

# **EXHIBIT B**

## Summary of benefits for the Blue Cross and Blue Shield Service Benefit Plan Basic Option – 2008

**Do not rely on this chart alone.** All benefits are subject to the definitions, limitations, and exclusions in this brochure. On this page we summarize specific expenses we cover; for more detail, look inside.

If you want to enroll or change your enrollment in this Plan, be sure to put the correct enrollment code from the cover on your enrollment form.

Basic Option does not provide benefits when you use Non-preferred providers. For a list of the exceptions to this requirement, see page 13. There is no deductible for Basic Option.

Basic Option Benefits	You pay	Page
<b>Medical services provided by physicians:</b>		
<ul style="list-style-type: none"> <li>Diagnostic and treatment services provided in the office</li> </ul>	PPO: \$20 per office visit for primary care physicians and other health care professionals; \$30 per office visit for specialists Non-PPO: You pay all charges	28-30
<b>Services provided by a hospital:</b>		
<ul style="list-style-type: none"> <li>Inpatient</li> </ul>	PPO: \$100 per day up to \$500 per admission Non-PPO: You pay all charges	63-65
<ul style="list-style-type: none"> <li>Outpatient</li> </ul>	PPO: \$40 per day per facility Non-PPO: You pay all charges	66-68
<b>Emergency benefits:</b>		
<ul style="list-style-type: none"> <li>Accidental injury</li> </ul>	PPO: \$50 copayment for emergency room care; \$30 copayment for urgent care Non-PPO: \$50 copayment for emergency room care	73-75
<ul style="list-style-type: none"> <li>Medical emergency</li> </ul>	Same as for accidental injury	73, 76-77
<b>Mental health and substance abuse treatment</b>	In-Network (PPO): Regular cost-sharing, such as \$20 office visit copayment (prior approval required); \$100 per day up to \$500 per inpatient admission Out-of-Network (Non-PPO): You pay all charges	78-84
<b>Prescription drugs</b>	Retail Pharmacy Program: <ul style="list-style-type: none"> <li>PPO: \$10 generic/\$30 formulary brand-name per prescription/50% coinsurance (\$35 minimum) for non-formulary brand-name drugs. 34-day maximum supply on initial prescription; up to 90 days for refills with 3 copayments</li> <li>Non-PPO: You pay all charges</li> </ul>	85-92
<b>Dental care</b>	PPO: \$20 copayment per evaluation (exam, cleaning, and X-rays); most services limited to 2 per year; sealants for children up to age 16; \$20 copayment for dental services required due to accidental injury; regular benefits for covered oral and maxillofacial surgery Non-PPO: You pay all charges	52, 93-94, 98
<b>Special features:</b> Flexible benefits option; online customer and claims service; 24-hour nurse line; services for deaf and hearing impaired; Web accessibility for the visually impaired; travel benefit/services overseas; health support programs; and Healthy Families Program		99
<b>Protection against catastrophic costs</b> (your catastrophic protection out-of-pocket maximum)	Nothing after \$5,000 (PPO) per contract per year; some costs do not count toward this protection	20-21