

Active ChoiceSM Plan 500

For groups of 51 and above

A health plan designed to allow members to be active participants in their own health care. The Active Choice Plan offers coverage for preventive care services with no up-front deductible, as well as a \$500 individual/\$1,000 family "First Dollar Services" coverage for specified services. Each calendar year, the member can spend this First Dollar Services coverage on certain outpatient professional and diagnostic services, from an office visit for preventive care to physical therapy benefits.

| Covered Services | | Active Choice Plan 500 | |
|---|---|---|---|
| Calendar Year In-Network Copayment Maximum ^{#,1} | | \$5,000/\$10,000 (individual/family) | |
| Category One # | Preventive Care <ul style="list-style-type: none"> Routine physical exams Well-baby care Immunizations | First Dollar Services ² Coverage: \$500 Individual/\$1,000 Family (Each insured family member has access to the entire amount of the family First Dollar Services) Then the Member is responsible for charges up to the Calendar Year Copayment Maximum | No Deductible. No Copayment or Coinsurance until First Dollar Services coverage is spent |
| | Outpatient Professional & Diagnostic <ul style="list-style-type: none"> Office visits Diagnostic testing | | |
| Category Two # | Outpatient & Inpatient Services <ul style="list-style-type: none"> Surgeries Emergency room visits Chemotherapy | 20% Preferred Providers 50% Non-Preferred Providers (some copayments apply) | No Deductible |
| Category Three | Prescription Drugs | 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 Customer Service at (800) 200-3242 . | |

Charges in excess of the allowable amount do not count toward the calendar year copayment maximum.

- 1) After the calendar year copayment maximum is met Blue Shield Life covers many benefits at 100 percent of the allowable amount.
- 2) For more information on First Dollar Services coverage, see page 2.

Three Categories of Care

Active Choice Plans give you more control over your benefits and out-of-pocket expenses. Under this plan, you have affordable coverage across three categories of healthcare services without paying up-front deductibles for Categories One and Two. In the first category, you receive a set amount of healthcare dollars – these dollars cover routine physician office services and outpatient professional and diagnostic services. At the same time, you have valuable protection against the costly impact of hospital services and prescription drugs through more traditional benefits of coinsurance and copayments. To help you understand each category of care, we've outlined your coverage below.

Category One. Preventive Care, Outpatient Professional and Diagnostic Services

Each Calendar Year, the member has a set amount to spend on the category of preventive care services, outpatient professional and diagnostic care:

- With Active Choice Plan 500 – Up to \$500 per individual and \$1,000 per family

(Each insured family member has access to the entire amount of the family First Dollar Services)

It's up to you to decide how to spend these amounts on the services covered under Category One, which provides for First Dollar Services coverage. This category includes a wide range of services to pick from, such as outpatient professional and diagnostic care, including physician office visits, testing, screenings, and mental health services. For these services you can choose your own physician from our broad, statewide network of preferred providers, to stretch your dollars even further. If you choose a non-preferred provider, First Dollar Services only cover the allowable amount, and you are responsible for the remainder of the costs. In addition, once the First Dollar Services coverage is spent, you are responsible for 100 percent of medical costs until the calendar year copayment maximum is met.

Also, as long as you are a member of this plan through your current employer, you can roll over unused dollars starting from the 2004 calendar year and thereafter in this category of care. Each insured family member may use any or all of the family carryover credit. Any amounts covered in this category do not apply to the calendar year copayment maximum.

Category Two. Outpatient and Inpatient Services – Including Emergency Care Services

When you need care the most, you can rely on immediate coverage. If an unexpected illness or injury happens, this category includes emergency care and surgery in hospitals and facilities (including professional services associated with such facility services). We share the cost of care with you at the following levels:

- With Active Choice Plan 500 – the member pays 20 percent for preferred providers, 50 percent of the allowable amount for non-preferred providers. (some copayments may apply)

Category Three. Coverage for Prescription Drugs

To keep prescription drugs affordable, Active Choice Plans provide immediate coverage for generic drugs.

- No generic drug deductible
- Coverage includes covered brand-name drugs
- Prescription drug coverage includes no annual benefit maximums
- The copayments and any applicable brand-name drug deductible for prescription drugs do not accrue to your calendar year copayment maximum

The following benefits and services do not accrue towards the calendar year copayment maximum. This means that coinsurance, copayments and charges for services that are not included in the calculation of the calendar year copayment maximum remain the member's responsibility, even after the copayment maximum has been reached.

- Copayments and any applicable brand-name drug deductible for prescription drugs.
- Any charges above the allowable amounts. When members use non-preferred providers, they must pay the applicable coinsurance or copayments plus any amount that exceeds Blue Shield Life's allowable amount. These charges above the allowable amount do not count toward the calendar year copayment maximum.
- First Dollar Services payments or First Dollar Services carryover credit.

