

Shield Savings<sup>SM</sup> Plus 2400 Foundation  
Benefit Summary (For groups of 51 and above)  
(Uniform Health Plan Benefits and Coverage Matrix)

**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.**

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

Foundation plans are only available to groups within the service areas of Tulare/Kings, Mendocino/Lake, and Kern counties.

Highlights: \$2,400 individual coverage deductible  
or \$4,800 family coverage deductible

Effective January 1, 2012

|  | Preferred Providers <sup>1</sup>                           | Non-Preferred Providers <sup>1</sup>            |
|--|--|---|
| <b>Calendar Year Medical Deductible</b> (All providers combined)<br>(For individual on family coverage plan, enrollee can receive benefits for covered services once individual deductible is met.)  |  | \$2,400 per Individual /<br>\$4,800 per Family  |
| <b>Calendar Year Out-Of-Pocket Maximum<sup>1</sup></b> (Includes the plan deductible)<br>(For individual on family coverage plan, enrollee can receive 100% benefits for covered services once individual out-of-pocket maximum is met.)   |  | \$5,000 per Individual /<br>\$10,000 per Family |
| <b>LIFETIME BENEFIT MAXIMUM</b>  |  | None  |
| <b>Covered Services</b>  | <b>Member Copayment</b>                                    |   |
|  | Preferred Providers <sup>1</sup>                           | Non-Preferred Providers <sup>1</sup>            |
| <b>PROFESSIONAL SERVICES</b>   |  |   |
| <b>Professional (Physician) Benefits</b>   |  |   |
| • Physician and specialist office visits   | 20%  | 40%   |
| • CT scans, MRIs, MRAs, PET scans, and cardiac diagnostic procedures utilizing nuclear medicine <sup>2</sup> (prior authorization is required)   | 20%  | 40%   |
| • Other outpatient X-ray, pathology and laboratory (Diagnostic testing by providers other than outpatient laboratory, pathology, and imaging departments of hospitals/facilities) <sup>2</sup>   | 20%  | 40%   |
| <b>Allergy Testing and Treatment Benefits</b>  |  |   |
| • Office visits (includes visits for allergy serum injections)   | 20%  | 40%   |
| <b>Preventive Health Benefits</b>  |  |   |
| • Preventive Health Services (see the description of Preventive Health Services in the definitions section of the Certificate of Insurance for more information)   | No Charge<br>(Not subject to the Calendar-Year Deductible) | Not Covered                                     |
| <b>OUTPATIENT SERVICES</b>   |  |   |
| <b>Hospital Benefits (Facility Services)</b>   |  |   |
| 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 40% of this \$350 per day, plus all charges in excess of \$350. |  |   |
| • Outpatient surgery performed at an Ambulatory Surgery Center <sup>3</sup>  | 20%  | 40%   |
| • Outpatient surgery in a hospital   | 20%  | 40%   |
| • Outpatient Services for treatment of illness or injury and necessary supplies (Except as described under "Rehabilitation benefits")  | 20%  | 40%   |
| • CT scans, MRIs, MRAs, PET scans, and cardiac diagnostic procedures utilizing nuclear medicine performed in a hospital (prior authorization is required) <sup>2</sup>   | \$100 per visit + 20%                                      | 40%   |
| • Other outpatient X-ray, pathology and laboratory performed in a hospital <sup>2</sup>  | \$25 per visit + 20%                                       | 40%   |
| • Bariatric Surgery <sup>4</sup> (pre-authorization required; medically necessary surgery for weight loss, only for morbid obesity)  | 20%  | 40%   |
| <b>HOSPITALIZATION SERVICES</b>  |  |   |
| <b>Hospital Benefits (Facility Services)</b>   |  |   |
| • Inpatient Physician Services   | 20%  | 40%   |
| • Inpatient Non-emergency Facility Services (Semi-private room and board, medically necessary services and supplies)   | 20%  | 40% <sup>5</sup>                                |
| • Bariatric Surgery <sup>4</sup> (pre-authorization required; medically necessary surgery for weight loss, only for morbid obesity)  | 20%  | 40% <sup>5</sup>                                |
| <b>Skilled Nursing Facility Benefits<sup>6</sup></b><br>(Combined maximum of up to 100 preauthorized days per calendar year; semi-private accommodations)  |  |   |
| • Services by a free-standing Skilled Nursing Facility   | 20%  | 20% <sup>6</sup>                                |
| • Skilled Nursing Unit of a Hospital   | 20%  | 40% <sup>6</sup>                                |
| <b>EMERGENCY HEALTH COVERAGE</b>   |  |   |

|  |                       |                       |
|--|-----------------------|-----------------------|
| • Emergency room Services not resulting in admission (ER Facility copay does not apply if the member is admitted directly from the ER for inpatient services.) | \$100 per visit + 20% | \$100 per visit + 20% |
| • Emergency room Services resulting in admission (When the member is admitted directly from the ER)  | 20%                   | 20%                   |
| • Emergency room Physician Services  | 20%                   | 20%                   |

