SISC
ASO Minimum Value Plan
Benefit Summary

Blue Shield of California

Highlights: $5,000 individual coverage deductible or $10,000 family coverage deductible

Effective: October 1, 2014

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.

<table>
<thead>
<tr>
<th>Covered Services</th>
<th>Preferred Providers</th>
<th>Non-Preferred Providers</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>PROFESSIONAL SERVICES</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Professional (Physician) Benefits</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Physician and specialist office visits</td>
<td>$60 per visit (for the 1st 3 visits, thereafter 30%)</td>
<td>50%</td>
</tr>
<tr>
<td></td>
<td>(Not subject to the Calendar Year Deductible)</td>
<td></td>
</tr>
<tr>
<td>• CT scans, MRIs, MRAs, PET scans, and cardiac diagnostic procedures utilizing nuclear medicine (prior authorization is required)</td>
<td>30%</td>
<td>50%</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>30%</td>
<td>50%</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>30%</td>
<td>50%</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</td>
<td>Not Covered</td>
</tr>
<tr>
<td></td>
<td>(Not subject to the Calendar Year Deductible)</td>
<td></td>
</tr>
<tr>
<td><strong>OUTPATIENT SERVICES</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hospital Benefits (Facility Services)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Outpatient surgery performed at an Ambulatory Surgery Center</td>
<td>30%</td>
<td>No Charge</td>
</tr>
<tr>
<td>• Outpatient surgery in a hospital</td>
<td>30%</td>
<td>No Charge</td>
</tr>
<tr>
<td>• Outpatient Services for treatment of illness or injury and necessary supplies (Except as described under “Rehabilitation Benefits”)</td>
<td>30%</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>30%</td>
<td>50%</td>
</tr>
<tr>
<td>• Other outpatient X-ray, pathology and laboratory performed in a hospital</td>
<td>30%</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>30%</td>
<td>No Charge</td>
</tr>
<tr>
<td><strong>HOSPITALIZATION SERVICES</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hospital Benefits (Facility Services)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Inpatient Physician Services</td>
<td>30%</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>30%</td>
<td>No Charge</td>
</tr>
<tr>
<td>• Bariatric Surgery (prior authorization required by the Plan; medically necessary surgery for weight loss, for morbid obesity only)</td>
<td>30%</td>
<td>No Charge</td>
</tr>
<tr>
<td><strong>Skilled Nursing Facility Benefits</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(Combined maximum of up to 100 prior authorized days per Calendar Year; semi-private accommodations)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Services by a free-standing Skilled Nursing Facility</td>
<td>30%</td>
<td>30%</td>
</tr>
<tr>
<td>• Skilled Nursing Unit of a Hospital</td>
<td>30%</td>
<td>50%</td>
</tr>
</tbody>
</table>
**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 + 30%
- Emergency room Services resulting in admission (when the member is admitted directly from the ER)  
  - 30%
- Emergency room Physician Services  
  - 30%

**AMBULANCE SERVICES**

- Emergency or authorized transport  
  - 30%

**PRESCRIPTION DRUG COVERAGE**¹¹, ¹², ¹³, ¹⁴, ¹⁵  
*(Subject to deductible)*

<table>
<thead>
<tr>
<th></th>
<th>Participating Pharmacy</th>
<th>Non-Participating Pharmacy</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Outpatient Prescription Drug Benefits</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Retail Prescriptions (For up to a 30-day supply)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Contraceptive Drugs and Devices</td>
<td>No Charge</td>
<td>Not Covered</td>
</tr>
<tr>
<td>Formulary Generic Drugs</td>
<td>$9 per prescription</td>
<td>$9 per prescription</td>
</tr>
<tr>
<td>Formulary Brand Name Drugs</td>
<td>$35 per prescription</td>
<td>$35 per prescription</td>
</tr>
<tr>
<td><strong>Mail Service Prescriptions</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Contraceptive Drugs and Devices</td>
<td>No Charge</td>
<td>Not Covered</td>
</tr>
<tr>
<td>Formulary Generic Drugs</td>
<td>$18 per prescription</td>
<td>Not Covered</td>
</tr>
<tr>
<td>Formulary Brand Name Drugs</td>
<td>$90 per prescription</td>
<td>Not Covered</td>
</tr>
<tr>
<td><strong>Specialty Pharmacies</strong> (up to a 30-day supply)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Specialty Drugs</td>
<td>$35 per prescription</td>
<td>Not Covered</td>
</tr>
</tbody>
</table>

**PROSTHETICS/ORTHOTICS**

- Prosthetic equipment and devices (Separate office visit copay may apply)  
  - 30%
- Orthotic equipment and devices (Separate office visit copay may apply)  
  - 30%

**DURABLE MEDICAL EQUIPMENT**

- Breast pump  
  - No Charge  
  - (Not subject to the Calendar Year Deductible)  
  - 30%
- Other Durable Medical Equipment  
  - 30%

**MENTAL HEALTH SERVICES AND SUBSTANCE ABUSE SERVICES**¹⁸, ¹⁹

- Inpatient Hospital Services/Residential Treatment  
  - 30%
- Outpatient Mental Health and Substance Abuse Services (includes professional/physician visits)  
  - $60 per visit (for the 1st 3 visits, thereafter 30%)  
  - ($60 per visit - Not subject to the Calendar Year Deductible)  
  - 30%

