



Summary of Benefits

Group Plan
PPO Plan

Full PPO Combined Deductible 25-250 90/60

This Summary of Benefits shows the amount you will pay for Covered Services under this Blue Shield of California Plan. It is only a summary and it is included as part of the Evidence of Coverage (EOC).¹ Please read both documents carefully for details.

Medical Provider Network:

Full PPO Network

This Plan uses a specific network of Health Care Providers, called the Full PPO provider network. Providers in this network are called Participating Providers. You pay less for Covered Services when you use a Participating Provider than when you use a Non-Participating Provider. You can find Participating Providers in this network at blueshieldca.com.

Calendar Year Deductibles (CYD)²

A Calendar Year Deductible (CYD) is the amount a Member pays each Calendar Year before Blue Shield pays for Covered Services under the Plan. Blue Shield pays for some Covered Services before the Calendar Year Deductible is met, as noted in the Benefits chart below.

When using a Participating³ or Non-Participating⁴ Provider

| | | |
|----------------------------------|---------------------|-------------------|
| Calendar Year medical Deductible | Individual coverage | \$250 |
| | Family coverage | \$250: individual |
| | | \$750: Family |

Calendar Year Out-of-Pocket Maximum⁵

An Out-of-Pocket Maximum is the most a Member will pay for Covered Services each Calendar Year. Any exceptions are listed in the Notes section at the end of this Summary of Benefits.

No Annual or Lifetime Dollar Limit

Under this Plan there is no annual or lifetime dollar limit on the amount Blue Shield will pay for Covered Services.

| | When using a Participating Provider ³ | When using any combination of Participating ³ or Non-Participating ⁴ Providers |
|---------------------|--|--|
| Individual coverage | \$3,750 | \$7,750 |
| Family coverage | \$3,750: individual | \$7,750: individual |
| | \$7,500: Family | \$15,500: Family |

Benefits⁶
Your payment

| | When using a Participating Provider ³ | CYD ² applies | When using a Non-Participating Provider ⁴ | CYD ² applies |
|---|--|-----------------------------|--|-----------------------------|
| Preventive Health Services⁷ | | | | |
| Preventive Health Services | \$0 | | Not covered | |
| California Prenatal Screening Program | \$0 | | \$0 | |
| Physician services | | | | |
| Primary care office visit | \$25/visit | | 40% | ✓ |
| Specialist care office visit | \$25/visit | | 40% | ✓ |
| Physician home visit | \$25/visit | | 40% | ✓ |
| Physician or surgeon services in an Outpatient Facility | 10% | ✓ | 40% | ✓ |
| Physician or surgeon services in an inpatient facility | 10% | ✓ | 40% | ✓ |
| Other professional services | | | | |
| Other practitioner office visit <i>Includes nurse practitioners, physician assistants, and therapists.</i> | \$25/visit | | 40% | ✓ |
| Acupuncture services <i>Up to 20 visits per Member, per Calendar Year.</i> | \$25/visit | | 40% | ✓ |
| Chiropractic services <i>Up to 20 visits per Member, per Calendar Year.</i> | \$25/visit | | 40% | ✓ |
| Teladoc consultation | \$0 | | Not covered | |
| Family planning | | | | |
| • Counseling, consulting, and education | \$0 | | Not covered | |
| • Injectable contraceptive, diaphragm fitting, intrauterine device (IUD), implantable contraceptive, and related procedure. | \$0 | | Not covered | |
| • Tubal ligation | \$0 | | Not covered | |
| • Vasectomy | 10% | ✓ | Not covered | |
| Podiatric services | \$25/visit | | 40% | ✓ |
| Medical nutrition therapy, not related to diabetes | 10% | ✓ | 40% | ✓ |
| Pregnancy and maternity care | | | | |
| Physician office visits: prenatal and postnatal | 10% | ✓ | 40% | ✓ |
| Abortion and abortion-related services | \$0 | | \$0 | |

