Benefit Sheet

	Blue Shield Bronze Tandem PPO Savings 5300/40% OffEx (Narrow Network)	
Benefit	**In Network**	**Out of Network**
Individual Ded	$5,300	$10,600
Family Ded	$10,600 (embedded)	$21,200 (embedded)
Individual OOP Max	$6,900 (incl ded)	$13,800 (incl ded)
Family OOP Max	$13,800 (incl ded)	$27,600 (incl ded)
Co-insurance	40%	50%
Lifetime Max	Unlimited	Unlimited
PC/Specialist	40% after ded	50% after ded
Adult Preventive Care	No charge	Not covered
Child Preventive Care	No charge	Not covered
Pre/Postnatal Care	No charge	50% after ded
Physical Therapy	40% after ded	50% after ded
Chiropractic Care	50% after ded; 20 visits/cal yr	50% after ded; 20 visits/cal yr
Inpatient Hospital	40% after ded	50% after ded; $2,000 benefit max/day
Inpatient Surgery	40% after ded	50% after ded
Maternity Delivery/IP	40% after ded	50% after ded
Mental Health IP	40% after ded	50% after ded; $2,000 benefit max/day
Substance Abuse IP	40% after ded	50% after ded; $2,000 benefit max/day
Outpatient Facility	40% after ded/$200 + 40% after ded (ASC/Hospital)	50% after ded; $350 benefit max/day
Outpatient Surgery	40% after ded	50% after ded
Lab/X-Ray	40% after ded	50% after ded; $350 benefit max/day Hospital
Advanced Radiology	40% after ded/$100 + 40% after ded (FS/Hospital)	50% after ded; $350 benefit max/day Hospital
Mental Health OP	40% after ded	50% after ded
Substance Abuse OP	40% after ded	50% after ded
Emergency Room	$250 (waived if admitted) + 40% after ded	$250 (waived if admitted) + 40% after ded
Ambulance	40% after ded	40% after ded
Urgent Care	40% after ded	50% after ded
Rx Generic	40% after ded; $500 max/script	Not covered
Rx Preferred	40% after ded; $500 max/script	Not covered
Rx Non-Preferred	40% after ded; $500 max/script	Not covered
Rx Specialty	40% after ded; $500 max/script	Not covered
Rx Mail Order	2x retail copay	Not covered
Home Health Care	40% after ded; 100 visits/cal yr	Not covered
Skilled Nursing	40% after ded; 100 days/benefit period	40%/50% after ded (FS/Hosp); $2,000 benefit max/day Hosp; 100 days/benefit period
Infertility Treatment	Not covered	Not covered
DME	50% after ded	Not covered
Hospice Services	0% after ded	Not covered
Pediatric Vision	Covered; See brochure	Covered; See brochure
Pediatric Dental	Covered; See brochure	Covered; See brochure

Benefit Sheet

	Blue Shield Gold Tandem PPO 1200/35 OffEx (Narrow Network)	
Benefit	**In Network**	**Out of Network**
Individual Ded	$1,200	$2,400
Family Ded	$2,400	$4,800
Individual OOP Max	$7,800 (incl ded)	$13,850 (incl ded)
Family OOP Max	$15,600 (incl ded)	$27,700 (incl ded)
Co-insurance	20%	40%
Lifetime Max	Unlimited	Unlimited
PC/Specialist	$35/$50 ded waived	40% after ded
Adult Preventive Care	No charge	Not covered
Child Preventive Care	No charge	Not covered
Pre/Postnatal Care	No charge	40% after ded
Physical Therapy	20% after ded	40% after ded
Chiropractic Care	$10 ded waived; 20 visits/cal yr	50% after ded; 20 visits/cal yr
Inpatient Hospital	20% after ded	40% after ded; $2,000 benefit max/day
Inpatient Surgery	20% after ded	40% after ded
Maternity Delivery/IP	20% after ded	40% after ded
Mental Health IP	20% after ded	40% after ded; $2,000 benefit max/day
Substance Abuse IP	20% after ded	40% after ded; $2,000 benefit max/day
Outpatient Facility	20% after ded/$150 + 20% after ded (ASC/Hospital)	40% after ded; $350 benefit max/day
Outpatient Surgery	20% after ded	40% after ded
Lab/X-Ray	L-$35 ded waived/20% after ded; X-$50/$100 ded waived (FS/Hospital)	40% after ded; $350 benefit max/day Hospital
Advanced Radiology	20% after ded/$100 + 20% after ded (FS/Hospital)	40% after ded; $350 benefit max/day Hospital
Mental Health OP	$35 ded waived	40% after ded
Substance Abuse OP	$35 ded waived	40% after ded
Emergency Room	$250 (waived if admitted) + 20% after ded	$250 (waived if admitted) + 20% after ded
Ambulance	20% after ded	20% after ded
Urgent Care	$35 ded waived	40% after ded
Rx Generic	$10/$15 ded waived	Not covered
Rx Preferred	$40/$60 after $300	Not covered
Rx Non-Preferred	$70/$100 after $300	Not covered
Rx Specialty	30% after $300; $250 max/script	Not covered
Rx Mail Order	2x retail copay	Not covered
Home Health Care	20% after ded; 100 visits/cal yr	Not covered
Skilled Nursing	20% after ded; 100 days/benefit period	20%/40% after ded (FS/Hosp); $2,000 benefit max/day Hosp; 100 days/benefit period
Infertility Treatment	Not covered	Not covered
DME	50% after ded	Not covered
Hospice Services	0% after ded	Not covered
Pediatric Vision	Covered; See brochure	Covered; See brochure
Pediatric Dental	Covered; See brochure	Covered; See brochure

