Simple Savings 2500/5000  
Benefit Summary (For groups 2 to 50)  
(Uniform Health Plan Benefits and Coverage Matrix)  
Blue Shield of California Life & Health Insurance Company  
Effective January 1, 2013  

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.

<table>
<thead>
<tr>
<th><strong>DEDUCTIBLE</strong></th>
<th><strong>Preferred Providers</strong></th>
<th><strong>Non-Preferred Providers</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Calendar Year Medical Deductible</strong></td>
<td>$2,500 per Individual / $5,000 per Family</td>
<td>$2,500 per Individual / $5,000 per Family</td>
</tr>
<tr>
<td><strong>Calendar Year Out-of-Pocket Maximum</strong></td>
<td>$3,500 per Individual / $7,000 per Family</td>
<td>$10,000 per Individual / $20,000 per Family</td>
</tr>
</tbody>
</table>

**LIFETIME BENEFIT MAXIMUM**: None

### Covered Services

#### Professional (Physician) Benefits
- **Physician and specialist office visits**: 20% preferred, 50% non-preferred
- **CT scans, MRIs, MRAs, PET scans, and cardiac diagnostic procedures utilizing nuclear medicine**: 20% preferred, 50% non-preferred
- **Other outpatient X-ray, pathology and laboratory**: 20% preferred, 50% non-preferred

#### Allergy Testing and Treatment Benefits
- **Office visits (includes visits for allergy serum injections)**: 20% preferred, 50% non-preferred

#### Preventive Health Benefits
- **Preventive Health Services (As required by applicable federal and California law.)**
  - No Charge (Not subject to the Calendar Year Medical Deductible)
  - Not Covered

### Outpatient Services

#### Hospital Benefits (Facility Services)
- **Outpatient surgery performed at an Ambulatory Surgery Center**: 10% preferred, 50% non-preferred
- **Outpatient surgery in a hospital**: 20% preferred, 50% non-preferred
- **Outpatient Services for treatment of illness or injury and necessary supplies (Except as described under "Rehabilitation Benefits")**: 20% preferred, 50% non-preferred
- **CT scans, MRIs, MRAs, PET scans, and cardiac diagnostic procedures utilizing nuclear medicine performed in a hospital**: $100 per visit + 20% preferred, 50% non-preferred
- **Other outpatient X-ray, pathology and laboratory performed in a hospital**: 20% preferred, 50% non-preferred
- **Bariatric Surgery**: 20% preferred, 50% non-preferred

### Hospitalization Services

#### Hospital Benefits (Facility Services)
- **Inpatient Physician Services**: 20% preferred, 50% non-preferred
- **Inpatient non-Emergency Facility Services (Semi-private room and board, and medically-necessary Services and supplies, including Subacute Care)**: 20% preferred, 50% non-preferred
- **Bariatric Surgery**: 20% preferred, 50% non-preferred

#### Skilled Nursing Facility Benefits
- **Skilled Nursing Facility Benefits (Combined maximum of up to 100 prior authorized days per Calendar Year; semi-private accommodations)**
  - **Services by a free-standing Skilled Nursing Facility**: 20% preferred, 50% non-preferred
  - **Skilled Nursing Unit of a Hospital**: 20% preferred, 50% non-preferred
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 + 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 (surface or air) 20% 20%

PRESCRIPTION DRUG COVERAGE\(^{10, 11, 12, 13}\) (Subject to deductible)

<table>
<thead>
<tr>
<th>Participating Pharmacy</th>
<th>Non-Participating Pharmacy</th>
</tr>
</thead>
<tbody>
<tr>
<td>Retail Prescriptions (up to a 30-day supply)</td>
<td></td>
</tr>
<tr>
<td>- Contraceptive Drugs and Devices(^{14}) No Charge Not Covered</td>
<td></td>
</tr>
<tr>
<td>- Formulary Generic Drugs $10 per prescription Not Covered</td>
<td></td>
</tr>
<tr>
<td>- Formulary Brand Name Drugs $30 per prescription Not Covered</td>
<td></td>
</tr>
<tr>
<td>- Non-Formulary Brand Name Drugs $50 per prescription Not Covered</td>
<td></td>
</tr>
<tr>
<td>Mail Service Prescriptions (up to a 90-day supply)</td>
<td></td>
</tr>
<tr>
<td>- Contraceptive Drugs and Devices(^{14}) No Charge Not Covered</td>
<td></td>
</tr>
<tr>
<td>- Formulary Generic Drugs $20 per prescription Not Covered</td>
<td></td>
</tr>
<tr>
<td>- Formulary Brand Name Drugs $60 per prescription Not Covered</td>
<td></td>
</tr>
<tr>
<td>- Non-Formulary Brand Name Drugs $100 per prescription Not Covered</td>
<td></td>
</tr>
<tr>
<td>Specialty Pharmacies (up to a 30-day supply)</td>
<td></td>
</tr>
<tr>
<td>- Specialty Drugs (May require prior authorization from Blue Shield Life Pharmacy Services. Specialty drugs are covered only when dispensed by select participating pharmacies in the Specialty Pharmacy Network. Drugs from non-participating pharmacies are not covered except in emergency and urgent situations. Mail service prescriptions are not covered.) 30% per prescription Not Covered</td>
<td></td>
</tr>
</tbody>
</table>

