## EIA Health/Small Group Program
### ASO EPO Medicare
#### Benefit Summary
(Uniform Health Plan Benefits and Coverage Matrix)

**Blue Shield of California**

**Effective:** January 1, 2015

<table>
<thead>
<tr>
<th>Covered Services</th>
<th>Member Copayment</th>
<th>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 (Physicians include OB/GYN, Pediatrician, Internal Medicine, Family Practice, General Practice)</td>
<td>$30 per visit</td>
<td>(Not subject to the Calendar-Year Deductible)</td>
</tr>
<tr>
<td>• CT scans, MRIs, MRAs, PET scans, and cardiac diagnostic procedures utilizing nuclear medicine (prior authorization is required)(^3)</td>
<td>No Charge</td>
<td></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)(^3)</td>
<td>No Charge</td>
<td>(Not subject to the Calendar-Year Deductible)</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>No Charge</td>
<td></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></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(^4)</td>
<td>No Charge</td>
<td></td>
</tr>
<tr>
<td>• Outpatient surgery in a hospital</td>
<td>No Charge</td>
<td></td>
</tr>
<tr>
<td>• Outpatient Services for treatment of illness or injury and necessary supplies (Except as described under &quot;Rehabilitation Benefits&quot;)</td>
<td>No Charge</td>
<td></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)(^7)</td>
<td>$100 per visit</td>
<td></td>
</tr>
<tr>
<td>• Other outpatient X-ray, pathology and laboratory performed in a hospital(^3)</td>
<td>$25 per visit</td>
<td></td>
</tr>
<tr>
<td>• Bariatric Surgery (prior authorization required by the Plan; medically necessary surgery for weight loss, for morbid obesity only)(^5)</td>
<td>No Charge</td>
<td></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>No Charge</td>
<td></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>No Charge</td>
<td></td>
</tr>
<tr>
<td>• Bariatric Surgery (prior authorization required by the Plan; medically necessary surgery for weight loss, for morbid obesity only)(^5)</td>
<td>No Charge</td>
<td></td>
</tr>
<tr>
<td><strong>Skilled Nursing Facility Benefits(^7,10)</strong> (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>No Charge</td>
<td></td>
</tr>
<tr>
<td>• Skilled Nursing Unit of a Hospital</td>
<td>No Charge</td>
<td></td>
</tr>
</tbody>
</table>

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\(^1\) 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.

\(^2\) Deductible applies to all services, including where member copayment is stated as No Charge, unless next to service it explicitly states deductible is waived.

\(^3\) The plan contract should be consulted for a detailed description of coverage benefits and limitations.

\(^4\) ([Outside Ambulatory Care Centers & Hospitals](https://www.bluehealth.com/ambulatory-care-center))

\(^5\) ([Outside Ambulatory Care Centers & Hospitals](https://www.bluehealth.com/ambulatory-care-center))

\(^6\) ([Outside Ambulatory Care Centers & Hospitals](https://www.bluehealth.com/ambulatory-care-center))

\(^7\) ([Outside Ambulatory Care Centers & Hospitals](https://www.bluehealth.com/ambulatory-care-center))

\(^8\) ([Outside Ambulatory Care Centers & Hospitals](https://www.bluehealth.com/ambulatory-care-center))

\(^9\) ([Outside Ambulatory Care Centers & Hospitals](https://www.bluehealth.com/ambulatory-care-center))
EMERGENCY HEALTH COVERAGE

- Emergency room Services not resulting in admission (Copayment does not apply if the member is directly admitted to the hospital for inpatient services)  $100 per visit
- Emergency room Services resulting in admission (when the member is admitted directly from the ER)  No Charge
- Emergency room Physician Services  No Charge

AMBULANCE SERVICES
- Emergency or authorized transport  $50 per transport

PROSTHETICS/ORTHOTICS
- Prosthetic equipment and devices (Separate office visit copay may apply) 20%
- Orthotic equipment and devices (Separate office visit copay may apply) 20%

DURABLE MEDICAL EQUIPMENT
- Breast pump  No Charge
- Other Durable Medical Equipment  20%

MENTAL HEALTH AND SUBSTANCE ABUSE SERVICES
- Inpatient Hospital Services  No Charge
- Residential care  No Charge
- Outpatient Mental Health and Substance Abuse Services  $30 per visit (Not subject to the Calendar-Year Deductible)

HOME HEALTH SERVICES
- Home health care agency Services (up to 100 prior authorized visits per Calendar Year)  $30 per visit
- Home infusion/home intravenous injectable therapy and infusion nursing visits provided by a Home Infusion Agency  No Charge

OTHER

Hospice Program Benefits
- Routine home care  No Charge
- Inpatient Respite Care  No Charge
- 24-hour Continuous Home Care  No Charge
- General Inpatient care  No Charge

Chiropractic Benefits
- Chiropractic Services  $30 per visit (up to 26 visits per Calendar Year combined with Acupuncture services)