Benefit Sheet

	Blue Shield Gold Tandem PPO 500/30 OffEx (Narrow Network)	
Benefit	**In Network**	**Out of Network**
Individual Ded	$500	$1,000
Family Ded	$1,000	$2,000
Individual OOP Max	$7,800 (incl ded)	$13,850 (incl ded)
Family OOP Max	$15,600 (incl ded)	$27,700 (incl ded)
Co-insurance	20%	40%
Lifetime Max	Unlimited	Unlimited
PC/Specialist	$30/$50 ded waived	40% after ded
Adult Preventive Care	No charge	Not covered
Child Preventive Care	No charge	Not covered
Pre/Postnatal Care	No charge	40% after ded
Physical Therapy	20% after ded	40% after ded
Chiropractic Care	$10 ded waived; 20 visits/cal yr	50% after ded; 20 visits/cal yr
Inpatient Hospital	20% after ded	40% after ded; $2,000 benefit max/day
Inpatient Surgery	20% after ded	40% after ded
Maternity Delivery/IP	20% after ded	40% after ded
Mental Health IP	20% after ded	40% after ded; $2,000 benefit max/day
Substance Abuse IP	20% after ded	40% after ded; $2,000 benefit max/day
Outpatient Facility	20% after ded/$150 + 20% after ded (ASC/Hospital)	40% after ded; $350 benefit max/day
Outpatient Surgery	20% after ded	40% after ded
Lab/X-Ray	L-$30 ded waived/20% after ded; X-$50/$100 ded waived (FS/Hospital)	40% after ded; $350 benefit max/day Hospital
Advanced Radiology	20% after ded/$100 + 20% after ded (FS/Hospital)	40% after ded; $350 benefit max/day Hospital
Mental Health OP	$30 ded waived	40% after ded
Substance Abuse OP	$30 ded waived	40% after ded
Emergency Room	$250 (waived if admitted) + 20% after ded	$250 (waived if admitted) + 20% after ded
Ambulance	20% after ded	20% after ded
Urgent Care	$30 ded waived	40% after ded
Rx Generic	$15/$20 ded waived	Not covered
Rx Preferred	$50/$70 after $100	Not covered
Rx Non-Preferred	$80/$110 after $100	Not covered
Rx Specialty	30% after $100; $250 max/script	Not covered
Rx Mail Order	2x retail copay	Not covered
Home Health Care	20% after ded; 100 visits/cal yr	Not covered
Skilled Nursing	20% after ded; 100 days/benefit period	20%/40% after ded (FS/Hosp); $2,000 benefit max/day Hosp; 100 days/benefit period
Infertility Treatment	Not covered	Not covered
DME	50% after ded	Not covered
Hospice Services	0% after ded	Not covered
Pediatric Vision	Covered; See brochure	Covered; See brochure
Pediatric Dental	Covered; See brochure	Covered; See brochure

