

Simple Savings 4500/9000†
 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, 2012

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.

DEDUCTIBLE	Preferred Providers ¹	Non-Preferred Providers ¹
Calendar Year Medical Deductible (For family coverage, there is no individual deductible. All family members will receive benefits for covered services once the full family deductible has been satisfied by one, or any combination of family members.)	\$4,500 per individual/\$9,000 per family	\$4,500 per individual/\$9,000 per family
Calendar Year Out-Of-Pocket Maximum (Includes the medical plan deductible. For family coverage, there is no individual out-of-pocket maximum. All family members will receive 100% benefits for covered services once the full family out-of-pocket maximum has been satisfied by one, or any combination of family members.)	\$5,500 per individual/\$11,000 per family	\$10,000 per individual/\$20,000 per family

LIFETIME BENEFIT MAXIMUM None

Covered Services	Member Copayment	
<i>Benefits are subject to the plan's Calendar Year deductible unless otherwise noted.</i>		

PROFESSIONAL SERVICES	Preferred Providers ¹	Non-Preferred Providers ¹
Professional (Physician) Benefits		
<ul style="list-style-type: none"> Physician and specialist office visits 	20%	50%
<ul style="list-style-type: none"> Other outpatient X-ray, pathology and laboratory (Diagnostic testing by providers other than outpatient laboratory, pathology, and imaging departments of hospitals/facilities)¹⁶ 	20%	50%
<ul style="list-style-type: none"> CT scans, MRIs, MRAs, PET scans, and cardiac diagnostic procedures utilizing nuclear medicine (prior authorization is required)¹⁶ 	20%	50%
Allergy Testing and Treatment Benefits		
<ul style="list-style-type: none"> Office visits (includes visits for allergy serum injections) 	20%	50%
Preventive Health Benefits		
<ul style="list-style-type: none"> Preventive Health Services (see the description of Preventive Health Services in the definitions section of <i>Certificate of Insurance</i> for more information) 	No charge ² (not subject to the Calendar Year Deductible)	Not covered

OUTPATIENT SERVICES

Hospital Benefits (Facility Services)		
<ul style="list-style-type: none"> Outpatient surgery performed at an Ambulatory Surgery Center³ 	10%	50% ⁴
<ul style="list-style-type: none"> Outpatient surgery in a hospital 	20%	50% ⁴
<ul style="list-style-type: none"> Outpatient Services for treatment of illness or injury and necessary supplies (Except as described under "Rehabilitation benefits") 	20%	50% ⁴