Acupuncture Benefits
- Acupuncture  $30 per visit (up to 26 visits per Calendar Year combined with Chiropractic services)

Rehabilitation Benefits (Physical, Occupational and Respiratory Therapy)
- Office location  $30 per visit

Speech Therapy Benefits
- Office location  $30 per visit

Pregnancy and Maternity Care Benefits
- Prenatal and postnatal Physician office visits (For inpatient hospital services, see “Hospitalization Services.”)  No Charge
- Abortion services  No Charge

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

Diabetes Care Benefits
- Devices, equipment, and non-testing supplies  No Charge
- Diabetes self-management training  $30 per visit (Not subject to the Calendar-Year Deductible)

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

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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.
2 Includes insertion of IUD as well as injectable contraceptives for women.
Participating ambulatory surgery and 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 surgery services or 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.

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.

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.

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 may require prior authorization by the Plan.

Mental health and substance abuse services are accessed using Blue Shield's participating providers.

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.

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.

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

(1/15) ASO jt082514 091614
## Benefit Overview

Express Scripts Medicare® (PDP) for EIA

**YOUR 2015 PRESCRIPTION DRUG PLAN BENEFIT**

The benefit described in this document is your final benefit after combining the standard Medicare Part D benefit with additional coverage being provided by EIA. The following table provides a summary of your benefit, including final cost-sharing information. This plan provides coverage across all stages of your benefit.

<table>
<thead>
<tr>
<th>Tier</th>
<th>Retail One-Month (31-day) Supply</th>
<th>Retail Two-Month (60-day) Supply</th>
<th>Retail Three-Month (90-day) Supply</th>
<th>Home Delivery Three-Month (90-day) Supply</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tier 1: Generic Drugs</td>
<td>$5 copayment</td>
<td>$10 copayment</td>
<td>$15 copayment</td>
<td>$10 copayment</td>
</tr>
<tr>
<td>Tier 2: Preferred Brand Drugs</td>
<td>$20 copayment</td>
<td>$40 copayment</td>
<td>$60 copayment</td>
<td>$40 copayment</td>
</tr>
<tr>
<td>Tier 3: Non-Preferred Brand Drugs</td>
<td>$50 copayment</td>
<td>$100 copayment</td>
<td>$150 copayment</td>
<td>$100 copayment</td>
</tr>
</tbody>
</table>

If your doctor prescribes less than a full month’s supply of certain drugs, you will pay a daily cost-sharing rate based on the actual number of days of the drug that you receive.

You may receive up to a 90-day supply of certain maintenance drugs (medications taken on a long-term basis) by mail through our home delivery service. There is no charge for standard shipping.

Not all drugs are available at a 90-day supply, and not all retail pharmacies offer a 90-day supply. Please contact Express Scripts Medicare Customer Service at the numbers on the back of this document for more information.
Coverage Gap stage

After your total yearly drug costs reach $2,960, you will continue to pay the same cost-sharing amount as in the Initial Coverage stage until your yearly out-of-pocket drug costs reach $4,700.

Catastrophic Coverage stage

After your yearly out-of-pocket drug costs (what you and others pay on your behalf, including manufacturer discounts but excluding payments made by your Medicare prescription drug plan) reach $4,700, you will pay the greater of 5% coinsurance or:

- a $2.65 copayment for covered generic drugs (including brand drugs treated as generics), with a maximum not to exceed the standard copayment during the Initial Coverage stage
- a $6.60 copayment for all other covered drugs, with a maximum not to exceed the standard copayment during the Initial Coverage stage.

Long-Term Care (LTC) Pharmacy

If you reside in a long-term care facility, you pay the same as at a network retail pharmacy. Long-term care pharmacies must dispense brand-name drugs in amounts less than a 14-day supply at a time. They may also dispense less than a one month’s supply of generic drugs at a time. Contact your plan if you have questions about cost-sharing or billing when less than a one-month supply is dispensed.

Out-of-Network Coverage

For prescriptions filled at out-of-network pharmacies, you will pay the same copayments as for prescriptions filled at in-network retail pharmacies. If you go to an out-of-network pharmacy and try to use your member ID card to fill a prescription, the pharmacy may not be able to submit the claim directly to us. When that happens, you will have to pay the full cost of your prescription and the plan will reimburse you for your share of the cost. You will need to send us your request for payment, along with your receipt documenting the payment you have made. It’s a good idea to make a copy of all of your receipts for your records. For information on how to submit a claim, please review the information provided in the Quick Reference Guide included with your Welcome Kit, contact Customer Service at the numbers at the end of this document or visit our website to download a copy of the “Direct Claim Form.”

