Blue Shield of California

Plan G – Deductible $500/$1,000 – Copayment Maximum $1,000/$3,000

Effective October 1, 2008

<table>
<thead>
<tr>
<th>DEDUCTIBLES&lt;sup&gt;1&lt;/sup&gt; (All providers combined)</th>
<th>Preferred Providers&lt;sup&gt;2&lt;/sup&gt;</th>
<th>Non-Preferred Providers&lt;sup&gt;2&lt;/sup&gt;</th>
</tr>
</thead>
<tbody>
<tr>
<td>Calendar-year medical deductible</td>
<td>$500/$1,000</td>
<td></td>
</tr>
<tr>
<td>Calendar-year Copayment Maximum</td>
<td>$1,000/$3,000</td>
<td></td>
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<tr>
<td>LIFETIME MAXIMUM</td>
<td>$5,000,000</td>
<td></td>
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</tbody>
</table>

Covered Services

PROFESSIONAL SERVICES

Physician services
- Physician and specialist office visits
  - Preferred Providers: $10/visit<sup>1</sup>
  - Non-Preferred Providers: 50%<sup>1</sup>
- Laboratory and X-rays
  - Preferred Providers: 20%
  - Non-Preferred Providers: 50%<sup>1</sup>
- Allergy testing or treatment
  - Preferred Providers: 20%
  - Non-Preferred Providers: 50%<sup>1</sup>
- Diagnostic testing
  - Preferred Providers: 20%
  - Non-Preferred Providers: 50%<sup>1</sup>
- Surgeon and anesthetist
  - Preferred Providers: 20%
  - Non-Preferred Providers: 50%<sup>1</sup>

Preventive care
- Annual routine physical exam and immunizations for dependent children (age 0-25)
  - Preferred Providers: 20%
  - Non-Preferred Providers: 50%<sup>1</sup>
- Annual routine physical exam for employee and spouse
  - Preferred Providers: 20%
  - Non-Preferred Providers: Not covered
- Laboratory, including mammogram and Pap test screening or other FDA-approved cervical cancer screening tests (One per calendar year)
  - Preferred Providers: 20%
  - Non-Preferred Providers: 50%<sup>1</sup>

OUTPATIENT SERVICES

The maximum plan payment for non-emergency surgery and services performed in a non-participating Ambulatory Surgery Center is $350 per day. Members are responsible charges in excess of $350 per day.
- Outpatient surgery performed in a Participating Ambulatory Surgery Center<sup>3</sup>(ASC)
  - Preferred Providers: 20%
  - Non-Preferred Providers: $50 + 50%<sup>1</sup>
- Outpatient surgery in hospital/facility
  - Preferred Providers: 20%
  - Non-Preferred Providers: $50 + 50%<sup>1</sup>
- Outpatient treatment and necessary supplies
  - Preferred Providers: 20%
  - Non-Preferred Providers: $50 +50%<sup>1</sup>

HOSPITALIZATION SERVICES

Inpatient services – non-emergency
- Inpatient physician services (Including pregnancy and maternity care)
  - Preferred Providers: 20%
  - Non-Preferred Providers: 50%<sup>1</sup>
- Semi-private room and board, medically necessary services and supplies
  - Preferred Providers: 20%
  - Non-Preferred Providers: 50%<sup>1,4</sup>

Skilled nursing facility (SNF) services<sup>6</sup>
(Combined maximum of up to 100 preauthorized days per confined period; semi-private accommodations)
- Freestanding SNF
  - Preferred Providers: 20%
  - Non-Preferred Providers: 20%
- Hospital SNF unit
  - Preferred Providers: 20%
  - Non-Preferred Providers: 20%

EMERGENCY HEALTH COVERAGE
- ER facility services
  - Preferred Providers: $50 copay + 20% copay
  - Non-Preferred Providers: $50 copay + 20%
- Inpatient facility services (when the member is admitted directly from the ER)
  - Preferred Providers: 20%
  - Non-Preferred Providers: 20%
- Emergency room physician visits
  - Preferred Providers: 20%
  - Non-Preferred Providers: 20%

AMBULANCE SERVICES
- Preferred Providers: 20%
- Non-Preferred Providers: 20%

PRESCRIPTION DRUG COVERAGE
Administered by Medco Health

PROSTHETICS/ORTHOTICS<sup>5</sup> (Equipment and devices only)
- Preferred Providers: 20%
- Non-Preferred Providers: 50%<sup>1</sup>

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THIS MATRIX IS INTENDED TO BE USED TO HELP YOU COMPARE COVERAGE BENEFITS AND IS A SUMMARY ONLY. THE EVIDENCE OF COVERAGE, DISCLOSURE FORM AND PLAN CONTRACT SHOULD BE CONSULTED FOR A DETAILED DESCRIPTION OF COVERAGE BENEFITS AND LIMITATIONS.