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Covered Services	Member Copayment	
<ul style="list-style-type: none"> Bariatric Surgery (prior authorization required by the Plan; medically necessary surgery for weight loss, for morbid obesity only)⁵ CT scans, MRIs, MRAs, PET scans, and cardiac diagnostic procedures utilizing nuclear medicine performed in a hospital (prior authorization is required)¹⁶ Other outpatient X-ray, pathology and laboratory performed in a hospital¹⁶ 	20%	50% ⁴
	\$100 per visit + 20%	50% ⁴
	20%	50% ⁴
HOSPITALIZATION SERVICES		
Hospital Benefits (Facility Services)		
<ul style="list-style-type: none"> Inpatient Physician Services 	20%	50%
<ul style="list-style-type: none"> Inpatient Non-emergency Facility Services (Semi-private room and board, and medically necessary Services and supplies, including Subacute Care) 	20%	50% ⁴
<ul style="list-style-type: none"> Bariatric Surgery⁵ (prior authorization required by the Plan; medically necessary surgery for weight loss, for morbid obesity only) 	20%	50% ⁴
Skilled Nursing Facility Benefits⁶		
(Combined maximum of up to 100 prior authorized days per Calendar Year; semi-private accommodations)		
<ul style="list-style-type: none"> Services by a free-standing Skilled Nursing Facility 	20%	20%
<ul style="list-style-type: none"> Skilled Nursing Unit of a Hospital 	20%	50% ⁴
EMERGENCY HEALTH COVERAGE		
<ul style="list-style-type: none"> 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%
<ul style="list-style-type: none"> Emergency room Services resulting in admission (when the member is admitted directly from the ER) 	20%	20%
<ul style="list-style-type: none"> Emergency room Physician Services 	20%	20%
AMBULANCE SERVICES		
<ul style="list-style-type: none"> Emergency or authorized transport (surface or air) 	20%	20%
PRESCRIPTION DRUG COVERAGE^{7, 8, 9, 15}		
(Subject to deductible; includes oral contraceptives, diaphragms, and covered diabetic drugs and testing supplies)		
Retail Prescriptions (up to a 30-day supply)		
<ul style="list-style-type: none"> Formulary Generic Drugs 	\$10 per prescription	Not covered
<ul style="list-style-type: none"> Formulary Brand Name Drugs 	\$30 per prescription	Not covered
<ul style="list-style-type: none"> Non-Formulary Brand Name Drugs 	\$50 per prescription	Not covered
Mail Service Prescriptions (up to a 90-day supply)		
<ul style="list-style-type: none"> Formulary Generic Drugs 	\$20 per prescription	Not covered
<ul style="list-style-type: none"> Formulary Brand Name Drugs 	\$60 per prescription	Not covered
<ul style="list-style-type: none"> Non-Formulary Brand Name Drugs 	\$100 per prescription	Not covered
Specialty Pharmacies (up to a 30-day supply)		
<ul style="list-style-type: none"> 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. Mail service prescriptions are not covered. Drugs from non-participating pharmacies are not covered except in emergency and urgent situations.) 	30% per prescription	Not covered

Covered Services	Member Copayment	
PROSTHETICS/ORTHOTICS	Preferred Providers¹	Non-Preferred Providers¹
<ul style="list-style-type: none"> Prosthetic equipment and devices (Separate office visit copay may apply.) Orthotic equipment and devices (Separate office visit copay may apply.) 	20%	Not covered
DURABLE MEDICAL EQUIPMENT		
<ul style="list-style-type: none"> Durable Medical Equipment 	50%	Not covered
MENTAL HEALTH SERVICES (PSYCHIATRIC)¹⁰	MHSA Participating Providers¹	MHSA Non-Participating Providers¹
<ul style="list-style-type: none"> Inpatient Hospital Services Outpatient visits for severe mental health conditions Outpatient visits for non-severe mental health conditions (up to 20 visits per Calendar Year combined with outpatient chemical dependency visits)¹¹ 	20%	50% ⁴
	20%	50%
	50%	Not covered
CHEMICAL DEPENDENCY SERVICES (SUBSTANCE ABUSE)¹⁰, PLEASE SEE FOOTNOTE 14		
<ul style="list-style-type: none"> Inpatient Hospital Services for medical acute detoxification Outpatient visits (up to 20 visits per Calendar Year combined with outpatient non-severe mental health visits)¹¹ 	20%	50% ⁴
	50%	Not covered
HOME HEALTH SERVICES	Preferred Providers¹	Non-Preferred Providers¹
<ul style="list-style-type: none"> Home health care agency Services (up to 100 prior authorized visits per Calendar Year) Home infusion/home intravenous injectable therapy and infusion nursing visits provided by a Home Infusion Agency 	20%	Not covered ¹²
	20%	Not covered ¹²
OTHER		
Hospice Program Benefits		
<ul style="list-style-type: none"> Routine home care Inpatient Respite Care 24-hour Continuous Home Care General Inpatient care 	No charge	Not covered ¹²
	No charge	Not covered ¹²
	20%	Not covered ¹²
	20%	Not covered ¹²
Chiropractic Benefits		
<ul style="list-style-type: none"> Chiropractic Services (up to 20 visits per Calendar Year)¹¹ 	20%	50%
Acupuncture Benefits		
<ul style="list-style-type: none"> Acupuncture 	Not covered	Not covered
Rehabilitation Benefits		
<ul style="list-style-type: none"> Office location (up to 12 visits per Calendar Year; visit limit combines Outpatient, Physical, Occupational, Respiratory, and Speech Therapy Services) 	20%	50%
Pregnancy and Maternity Care Benefits		
<ul style="list-style-type: none"> Prenatal and postnatal Physician office visits (For inpatient hospital services, see "Hospitalization Services.") 	20%	50%