Active ChoiceSM Plan 500

Benefit Summary (For groups of 51 and above)

Blue Shield of California Life & Health Insurance Company

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.

Highlights: \$500 individual/
\$1,000 family first dollar services amount

Effective July 1, 2010

The Active Choice Plan has three categories of benefit coverage.

Category One: Preventive Care, Outpatient Professional and Diagnostic

Category Two: Outpatient & Inpatient Surgery

Category Three: Outpatient Prescription Drugs

| Benefits | Member Responsibility | |
|---|---|--|
| | Preferred Providers ² | Non-Preferred Providers ² |
| <ul style="list-style-type: none"> Calendar Year Medical Deductible Calendar Year Copayment Maximum (For many covered services) | <p>\$0 per individual/\$0 per family</p> <p>\$5,000 per individual/ \$10,000 per family</p> | <p>\$10,000 per individual / \$20,000 per family</p> |
| LIFETIME MAXIMUM | \$6,000,000 | |

| Covered Services | First Dollar Services & Member Responsibility | |
|------------------|---|--|
|------------------|---|--|

Category One: Outpatient Professional And Diagnostic¹

PROFESSIONAL SERVICES

Professional (physician) benefits

- Physician and specialist office visits
- Outpatient X-ray, pathology and laboratory
- Diagnostic testing

Allergy testing and treatment benefits

- Office visits (includes visits for allergy serum injections)

PREVENTIVE SERVICES

(As recommended by the United States Preventive Services Task Force)

- Annual routine physical examination, vision and hearing screening, and immunizations
- Routine laboratory services, including annual mammography, Papanicolaou test, or cervical cancer and human papillomavirus (HPV) screening
- Well baby care (includes: Eye/ear screening, immunizations and vaccinations) (Up to 7 visits per calendar year)
- Well baby laboratory

DURABLE MEDICAL EQUIPMENT

- Durable medical equipment services

PROSTHETICS/ORTHOTICS

- Prosthetic equipment and devices
- Orthotic equipment and devices

MENTAL HEALTH SERVICES (PSYCHIATRIC)³

- Outpatient mental health services

OTHER

Chiropractic benefits

- Chiropractic services - provided by a chiropractor

Rehabilitation services (physical, occupational and respiratory therapy)

- In an office location

The \$500 individual or \$1,000 family First Dollar Services covers any combination of covered outpatient professional and diagnostic services and supplies. Each insured family member has access to the entire amount of the family First Dollar Services. These services are paid at 100 percent of the allowable amount². The member is responsible for all charges above the \$500 individual or \$1,000 family First Dollar Services amount until the member's maximum calendar year copayment amount has been reached.¹

Once the member's maximum calendar year copayment has been reached, many benefits will be paid at 100 percent of the allowable amount. The member's responsibility for charges over the allowable amount does not accrue to the calendar year copayment maximum. Outpatient chiropractic services are only covered under the \$500 individual/ \$1,000 family First Dollar Services amount. After the First Dollar Services limit is reached, these services are no longer covered until the next calendar year.

Speech therapy benefits

- In an office location

Pregnancy and maternity care benefits

- Prenatal and postnatal physician office visits (Initial office visit to determine the diagnosis only)
All subsequent office visits for prenatal and postnatal care, including professional services for delivery and inpatient hospital services are covered under "Hospitalization Services"

Family planning benefits

- Counseling and consulting
- Elective abortion⁴
- Tubal ligation⁴
- Vasectomy⁴

Diabetes care benefits

- Devices, equipment and non-testing supplies (For testing supplies, see "Outpatient Prescription Drug Coverage Summary")
- Diabetes self-management training (If billed by your provider, you will also be responsible for the office visit copayment)