#### AMBULANCE SERVICES

|                                     |     |     |
|-------------------------------------|-----|-----|
| • Emergency or authorized transport | 20% | 20% |
|-------------------------------------|-----|-----|

#### PRESCRIPTION DRUG COVERAGE<sup>7, 8, 9, 10, 11, 12, 13</sup>

(Subject to deductible; includes oral contraceptives, diaphragms, and covered diabetic drugs and testing supplies)

##### Outpatient Prescription Drug Benefits

##### Retail Prescriptions (For up to a 30-day supply)

|                                  | Participating Pharmacy | Non-Participating Pharmacy  |
|----------------------------------|------------------------|-----------------------------|
| • Formulary Generic Drugs        | \$10 per prescription  | 25% + \$10 per prescription |
| • Formulary Brand Name Drugs     | \$25 per prescription  | 25% + \$25 per prescription |
| • Non-Formulary Brand Name Drugs | \$40 per prescription  | 25% + \$40 per prescription |

##### Mail Service Prescriptions (For up to a 90-day supply)

|                                  |                       |             |
|----------------------------------|-----------------------|-------------|
| • Formulary Generic Drugs        | \$20 per prescription | Not Covered |
| • Formulary Brand Name Drugs     | \$50 per prescription | Not Covered |
| • Non-Formulary Brand Name Drugs | \$80 per prescription | Not Covered |

##### Specialty Pharmacies (For up to a 30-day supply)

|                   |  |             |
|-------------------|--|-------------|
| • Specialty Drugs | 30% up to \$150 out-of-pocket copayment maximum per prescription | Not Covered |
|-------------------|--|-------------|

#### PROSTHETICS/ORTHOTICS

|  |     |     |
|--|-----|-----|
| • Prosthetic equipment and devices (Separate office visit copay may apply) | 20% | 40% |
| • Orthotic equipment and devices (Separate office visit copay may apply)   | 20% | 40% |

#### DURABLE MEDICAL EQUIPMENT

|                             |     |     |
|-----------------------------|-----|-----|
| • Durable Medical Equipment | 20% | 40% |
|-----------------------------|-----|-----|

#### MENTAL HEALTH SERVICES (PSYCHIATRIC)<sup>14</sup>

|                                     | MHSA Participating Providers <sup>1</sup> | MHSA Non-Participating Providers <sup>1</sup> |
|-------------------------------------|---|---|
| • Inpatient Hospital Services       | 20%                                       | 40% <sup>5</sup>                              |
| • Outpatient Mental Health Services | 20%                                       | 40%   |

#### CHEMICAL DEPENDENCY SERVICES (SUBSTANCE ABUSE)<sup>15</sup>

##### Please see footnote 19

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

#### HOME HEALTH SERVICES<sup>16</sup>

|   | Preferred Providers <sup>1</sup> | Non-Preferred Providers <sup>1</sup> |
|---|----------------------------------|--------------------------------------|
| • Home health care agency Services (Up to 100 prior authorized visit maximum per Calendar Year)   | 20%                              | Not Covered <sup>16</sup>            |
| • Home infusion/home intravenous injectable therapy and infusion nursing visits provided by a Home Infusion Agency (See "Prescription Drug Coverage" for specialty drugs) | 20%                              | Not Covered <sup>16</sup>            |

#### OTHER

##### Hospice Program Benefits<sup>16</sup>

|                                |           |                           |
|--------------------------------|-----------|---------------------------|
| • Routine home care            | No Charge | Not Covered <sup>16</sup> |
| • Inpatient Respite Care       | No Charge | Not Covered <sup>16</sup> |
| • 24-hour Continuous Home Care | 20%       | Not Covered <sup>16</sup> |
| • General Inpatient care       | 20%       | Not Covered <sup>16</sup> |

##### Chiropractic Benefits<sup>17</sup>

|  |     |     |
|--|-----|-----|
| • Chiropractic Services - provided by a chiropractor (Up to 20 visits per Calendar Year) | 20% | 50% |
|--|-----|-----|

##### Acupuncture Benefits

|               |             |             |
|---------------|-------------|-------------|
| • Acupuncture | Not Covered | Not Covered |
|---------------|-------------|-------------|