Covered Services

Member Copayment

Family Planning Benefits

• Counseling and consulting	20%	Not covered
• Elective abortion ¹³	20%	Not covered
• Tubal ligation ¹³	20%	Not covered
• Vasectomy ¹³	20%	Not covered

Diabetes Care Benefits

• Devices, equipment, and non-testing supplies (for testing supplies see Outpatient Prescription Drug Coverage)	50%	Not covered
• Diabetes self-management training (If billed by your provider, you will also be responsible for the office visit copayment)	20%	50%

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	See Applicable Benefit
• Outside of US: BlueCard Worldwide	See Applicable Benefit	See Applicable Benefit

Optional Benefits

Optional dental, vision, substance abuse treatment or infertility benefits are available. If your employer purchased any of these benefits, a description of the benefit is provided separately.

1 Member is responsible for copayment in addition to any charges above allowable amounts. The coinsurance indicated is a percentage of allowed amounts. Preferred providers accept Blue Shield of California Life & Health Insurance Company's (Blue Shield Life) 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 Life's allowable amount. Charges above 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 Maximum Calendar Year Out-of-Pocket Responsibility.

2 The preventive care and well-baby care office visit do not apply toward the plan deductible. Other covered non-preventive services received during or in connection with the office visit are subject to the plan deductible and the applicable copayment percentage.

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 allowed charges for non-emergency hospital services received from a non-preferred hospital is \$600 per day. Members are responsible for 50 percent of this \$600 per day, plus all charges in excess of \$600. 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. Payments that exceed the allowed charge do not count toward the Calendar Year out-of-pocket maximum.

5 Bariatric surgery is covered when pre-authorized by Blue Shield Life. 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 of bariatric services from non-preferred providers. In addition, if prior authorized by Blue Shield Life, 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 *Certificate of Insurance* for further benefit details.

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

7 If the member requests a brand-name drug and a generic drug equivalent is available, the member is responsible for paying the difference between the cost to Blue Shield Life of the brand-name drug and its generic drug equivalent, as well as the applicable generic drug copayment. This difference in cost that the Subscriber must pay is not applied to the Calendar Year Deductible and is not included in the Calendar Year maximum out-of-pocket responsibility calculations.

8 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.

This plan's prescription drug coverage provides less coverage on average than the standard benefit set by the federal government for Medicare Part D (also called non-creditable coverage). It is important to know that generally you may only enroll in a Medicare Part D plan from October 15th through December 7th of each year. If you do not enroll in a Medicare Part D plan when you are first eligible to join, you may be subject to a late enrollment penalty in addition to your Part D premium when you enroll at a later date. For more information about your current plan's prescription drug coverage, call the Customer Service at 1-888-239-6469, Monday through Thursday between 8:00 a.m. and 5:00 p.m. or on Friday between 9:00 a.m. and 5:00 p.m. The hearing impaired may call the TTY number at 1-888-239-6482.

9 For the Outpatient Drugs benefit, covered drugs obtained from Non-Participating Pharmacies will be subject to and accrue to the deductible and the copayment maximum for Preferred Providers.

10 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 group policy.

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- 11 All outpatient non-severe mental health, outpatient substance abuse, and chiropractic visits accrue to the Calendar Year visit maximum regardless of whether the plan deductible has been met.
- 12 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 benefits.
- 13 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.
- 14 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".**
- 15 Specialty Drugs are specific Drugs used to treat complex or chronic conditions which usually require close monitoring such as multiple sclerosis, hepatitis, rheumatoid arthritis, cancers, 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. Infused or Intravenous (IV) medications are not included as Specialty Drugs. These 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.
- 16 Participating 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 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.

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

[†]Pending regulatory approval