| | When using a Participating Provider ³ | CYD ² applies | When using a Non-Participating Provider ⁴ | CYD ² applies |
|---|--|--------------------------|--|--------------------------|
| Emergency Services | | | | |
| Emergency room services | \$150/visit plus 10% | | \$150/visit plus 10% | |
| <i>If admitted to the Hospital, this payment for emergency room services does not apply. Instead, you pay the Participating Provider payment under Inpatient facility services/ Hospital services and stay.</i> | | | | |
| Emergency room Physician services | 10% | | 10% | |
| Urgent care center services | \$25/visit | | 40% | ✓ |
| Ambulance services | 10% | ✓ | 10% | ✓ |
| <i>This payment is for emergency or authorized transport.</i> | | | | |
| Outpatient Facility services | | | | |
| Ambulatory Surgery Center | 5% | ✓ | 40% Subject to a Benefit maximum of \$350/day | ✓ |
| Outpatient Department of a Hospital: surgery | 15% | ✓ | 40% Subject to a Benefit maximum of \$350/day | ✓ |
| Outpatient Department of a Hospital: treatment of illness or injury, radiation therapy, chemotherapy, and necessary supplies | 10% | ✓ | 40% Subject to a Benefit maximum of \$350/day | ✓ |
| Inpatient facility services | | | | |
| Hospital services and stay | 10% | ✓ | 40% Subject to a Benefit maximum of \$600/day | ✓ |
| Transplant services | | | | |
| <i>This payment is for all covered transplants except tissue and kidney. For tissue and kidney transplant services, the payment for Inpatient facility services/ Hospital services and stay applies.</i> | | | | |
| • Special transplant facility inpatient services | 10% | ✓ | Not covered | |
| • Physician inpatient services | 10% | ✓ | Not covered | |

Benefits⁶

Your payment

| | When using a Participating Provider ³ | CYD ² applies | When using a Non-Participating Provider ⁴ | CYD ² applies |
|---|--|--------------------------|--|--------------------------|
| Bariatric surgery services, designated California counties | | | | |
| <i>This payment is for bariatric surgery services for residents of designated California counties. For bariatric surgery services for residents of non-designated California counties, the payments for Inpatient facility services/ Hospital services and stay and Physician inpatient and surgery services apply for inpatient services; or, if provided on an outpatient basis, the Outpatient Facility services and outpatient Physician services payments apply.</i> | | | | |
| Inpatient facility services | 10% | ✓ | Not covered | |
| Outpatient Facility services | 15% | ✓ | Not covered | |
| Physician services | 10% | ✓ | Not covered | |
| Diagnostic x-ray, imaging, pathology, and laboratory services | | | | |
| <i>This payment is for Covered Services that are diagnostic, non-Preventive Health Services, and diagnostic radiological procedures, such as CT scans, MRIs, MRAs, and PET scans. For the payments for Covered Services that are considered Preventive Health Services, see Preventive Health Services.</i> | | | | |
| Laboratory services | | | | |
| <i>Includes diagnostic Papanicolaou (Pap) test.</i> | | | | |
| • Laboratory center | \$25/visit | ✓ | 40% | ✓ |
| • Outpatient Department of a Hospital | \$50/visit | ✓ | 40% Subject to a Benefit maximum of \$350/day | ✓ |
| X-ray and imaging services | | | | |
| <i>Includes diagnostic mammography.</i> | | | | |
| • Outpatient radiology center | \$25/visit | ✓ | 40% | ✓ |
| • Outpatient Department of a Hospital | \$50/visit | ✓ | 40% Subject to a Benefit maximum of \$350/day | ✓ |
| Other outpatient diagnostic testing | | | | |
| <i>Testing to diagnose illness or injury such as vestibular function tests, EKG, ECG, cardiac monitoring, non-invasive vascular studies, sleep medicine testing, muscle and range of motion tests, EEG, and EMG.</i> | | | | |
| • Office location | \$25/visit | ✓ | 40% | ✓ |

Benefits⁶
Your payment

| | When using a Participating Provider ³ | CYD ² applies | When using a Non-Participating Provider ⁴ | CYD ² applies |
|---|--|--------------------------|--|--------------------------|
| <ul style="list-style-type: none"> Outpatient Department of a Hospital | \$50/visit | ✓ | 40% Subject to a Benefit maximum of \$350/day | ✓ |
| Radiological and nuclear imaging services | | | | |
| <ul style="list-style-type: none"> Outpatient radiology center | 10% | ✓ | 40% | ✓ |
| <ul style="list-style-type: none"> Outpatient Department of a Hospital | 20% | ✓ | 40% Subject to a Benefit maximum of \$350/day | ✓ |
| Rehabilitative and Habilitative Services | | | | |
| <i>Includes physical therapy, occupational therapy, respiratory therapy, and speech therapy services.</i> | | | | |
| Office location | \$25/visit | ✓ | 40% | ✓ |
| Outpatient Department of a Hospital | \$25/visit | ✓ | 40% Subject to a Benefit maximum of \$350/day | ✓ |
| Durable medical equipment (DME) | | | | |
| DME | 10% | ✓ | 40% | ✓ |
| Breast pump | \$0 | | Not covered | |
| Orthotic equipment and devices | 10% | ✓ | 40% | ✓ |
| Prosthetic equipment and devices | 10% | ✓ | 40% | ✓ |
| Home health care services | | | | |
| | 10% | ✓ | Not covered | |
| <i>Up to 100 visits per Member, per Calendar Year, by a home health care agency. All visits count towards the limit, including visits during any applicable Deductible period. Includes home visits by a nurse, Home Health Aide, medical social worker, physical therapist, speech therapist, or occupational therapist, and medical supplies.</i> | | | | |
| Home infusion and home injectable therapy services | | | | |
| Home infusion agency services | \$45/visit | ✓ | Not covered | |
| <i>Includes home infusion drugs, medical supplies, and visits by a nurse.</i> | | | | |
| Hemophilia home infusion services | \$45/visit | ✓ | Not covered | |
| <i>Includes blood factor products.</i> | | | | |