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

|                   |     |     |
|-------------------|-----|-----|
| • Office location | 20% | 50% |
|-------------------|-----|-----|

##### Speech Therapy Benefits

|                   |     |     |
|-------------------|-----|-----|
| • Office location | 20% | 40% |
|-------------------|-----|-----|

##### Pregnancy and Maternity Care Benefits

|   |     |     |
|---|-----|-----|
| • Prenatal and Postnatal Physician Office Visits (For inpatient hospital services, see "Hospitalization Services.") | 20% | 40% |
|---|-----|-----|

##### Family Planning Benefits

|                             |     |             |
|-----------------------------|-----|-------------|
| • Counseling and consulting | 20% | Not Covered |
|-----------------------------|-----|-------------|

|                                   |     |             |
|-----------------------------------|-----|-------------|
| • Tubal ligation <sup>18</sup>    | 20% | Not Covered |
| • Elective abortion <sup>18</sup> | 20% | Not Covered |
| • Vasectomy <sup>18</sup>         | 20% | Not Covered |

**Diabetes Care Benefits**

|   |     |     |
|---|-----|-----|
| • Devices, equipment, and non-testing supplies<br>(For testing supplies, see "Outpatient Prescription Drug Benefits.")        | 20% | 40% |
| • Diabetes self-management training (If billed by your provider, you will also be responsible for the office visit copayment) | 20% | 40% |

**Care Outside of Plan Service Area** (Benefits provided through the BlueCard®

Program) Benefits provided through 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 World         | See Applicable Benefit | See Applicable Benefit |
| • Outside of US: BlueCard Worldwide | See Applicable Benefit | See Applicable Benefit |

**Optional Benefits**

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

- 1 Member is responsible for copayment in addition to any charges above allowable amounts. The coinsurance indicated is a percentage of allowed 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 in excess of the allowable amount do not count toward the calendar-year deductible or out-of-pocket maximum. Payments applied to your Calendar Year Deductible accrue towards the Maximum Calendar Year Out-of-Pocket Responsibility.
- 2 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.
- 3 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.
- 4 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.
- 5 The maximum allowed charge for non-emergency hospital services received from a non-preferred hospital is \$600 per day. Members are responsible for 40 percent of this \$600 per day, plus all charges in excess of \$600. Payments that exceed the allowed charge do not count toward the calendar-year out-of-pocket maximum, and continue to be charged after it is reached.
- 6 Services may require prior authorization by Blue Shield. When services are prior authorized, members pay the preferred or participating provider amount.
- 7 This plan's prescription drug coverage is on average equivalent to or better than the standard benefit set by the federal government for Medicare Part D (also called creditable coverage). Because this plan's prescription drug coverage is creditable, you do not have to enroll in a Medicare prescription drug plan while you maintain this coverage. However, you should be aware that if you have a subsequent break in this coverage of 63 days or more anytime after you were first eligible to enroll in a Medicare prescription drug plan, you could be subject to a late enrollment penalty in addition to your Part D premium.
- 8 If the member requests a Brand Name Drug when a Generic Drug equivalent is available, the member is responsible for paying the difference between the cost to Blue Shield of the Brand Name Drug and its Generic Drug equivalent, as well as the applicable Generic Drug Copayment. This difference in cost that the member must pay is not applied to the Calendar Year Deductible and is not included in the Calendar Year maximum out-of-pocket responsibility calculations
- 9 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.
- 10 For the Outpatient Drugs benefit, covered drugs obtained from Non-Participating Pharmacies will be subject to and accrue to the deductible and the copay maximum for Preferred Providers.
- 11 Specialty drugs are covered only when dispensed by select pharmacies in the Specialty Pharmacy Network unless Medically Necessary for a covered emergency.
- 12 Selected formulary and non-formulary drugs require prior authorization by Blue Shield for Medical Necessity, and when effective, lower cost alternatives are available.
- 13 Specialty Drugs are specific Drugs that usually require close monitoring and are used to treat complex or chronic conditions 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. Infused or Intravenous (IV) medications are not included as Specialty Drugs. These Drugs may also require special handling, special manufacturing processes, and may have limited prescribing or limited pharmacy availability. 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.
- 14 Mental health services are accessed through Blue Shield of California Life and Health Insurance Company's Mental Health Service Administrator (MHSA) - using Blue Shield's MHSA participating and non-participating providers. Only Blue Shield MHSA contracted providers are administered by the Blue Shield MHSA. Behavioral health services rendered by non-participating providers are administered by Blue Shield. 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.
- 15 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.
- 16 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.
- 17 Chiropractic visits accrue to the calendar-year visit maximum regardless of whether the plan deductible has been met.
- 18 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.
- 19 **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."**

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