Benefit Sheet

	Blue Shield Silver Tandem PPO 2300/45 OffEx (Narrow Network)	
Benefit	**In Network**	**Out of Network**
Individual Ded	$2,300	$4,600
Family Ded	$4,600	$9,200
Individual OOP Max	$7,800 (incl ded)	$13,850 (incl ded)
Family OOP Max	$15,600 (incl ded)	$27,700 (incl ded)
Co-insurance	40%	50%
Lifetime Max	Unlimited	Unlimited
PC/Specialist	$45/$70 ded waived	50% after ded
Adult Preventive Care	No charge	Not covered
Child Preventive Care	No charge	Not covered
Pre/Postnatal Care	No charge	50% after ded
Physical Therapy	40% after ded	50% after ded
Chiropractic Care	$15 ded waived; 20 visits/cal yr	50% after ded; 20 visits/cal yr
Inpatient Hospital	40% after ded	50% after ded; $2,000 benefit max/day
Inpatient Surgery	40% after ded	50% after ded
Maternity Delivery/IP	40% after ded	50% after ded
Mental Health IP	40% after ded	50% after ded; $2,000 benefit max/day
Substance Abuse IP	40% after ded	50% after ded; $2,000 benefit max/day
Outpatient Facility	40% after ded/$250 + 40% after ded (ASC/Hospital)	50% after ded; $350 benefit max/day
Outpatient Surgery	40% after ded	50% after ded
Lab/X-Ray	L-$45 ded waived/40% after ded; X-$80/$130 ded waived (FS/Hospital)	50% after ded; $350 benefit max/day Hospital
Advanced Radiology	40% after ded/$150 + 40% after ded (FS/Hospital)	50% after ded; $350 benefit max/day Hospital
Mental Health OP	$45 ded waived	50% after ded
Substance Abuse OP	$45 ded waived	50% after ded
Emergency Room	$350 (waived if admitted) + 40% after ded	$350 (waived if admitted) + 40% after ded
Ambulance	40% after ded	40% after ded
Urgent Care	$45 ded waived	50% after ded
Rx Generic	$20/$25 ded waived	Not covered
Rx Preferred	$75/$100 after $300	Not covered
Rx Non-Preferred	$115/$155 after $300	Not covered
Rx Specialty	40% after $300; $250 max/script	Not covered
Rx Mail Order	2x retail copay	Not covered
Home Health Care	40% after ded; 100 visits/cal yr	Not covered
Skilled Nursing	40% after ded; 100 days/benefit period	40%/50% after ded (FS/Hosp); $2,000 benefit max/day Hosp; 100 days/benefit period
Infertility Treatment	Not covered	Not covered
DME	50% after ded	Not covered
Hospice Services	0% after ded	Not covered
Pediatric Vision	Covered; See brochure	Covered; See brochure
Pediatric Dental	Covered; See brochure	Covered; See brochure

Group Medical Proposal

Prepared For	Effective Date	Zip (County)	Employer Contribution
Teach Inc. by Simpolicy Insurance Solutions, LLC on September 09, 2021	December 01, 2020	90047 (Los Angeles)	EE: 0% Dep: 0%

Table Rates

Zip:90047 (Los Angeles) 12/01/2020 Monthly

Age	Blue Shield Region 16 Bronze Tandem PPO Savings 5300/40% OffEx	Blue Shield Region 16 Gold Tandem PPO 1200/35 OffEx	Blue Shield Region 16 Gold Tandem PPO 500/30 OffEx	Blue Shield Region 16 Silver Tandem PPO 2300/45 OffEx
0 -14	218.16	280.54	293.18	252.64
15 -15	237.55	305.47	319.24	275.10
16 -16	244.97	315.01	329.20	283.69
17 -17	252.38	324.54	339.16	292.27
18 -18	260.37	334.81	349.89	301.52
19 -19	268.35	345.08	360.63	310.77
20 -20	276.62	355.71	371.74	320.35
21 -21	285.18	366.71	383.24	330.25
22 -22	285.18	366.71	383.24	330.25
23 -23	285.18	366.71	383.24	330.25
24 -24	285.18	366.71	383.24	330.25
25 -25	286.32	368.18	384.77	331.57
26 -26	292.02	375.51	392.43	338.18
27 -27	298.87	384.32	401.63	346.11
28 -28	309.99	398.62	416.58	358.98
29 -29	319.12	410.35	428.84	369.55
30 -30	323.68	416.22	434.97	374.84
31 -31	330.52	425.02	444.17	382.76
32 -32	337.37	433.82	453.37	390.69
33 -33	341.65	439.32	459.12	395.64
34 -34	346.21	445.19	465.25	400.93
35 -35	348.49	448.12	468.31	403.57
36 -36	350.77	451.06	471.38	406.21
37 -37	353.05	453.99	474.45	408.85
38 -38	355.33	456.93	477.51	411.50
39 -39	359.90	462.79	483.64	416.78
40 -40	364.46	468.66	489.78	422.06
41 -41	371.30	477.46	498.97	429.99
42 -42	377.86	485.90	507.79	437.59
43 -43	386.99	497.63	520.05	448.15
44 -44	398.40	512.30	535.38	461.36
45 -45	411.80	529.53	553.39	476.89
46 -46	427.77	550.07	574.85	495.38
47 -47	445.74	573.17	599.00	516.19
48 -48	466.27	599.58	626.59	539.96
49 -49	486.52	625.61	653.80	563.41
50 -50	509.33	654.95	684.46	589.83
51 -51	531.86	683.92	714.74	615.92
52 -52	556.67	715.83	748.08	644.65
53 -53	581.77	748.10	781.80	673.72
54 -54	608.86	782.93	818.21	705.09
55 -55	635.95	817.77	854.62	736.46
56 -56	665.32	855.54	894.09	770.48
57 -57	694.98	893.68	933.95	804.83
58 -58	726.64	934.39	976.49	841.48
59 -59	742.32	954.56	997.56	859.65
60 -60	773.98	995.26	1040.10	896.31
61 -61	801.35	1030.47	1076.89	928.01
62 -62	819.32	1053.57	1101.04	948.82
63 -63	841.85	1082.54	1131.31	974.91
64 -99	855.54	1100.14	1149.71	990.76

This report doesn't include rider rates in the premium.