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SISC
Blue Shield of California 80%
(Uniform Health Plan Benefits and Coverage Matrix)
<table>
<thead>
<tr>
<th><strong>DURABLE MEDICAL EQUIPMENT</strong> 5</th>
<th>20%</th>
<th>50% 1</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>MENTAL HEALTH SERVICES (PSYCHIATRIC) &amp; CHEMICAL DEPENDENCY SERVICES</strong></td>
<td>All benefits are covered by PacifiCare Behavioral Health (including acute detoxification)</td>
<td>Please contact 1-800-999-9585</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>HOME HEALTH SERVICES</strong> 6</th>
<th>(Combined maximum of 100 prior authorized visits per calendar year)</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>• Home health and home infusion care</td>
<td>20%</td>
<td>Not covered 1,8</td>
</tr>
</tbody>
</table>

**OTHER**

<table>
<thead>
<tr>
<th><strong>Hospice</strong> 8</th>
<th>($10,000 maximum per member per lifetime)</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>• Routine home care and inpatient respite care</td>
<td>20%</td>
<td>Not covered 1,8</td>
</tr>
<tr>
<td>• 24 hour continuous home care and general inpatient care</td>
<td>20%</td>
<td>Not covered 1,8</td>
</tr>
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**Alternative care**

<table>
<thead>
<tr>
<th></th>
<th>20%</th>
<th>50% 1 up to $50/visit</th>
<th>up to $25/visit</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Chiropractic services (Up to 26 visits per calendar year) 7</td>
<td>20%</td>
<td>50% 1 up to $50/visit</td>
<td>up to $25/visit</td>
</tr>
<tr>
<td>• Acupuncture services</td>
<td>20%</td>
<td>50% 1</td>
<td></td>
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**Rehabilitative therapy services**

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<thead>
<tr>
<th></th>
<th>20%</th>
<th>50% 1</th>
</tr>
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<tbody>
<tr>
<td>• Outpatient visits (medically necessary)</td>
<td>20%</td>
<td>50% 1</td>
</tr>
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</table>

**Pregnancy and maternity care**

<table>
<thead>
<tr>
<th></th>
<th>$10/visit 1</th>
<th>50% 1</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Prenatal and postnatal professional (physician) services</td>
<td>(For all necessary inpatient hospital services, see “Hospitalization Services.”)</td>
<td>(Deductible waived)</td>
</tr>
</tbody>
</table>

**Family planning**

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<thead>
<tr>
<th></th>
<th>20%</th>
<th>50% 1</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Family planning counseling</td>
<td>20%</td>
<td>50% 1</td>
</tr>
<tr>
<td>• Elective abortion, tubal ligation, vasectomy</td>
<td>20%</td>
<td>50% 1</td>
</tr>
</tbody>
</table>

**Covered out-of-state benefits**

| 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. | See Applicable Benefit Line | See Applicable Benefit Line |

**Diabetes care**

<table>
<thead>
<tr>
<th></th>
<th>20%</th>
<th>50% 1</th>
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<tbody>
<tr>
<td>• Equipment, devices and non-testing supplies</td>
<td>20%</td>
<td>50% 1</td>
</tr>
<tr>
<td>• Self-management training and education</td>
<td>$10/visit 1</td>
<td>50% 1</td>
</tr>
</tbody>
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| (Deductible waived) |

**Hearing Aid**

<table>
<thead>
<tr>
<th></th>
<th>20%</th>
<th>20%</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Hearing aid and examination (maximum combined benefit payment of $1,000 per person every 36 months for hearing aid and ancillary equipment)</td>
<td>20%</td>
<td>20%</td>
</tr>
</tbody>
</table>

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1 Deductible and copayments marked with a (1) 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 Evidence of Coverage, the Disclosure Form and the Plan Contract for exact terms and conditions of coverage.

2 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.

3 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.

4 The maximum plan payment for non-emergency hospital services received from a Non-Preferred Hospital is $580 per day. Members are responsible for all charges in excess of $580.

5 Requires prior authorization for benefits over $500.

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

7 All chiropractic visits accrue to the calendar year visit maximum regardless of whether the plan deductible has been met.

8 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.

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