Benefits⁶

Your payment

| | When using a Participating Provider ³ | CYD ² applies | When using a Non-Participating Provider ⁴ | CYD ² applies |
|--|--|--------------------------|--|--------------------------|
| Skilled Nursing Facility (SNF) services | | | | |
| <i>Up to 100 days per Member, per benefit period, except when provided as part of a Hospice program. All days count towards the limit, including days during any applicable Deductible period and days in different SNFs during the Calendar Year.</i> | | | | |
| Freestanding SNF | 10% | ✓ | 40% | ✓ |
| Hospital-based SNF | 10% | ✓ | 40% Subject to a Benefit maximum of \$600/day | ✓ |
| Hospice program services | | | | |
| <i>Includes pre-Hospice consultation, routine home care, 24-hour continuous home care, short-term inpatient care for pain and symptom management, and inpatient respite care.</i> | | | | |
| | \$0 | | Not covered | |
| Other services and supplies | | | | |
| Diabetes care services | | | | |
| • Devices, equipment, and supplies | 10% | ✓ | 40% | ✓ |
| • Self-management training | \$25/visit | | 40% | ✓ |
| • Medical nutrition therapy | \$25/visit | | 40% | ✓ |
| Dialysis services | 10% | ✓ | 40% Subject to a Benefit maximum of \$350/day | ✓ |
| PKU product formulas and special food products | 10% | ✓ | 10% | ✓ |
| Allergy serum billed separately from an office visit | 10% | ✓ | 40% | ✓ |

Mental Health and Substance Use Disorder Benefits

Your payment

| <i>Mental health and substance use disorder Benefits are provided through Blue Shield's Mental Health Service Administrator (MHSA).</i> | When using a MHSA Participating Provider ³ | CYD ² applies | When using a MHSA Non-Participating Provider ⁴ | CYD ² applies |
|---|---|--------------------------|---|--------------------------|
| Outpatient services | | | | |
| Office visit, including Physician office visit | \$25/visit | | 40% | ✓ |
| Teladoc mental health | \$0 | | Not covered | |

Mental Health and Substance Use Disorder Benefits

Your payment

| <i>Mental health and substance use disorder Benefits are provided through Blue Shield's Mental Health Service Administrator (MHSA).</i> | When using a MHSA Participating Provider³ | CYD² applies | When using a MHSA Non-Participating Provider⁴ | CYD² applies |
|---|---|--------------------------------|---|--------------------------------|
| Other outpatient services, including intensive outpatient care, electroconvulsive therapy, transcranial magnetic stimulation, Behavioral Health Treatment for pervasive developmental disorder or autism in an office setting, home, or other non-institutional facility setting, and office-based opioid treatment | 10% | ✓ | 40% | ✓ |
| Partial Hospitalization Program | 10% | ✓ | 40% Subject to a Benefit maximum of \$350/day | ✓ |
| Psychological Testing | 10% | ✓ | 40% | ✓ |
| Inpatient services | | | | |
| Physician inpatient services | \$0 | ✓ | 40% | ✓ |
| Hospital services | 10% | ✓ | 40% Subject to a Benefit maximum of \$600/day | ✓ |
| Residential Care | 10% | ✓ | 40% Subject to a Benefit maximum of \$600/day | ✓ |

Prior Authorization

The following are some frequently-utilized Benefits that require prior authorization:

- Radiological and nuclear imaging services
- Outpatient mental health services, except office visits and office-based opioid treatment
- Inpatient facility services
- Hospice program services

Please review the Evidence of Coverage for more about Benefits that require prior authorization.