PROSTHETICS/ORTHOTICS

- Prosthetic equipment and devices (Separate office visit copay may apply) 20% Not Covered
- Orthotic equipment and devices (Separate office visit copay may apply) 20% Not Covered

DURABLE MEDICAL EQUIPMENT

- Breast pump No Charge Not Covered
- Other Durable Medical Equipment 50% Not Covered

MENTAL HEALTH SERVICES (PSYCHIATRIC)\(^{15}\)

<table>
<thead>
<tr>
<th>MHSA Participating Providers(^{1})</th>
<th>MHSA Non-Participating Providers(^{1})</th>
</tr>
</thead>
<tbody>
<tr>
<td>Inpatient Hospital Services 20% 50%(^{7})</td>
<td></td>
</tr>
<tr>
<td>Outpatient visits for severe mental health conditions 20% 50%</td>
<td></td>
</tr>
<tr>
<td>Outpatient visits for non-severe mental health conditions(^{8}) (up to 20 visits per Calendar Year combined with outpatient chemical dependency visits) 50% Not Covered</td>
<td></td>
</tr>
</tbody>
</table>

CHEMICAL DEPENDENCY SERVICES (SUBSTANCE ABUSE)\(^{15}\)

Please see footnote 19

- Inpatient Hospital Services for medical acute detoxification 20% 50%\(^{7}\)
- Outpatient visits\(^{6}\) (up to 20 visits per Calendar Year combined with outpatient non-severe mental health visits) 50% Not Covered

HOME HEALTH SERVICES

<table>
<thead>
<tr>
<th>Preferred Providers(^{1})</th>
<th>Non-Preferred Providers(^{1})</th>
</tr>
</thead>
<tbody>
<tr>
<td>Home health care agency Services(^{8}) (up to 100 prior authorized visits per Calendar Year) 20% Not Covered(^{16})</td>
<td></td>
</tr>
<tr>
<td>Home infusion/home intravenous injectable therapy and infusion nursing visits provided by a Home Infusion Agency 20% Not Covered(^{16})</td>
<td></td>
</tr>
</tbody>
</table>

OTHER

Hospice Program Benefits

- Routine home care No Charge Not Covered\(^{16}\)
- Inpatient Respite Care No Charge Not Covered\(^{16}\)
- 24-hour Continuous Home Care 20% Not Covered\(^{16}\)
- General Inpatient care 20% Not Covered\(^{16}\)

Chiropractic Benefits\(^{8}\)

- Chiropractic Services (up to 20 visits per Calendar Year) 20% 50%
**Acupuncture Benefits**
- Acupuncture: Not Covered

**Rehabilitation Benefits**
- Office location (up to 12 visits per Calendar Year; visit limit combines Outpatient Physical, Occupational, Respiratory, and Speech Therapy Services): 20% of the benefit is provided separately. 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.

**Pregnancy and Maternity Care Benefits**
- Prenatal and postnatal Physician office visits (For inpatient hospital services, see "Hospitalization Services.")
  - Not Covered
  - Not Covered

**Family Planning Benefits**
- Counseling and consulting
  - No Charge
  - (Not subject to the Calendar Year Medical Deductible)

**Diabetes Care Benefits**
- Devices, equipment, and non-testing supplies (for testing supplies see Outpatient Prescription Drug Benefits.)
  - Not Covered

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

**Optional Benefits**
- Optional dental, vision, substance abuse treatment and infertility benefits are available. If your employer purchased any of these benefits, a description of the benefit is provided separately.
Mental health and chemical dependency services, other than medical acute detoxification, are accessed through Blue Shield Life’s Mental Health Service Administrator (MHSA) - using Blue Shield Life MHSA participating and non-participating providers. Only Blue Shield Life MHSA-contracted providers are administered by the Blue Shield Life MHSA. Behavioral health services rendered by non-participating providers are administered by Blue Shield Life. Services for medical acute detoxification are accessed through Blue Shield Life using Blue Shield Life’s preferred providers or non-preferred providers. 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 the group policy.

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.

Includes insertion of IUD as well as injectable contraceptives for women.

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. Non-preferred facilities are not covered under this benefit.

Optional inpatient 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.

Pending Regulatory Approval