>
</tr>
<tr>
<td><strong>Preventive Health Benefits</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Preventive Health Services (As required by applicable federal law.)</td>
<td>No charge&lt;sup&gt;14&lt;/sup&gt;</td>
<td>Not covered</td>
</tr>
</tbody>
</table>

### OUTPATIENT SERVICES

**Hospital Benefits (Facility Services)**
The maximum plan payment for non-emergency surgery and services performed in a non-participating Ambulatory Surgery Center or outpatient unit of a non-preferred hospital is $350 per day. Members are responsible for all charges in excess of $350 plan payment per day.

- Outpatient surgery performed at an Ambulatory Surgery Center<sup>4</sup> 10%  No charge
- Outpatient surgery in a hospital 10%  No charge
- Outpatient Services for treatment of illness or injury and necessary supplies (Except as described under “Rehabilitation Benefits”) 10% 50%<sup>2,16</sup>
- CT scans, MRIs, MRAs, PET scans, and cardiac diagnostic procedures utilizing nuclear medicine performed in a hospital (prior authorization is required)<sup>7</sup> 10% 50%<sup>2</sup>
- Other outpatient X-ray, pathology and laboratory performed in a hospital<sup>3</sup> 10% 50%<sup>2</sup>
- Bariatric Surgery (prior authorization required by the Plan; medically necessary surgery for weight loss, for morbid obesity only)<sup>5</sup> 10%  No charge

### HOSPITALIZATION SERVICES

**Hospital Benefits (Facility Services)**

- Inpatient Physician Services 10% 50%<sup>2,15b</sup>
- Inpatient Non-emergency Facility Services (Semi-private room and board, and medically-necessary Services and supplies, including Subacute Care) 10%  No charge<sup>6</sup>
- Bariatric Surgery (prior authorization required by the Plan; medically necessary surgery for weight loss, for morbid obesity only)<sup>5</sup> 10%  No charge<sup>6</sup>

**Skilled Nursing Facility Benefits**<sup>11</sup>

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

- Services by a free-standing Skilled Nursing Facility 10%  No charge<sup>6</sup>
- Skilled Nursing Unit of a Hospital 10%  No charge<sup>6</sup>

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**THIS MATRIX IS INTENDED TO BE USED TO HELP YOU COMPARE COVERAGE BENEFITS AND IS A SUMMARY ONLY. THE PLAN CONTRACT SHOULD BE CONSULTED FOR A DETAILED DESCRIPTION OF COVERAGE BENEFITS AND LIMITATIONS.**
### EMERGENCY HEALTH COVERAGE
- Emergency room Services not resulting in admission: $100 per visit + 10%
- Emergency room Services resulting in admission (when the member is admitted directly from the ER): 10%
- Emergency room Physician Services: 10%

### AMBULANCE SERVICES
- Emergency or authorized transport: 10%

### PRESCRIPTION DRUG COVERAGE
**Outpatient Prescription Drug Benefits Administered by Medco**

### PROSTHETICS/ORTHOTICS
- Prosthetic equipment and devices (Separate office visit copay may apply): 10%
- Orthotic equipment and devices (Separate office visit copay may apply): 10%

### DURABLE MEDICAL EQUIPMENT
- Durable Medical Equipment: 10%

### MENTAL HEALTH SERVICES (PSYCHIATRIC)
- Inpatient Hospital Services: 10%
- Outpatient Mental Health Services: $10 per visit

### CHEMICAL DEPENDENCY SERVICES (SUBSTANCE ABUSE)
- Inpatient Hospital Services: 10%
- Outpatient Chemical dependency and substance abuse services: $10 per visit

### HOME HEALTH SERVICES
- Home health care agency Services (up to 100 prior authorized visits per Calendar Year): 10%
- Home infusion/home intravenous injectable therapy and infusion nursing visits provided by a Home Infusion Agency: 10%

### OTHER
#### Hospice Program Benefits
- Routine home care: 10%
- Inpatient Respite Care: 10%
- 24-hour Continuous Home Care: 10%
- General Inpatient care: 10%

#### Chiropractic Benefits
- Chiropractic Services - (provided by a chiropractor): 10%

#### Acupuncture Benefits
- Acupuncture - (up to 12 visits per Calendar Year) (maximum plan payment of $50 per visit): 10%

#### Rehabilitation Benefits (Physical, Occupational and Respiratory Therapy)
- Office location: 10%

#### Speech Therapy Benefits
- Office location: 10%

#### Pregnancy and Maternity Care Benefits
- Prenatal and postnatal Physician office visits: $10 per visit

#### Family Planning Benefits
- Counseling and consulting: No charge
- Elective abortion: 10%
- Tubal ligation: No charge
- Vasectomy: 10%

#### Diabetes Care Benefits
- Devices, equipment, and non-testing supplies: 10%
- Diabetes self-management training (if billed by your provider, you will also be responsible for the office visit copayment): $10 per visit

#### Hearing Aid
- Audiological evaluations: $10 per visit
- Hearing Aid (Maximum combined benefit of $700 per person every 24 months for hearing aid and ancillary equipment): 10%
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 preferred level of the local Blue Plan allowable amount when you use a Blue Cross/Blue Shield provider)

- Within US: BlueCard Program
- Outside of US: BlueCard Worldwide

See Applicable Benefit

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

2. Deductible and copayments marked with this footnote do not accrue to 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 Plan Contract for exact terms and conditions of coverage.

3. 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.

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

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 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 Plan Contract for further benefit details.

6. The maximum plan payment for non-emergency hospital services received from a non-preferred hospital is $600 per day. Members are responsible for all charges in excess of $600 plan payment per day.

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

8. Mental health and chemical dependency services are accessed through Blue Shield's using Blue Shield participating and non-participating providers.

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

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

11. Services with day or visit limits accrue to the calendar-year day or visit limit maximum regardless of whether the plan deductible has been met.

12. Includes insertion of IUD as well as injectable 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.

14. These services are not subject to the Calendar-Year Deductible.

15. When these services are rendered by a non-preferred Radiologist, Anesthesiologist, Pathologist and Emergency Room Physicians in a preferred facility, the member pays the Preferred Provider copayment.

16. The $350 per day maximum for non-preferred hospital services does not apply to Outpatient Services for treatment of illness or injury and necessary supplies.