**HOME HEALTH SERVICES**

- Home health care agency Services (up to 100 visits per Calendar Year)  
  - 30%
- Home infusion/home intravenous injectable therapy and infusion nursing visits provided by a Home Infusion Agency  
  - 30%

**OTHER**

**Hospice Program Benefits**

- Routine home care  
  - 30%
- Inpatient Respite Care  
  - 30%
- 24-hour Continuous Home Care  
  - 30%
- General Inpatient care  
  - 10%

**Chiropractic Benefits**

- Chiropractic Services (up to 20 visits per Calendar Year)  
  - 30%

**Acupuncture Benefits**

- Acupuncture (up to 12 visits per Calendar Year)  
  - 30%

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

- Office location  
  - 30%

**Speech Therapy Benefits**

- Office Visit  
  - 30%

**Pregnancy and Maternity Care Benefits**

- Prenatal and postnatal Physician office visits  
  - (For inpatient hospital services, see *Hospitization Services.*)  
  - 30%
- Abortion services (Facility charges may apply - see *Hospital Benefits (Facility Services)*)  
  - 30%

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Family Planning Benefits
- Counseling and consulting
  - No Charge (Not subject to the Calendar Year Deductible)
  - Not Covered
- Tubal ligation
  - No Charge (Not subject to the Calendar Year Deductible)
  - Not Covered
- Vasectomy
  - 30%
  - Not Covered

Diabetes Care Benefits
- Devices, equipment, and non-testing supplies (for testing supplies see Outpatient Prescription Drug Benefits.)
  - 30%
  - 50%
- Diabetes self-management training
  - 30%
  - 50%

Hearing Aid Benefits
- Audiological evaluations
  - 30%
  - 50%
- Hearing Aid Instrument and ancillary equipment (Up to a maximum combined benefit of $700 per person every 24 months for the hearing aid and ancillary equipment)
  - 30%

Care Outside of Plan Service Area 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 Program
  - See Applicable Benefit
- Outside of US: BlueCard Worldwide
  - See Applicable Benefit

1 Unless otherwise specified, copayments/coinsurance is calculated based on allowable amounts. Preferred 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-preferred providers can charge more than these amounts. When members use non-preferred providers, they must pay the applicable deductibles, copayments or coinsurance plus any amount that exceeds Blue Shield'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 out-of-pocket maximum.
2 Copayments/Coinsurance marked with this footnote do not accrue to Calendar Year out-of-pocket maximum. Copayments/Coinsurance and charges for services not accruing to the member's Calendar Year out-of-pocket maximum continue to be the member's responsibility after the Calendar Year out-of-pocket maximum is reached. This amount could be substantial. Please refer to the Plan Contract for exact terms and conditions of coverage.
3 Participating non-Hospital based ("freestanding") 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.
4 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.
5 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.
6 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.
7 The maximum allowed charge for non-emergency hospital services received from a non-preferred hospital is $600 per day. Members are responsible for 50% 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 owed after the maximum is reached.
8 For plans with a Calendar Year deductible amount, services with a day or visit limit accrue to the Calendar Year day or visit limit maximum regardless of whether the plan deductible has been met.
9 Services may require prior authorization by the Plan. When services are prior authorized, members pay the preferred or participating provider amount.
10 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.
11 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 for 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 their Calendar Year deductible and is not included in the Calendar Year out-of-pocket maximum responsibility calculations.
12 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.
13 For the Outpatient Prescription Drugs Benefit, Covered Drugs obtained from Non-Participating Pharmacies will be subject to and accrue to the Calendar Year Deductible and the Calendar Year Out-of-Pocket Maximum for Preferred Providers.
14 Specialty drugs are covered only when dispensed by select pharmacies in the Specialty Pharmacy Network unless Medically Necessary for a covered emergency.
15 Select formulary and non-formulary drugs require prior authorization by Blue Shield for Medical Necessity, or when effective, lower cost alternatives are available.
16 Specialty Drugs are specific Drugs used to treat complex or chronic conditions which usually require close monitoring such as multiple sclerosis, hepatitis, rheumatoid arthritis, 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 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. Infused or Intravenous (IV) medications are not included as Specialty Drugs.
17 Contraceptive Drugs and Devices covered under the outpatient prescription drug benefits will not be subject to the Calendar Year deductible. If a brand-name contraceptive is requested when a generic equivalent is available, the member will be responsible for paying the difference between the cost to Blue Shield for the brand-name contraceptive and its generic drug equivalent. In addition, select contraceptives may need prior authorization to be covered without a copayment.
18 Mental health and Substance Abuse services are accessed through Blue Shield's participating and non-participating providers.
19 Inpatient services for acute detoxification are covered under the medical benefit; see the Hospital Benefits (Facility Services) section of the Plan Contract for benefit details. Services for acute medical detoxification are accessed through Blue Shield using Blue Shield participating providers.
20 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 out-of-network provider co-payment.
21 Includes insertion of IUD, as well as injectable and implantable contraceptives for women.
22 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-preferred facilities are not covered under this benefit.