| Covered Services | Member Coinsurance | |
|--|----------------------------------|---|
| Category Two: Outpatient & Inpatient Surgery – including emergency care services | | |
| OUTPATIENT SERVICES | Preferred Providers ² | Non-Preferred Providers ² |
| Hospital benefits (facility services) | | |
| The maximum allowed charges 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 50% of this \$350 per day, plus all charges in excess of \$350. | | |
| • Outpatient surgery performed in a Participating Ambulatory Surgery Center (ASC) ⁵ | \$250 per surgery + 20% | 50% |
| • Outpatient surgery in a hospital | \$400 per surgery + 20% | 50% |
| • Outpatient services for treatment of illness or injury and necessary supplies | 20% | 50% |
| • Bariatric Surgery (pre-authorization required; medically necessary surgery for weight loss, only for morbid obesity) ⁷ | \$400 per surgery + 20% | 50% |
| HOSPITALIZATION SERVICES | | |
| Hospital benefits (facility services) | | |
| • Inpatient physician benefits, associated with inpatient or outpatient surgery and procedures (Including pregnancy and maternity care and services for medical acute detoxification) | 20% | 50% |
| • Semi-private room and board, medically necessary services and supplies | \$500 per admission + 20% | 50% ⁶ |
| • Bariatric Surgery (pre-authorization required; medically necessary surgery for weight loss, only for morbid obesity) ⁷ | \$500 per admission + 20% | 50% ⁶ |
| Skilled nursing facility benefits⁸ | | |
| (Combined maximum of up to 100 preauthorized days per calendar year; semi-private accommodations) | | |
| • Skilled nursing free standing facility | 20% | 20% with prior authorization ⁸ |
| • Skilled nursing facility unit of a hospital | 20% | 50% ⁶ |
| EMERGENCY HEALTH COVERAGE | | |
| • Emergency room services not resulting in admission (If ER services do not result in a direct admission the Calendar-Year Deductible does not apply) | 20% | 20% |
| • Emergency room services resulting in admission (When the member is admitted directly from the ER) | \$500 per admission + 20% | \$500 per admission + 20% |
| • Emergency room physician services | 20% | 20% |
| AMBULANCE SERVICES | | |
| • Emergency or authorized transport | 20% | 20% |
| MENTAL HEALTH SERVICES (PSYCHIATRIC)³ | MHSA Participating | MHSA Non-Participating |

| | | |
|--|---|--|
| • Inpatient hospital facility services | Providers² \$500 per admission + 20% | Providers² 50% ⁶ |
|--|---|--|

**CHEMICAL DEPENDENCY SERVICES
(SUBSTANCE ABUSE)¹⁰, Please see footnote 9**

| | | |
|--|-------------|-------------|
| • Chemical dependency and substance abuse services | Not covered | Not covered |
|--|-------------|-------------|

HOME HEALTH SERVICES¹¹

| | Preferred Providers² | Non-Preferred Providers² |
|--|--|--|
| • Home health care agency services (Maximum of 100 prior authorized visits per calendar year) | 20% | Not covered ¹¹ |
| • Home infusion/home injectable therapy and infusion nursing visits provided by a home infusion agency | 20% | Not covered ¹¹ |

(See "Prescription Drug Coverage" for home self-administered injectables)

OTHER

Hospice program benefits¹¹

| | | |
|--------------------------------|-----------|---------------------------|
| • Routine home care | No charge | Not covered ¹¹ |
| • Inpatient respite care | No charge | Not covered ¹¹ |
| • 24-hour continuous home care | 20% | Not covered ¹¹ |
| • General inpatient care | 20% | Not covered ¹¹ |

Care Outside of Plan Service Area

| | | |
|-------------------------------------|------------------------|------------------------|
| • Within US: BlueCard Program | See Applicable Benefit | See Applicable Benefit |
| • Outside of US: BlueCard Worldwide | See Applicable Benefit | See Applicable Benefit |

Benefits provided through the BlueCard Program for out-of-state emergency and non-emergency care, are provided at the Preferred Level of the local BlueCross and BlueShield Association Plan's Allowable Amount, when members use a BlueCross and BlueShield Association Plan provider. The \$500 individual or \$1,000 family First Dollar Services amount covers any combination of outpatient professional services and supplies, including benefits provided through the BlueCard Program.

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

Covered Services **Member Coinsurance**

Category Three: Outpatient Prescription Drugs

PRESCRIPTION DRUG COVERAGE 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 Customer Service at 800-200-3242.

1 Copayments marked with a "1" do not accrue to the calendar-year copayment maximum and continue to be charged after they are reached. Coinsurance or copayments for services not accruing to the member's calendar-year copayment maximum and continue to be the member's responsibility after the calendar-year copayment maximum is reached. After the First Dollar Services amount is reached, covered First Dollar Services will accrue to the calendar-year copayment maximum.

2 Member is responsible for coinsurance or copayments in addition to any charges above the allowable amounts. Preferred providers accept Blue Shield of California Life & Health Insurance Company's (Blue Shield Life'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 Coinsurance or Copayment plus any amount that exceeds Blue Shield Life's allowable amount. Charges above the allowable amount do not count toward the calendar year copayment maximum or First Dollar Services amounts. Mental health services are accessed through the Mental Health Service Administrator (MHSA) utilizing MHSA participating and MHSA non-participating providers. MHSA non-participating providers are not administered by the MHSA.

3 Mental health services are accessed through the MHSA. 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 Group Policy.

4 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.

5 Participating ambulatory surgery 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.

6 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 \$600 per day, plus all charges in excess of \$600.

7 Bariatric surgery is covered when pre-authorized by Blue Shield. 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 Blue Shield Life and Health, 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.

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

9 **Optional 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."**

10 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 Life using Blue Shield Life's preferred providers or non-preferred 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 Preferred Provider copayment.