IMPORTANT PLAN INFORMATION

- The service area for this plan is all 50 states, the District of Columbia, and Puerto Rico. You must live in one of these areas to participate in this plan. We may reduce our service area and no longer offer services in the area in which you reside.
- You may get your drugs at retail pharmacies and our home delivery pharmacy.
- Your plan uses a formulary—a list of covered drugs. Express Scripts may periodically add or remove drugs, make changes to coverage limitations on certain drugs, or change how much you pay for a drug. If any formulary change limits your ability to fill a prescription, you will be notified before the change is made.
- The plan may require you to first try one drug to treat your condition before it will cover another drug for that condition.
• Your healthcare provider must get prior authorization from Express Scripts Medicare for certain drugs.
• If the actual cost of a drug is less than the normal cost-sharing amount for that drug, you will pay the actual cost, not the higher cost-sharing amount.
• If you request an exception for a drug and Express Scripts Medicare approves the exception, you will pay the Non-Preferred Brand Drug cost-share for that drug.
• You must continue to pay your Medicare Part B premium, if not otherwise paid for under Medicaid or by another third party, even if your Medicare Part D plan premium is $0.

ANSWERS TO FREQUENTLY ASKED QUESTIONS

Who is eligible for this plan?
You are eligible for this plan if you are entitled to Medicare Part A and/or are enrolled in Medicare Part B, live in the plan’s service area, and are eligible for benefits from EIA.

You can be in only one Medicare prescription drug plan at a time. If you are currently enrolled in a Medicare Advantage (MA) Plan that includes Medicare prescription drug coverage, your enrollment in this plan may end that enrollment. In addition, you may not be enrolled in an individual MA Plan—even one without prescription drug coverage—at the same time as this plan. You may, however, be enrolled in this plan and an MA-only plan if it has been coordinated through your employer. Please contact your group benefits administrator if you have questions about other plan types and the impact your enrollment in this plan may have.

Important: If you choose a prescription drug plan outside your former employer/retiree group’s offering, this decision may impact other benefits, such as medical coverage. Please contact your group benefits administrator for more information before making a decision to leave this plan, or for information about other options that may be available to you.

Do I qualify for Extra Help to pay for my prescription drug premiums and costs?
To see if you qualify for Extra Help, call Medicare at 1.800.MEDICARE (1.800.633.4227), 24 hours a day, 7 days a week (TTY users should call 1.877.486.2048); the Social Security Office at 1.800.772.1213 between 7 a.m. and 7 p.m., Monday through Friday (TTY users should call 1.800.325.0778); or your State Medicaid Office. If you qualify, Medicare will tell the plan how much assistance you will receive, and Express Scripts will send you information on the amount you will pay once you are enrolled in this plan.

Will my income affect my Medicare Part D premium?
Most people will pay their plan’s standard Medicare Part D premium. However, some people may have to pay an extra amount because of their yearly income. If your modified adjusted gross income as reported on your IRS tax return from two years ago (the most recent tax return information provided to Social Security by the IRS) is more than $85,000 for individuals and married individuals filing separately or $170,000 for married individuals filing jointly, you’ll have to pay extra for your Medicare prescription drug coverage. This extra amount is called the income-related monthly adjustment amount. If you have to pay an extra amount, Social Security—not your Medicare plan—will send a letter telling
you what the extra amount will be and how to pay it. No matter how your plan premium is paid, the extra amount will be withheld from your Social Security or Office of Personnel Management benefit check. If your benefit check isn’t enough to cover the extra amount, you will get a bill from Medicare. The extra amount must be paid separately and cannot be paid with your monthly plan premium. If you have any questions about this extra amount, contact Social Security at 1.800.772.1213 between 7 a.m. and 7 p.m., Monday through Friday. TTY users should call 1.800.325.0778.

Does my plan cover Medicare Part B or non–Part D drugs?
This plan does not cover drugs that are covered under Medicare Part B as prescribed and dispensed. Generally, we only cover drugs, vaccines, biological products and medical supplies associated with the delivery of insulin that are covered under the Medicare prescription drug benefit (Part D) and that are on our formulary. However, in addition to providing coverage of Medicare Part D drugs, this plan does cover some non–Part D medications that are not normally covered by a Medicare prescription drug plan. The amounts paid for these medications will not count toward your total drug costs or total out-of-pocket expenses. Please call Customer Service for additional information about specific drug coverage and your cost-sharing amount.

The benefit information provided is a brief summary, not a complete description of benefits. For more information, contact Express Scripts Medicare. Limitations, copayments and restrictions may apply. Benefits, formulary, pharmacy network, premium and/or copayments/coinsurance may change on January 1 of each year.

Express Scripts Medicare Customer Service
1.844.468.0428
24 hours a day, 7 days a week
We have free language interpreter services available for non-English speakers.
TTY: 1.800.716.3231

You can also visit us on the Web at www.Express-Scripts.com.

This document may be available in braille. Please call Customer Service at the phone numbers listed above for assistance.

For questions about premiums, enrollment and eligibility, please contact the Benefits Office at the Organization from which you retired.

Express Scripts Medicare (PDP) is a prescription drug plan with a Medicare contract. Enrollment in Express Scripts Medicare depends on contract renewal.

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