Notes

1 Evidence of Coverage (EOC):

The Evidence of Coverage (EOC) describes the Benefits, limitations, and exclusions that apply to coverage under this Plan. Please review the EOC for more details of coverage outlined in this Summary of Benefits. You can request a copy of the EOC at any time.

Capitalized terms are defined in the EOC. Refer to the EOC for an explanation of the terms used in this Summary of Benefits.

2 Calendar Year Deductible (CYD):

Calendar Year Deductible explained. A Calendar Year Deductible is the amount you pay each Calendar Year before Blue Shield pays for Covered Services under the Plan.

If this Plan has any Calendar Year Deductible(s), Covered Services subject to that Deductible are identified with a check mark (✓) in the Benefits chart above.

Covered Services not subject to the Calendar Year medical Deductible. Some Covered Services received from Participating Providers are paid by Blue Shield before you meet any Calendar Year medical Deductible. These Covered Services do not have a check mark (✓) next to them in the "CYD applies" column in the Benefits chart above.

Family coverage has an individual Deductible within the Family Deductible. This means that the Deductible will be met for an individual with Family coverage who meets the individual Deductible prior to the Family meeting the Family Deductible within a Calendar Year.

3 Using Participating Providers:

Participating Providers have a contract to provide health care services to Members. When you receive Covered Services from a Participating Provider, you are only responsible for the Copayment or Coinsurance, once any Calendar Year Deductible has been met.

Teladoc. Teladoc mental health and substance use disorder consultations are provided through Teladoc. These services are not administered by Blue Shield's Mental Health Service Administrator (MHSA).

"Allowable Amount" is defined in the EOC. In addition:

- Coinsurance is calculated from the Allowable Amount.

4 Using Non-Participating Providers:

Non-Participating Providers do not have a contract to provide health care services to Members. When you receive Covered Services from a Non-Participating Provider, you are responsible for:

- the Copayment or Coinsurance (once any Calendar Year Deductible has been met), and
- any charges above the Allowable Amount.

"Allowable Amount" is defined in the EOC. In addition:

- Coinsurance is calculated from the Allowable Amount, which is subject to any stated Benefit maximum.
- Charges above the Allowable Amount do not count towards the Out-of-Pocket Maximum, and are your responsibility for payment to the provider. This out-of-pocket expense can be significant.

5 Calendar Year Out-of-Pocket Maximum (OOPM):

Calendar Year Out-of-Pocket Maximum explained. The Out-of-Pocket Maximum is the most you are required to pay for Covered Services in a Calendar Year. Once you reach your Out-of-Pocket Maximum, Blue Shield will pay 100% of the Allowable Amount for Covered Services for the rest of the Calendar Year.

Your payment after you reach the Calendar Year OOPM. You will continue to pay all charges for services that are not covered and charges above the Allowable Amount.

Any Deductibles count towards the OOPM. Any amounts you pay that count towards the medical Calendar Year Deductible also count towards the Calendar Year Out-of-Pocket Maximum.

This Plan has a Participating Provider OOPM as well as a combined Participating Provider and Non-Participating Provider OOPM. This means that any amounts you pay towards your Participating Provider OOPM also count towards your combined Participating and Non-Participating Provider OOPM.

Notes

Family coverage has an individual OOPM within the Family OOPM. This means that the OOPM will be met for an individual with Family coverage who meets the individual OOPM prior to the Family meeting the Family OOPM within a Calendar Year.

6 Separate Member Payments When Multiple Covered Services are Received:

Each time you receive multiple Covered Services, you might have separate payments (Copayment or Coinsurance) for each service. When this happens, you may be responsible for multiple Copayments or Coinsurance. For example, you may owe an office visit payment in addition to an allergy serum payment when you visit the doctor for an allergy shot.

7 Preventive Health Services:

If you only receive Preventive Health Services during a Physician office visit, there is no Copayment or Coinsurance for the visit. If you receive both Preventive Health Services and other Covered Services during the Physician office visit, you may have a Copayment or Coinsurance for the visit.

Plans may be modified to ensure compliance with State and Federal requirements.

Enhanced Rx \$10/25/40 with \$0 Pharmacy Deductible Summary of Benefits

This Summary of Benefits shows the amount you will pay for covered Drugs under this prescription Drug Benefit.

Pharmacy Network:

Rx Ultra

Drug Formulary:

Plus Formulary

Calendar Year Pharmacy Deductible(CYPD)¹

A Calendar Year Pharmacy Deductible (CYPD) is the amount a Member pays each Calendar Year before Blue Shield pays for covered Drugs under the outpatient prescription Drug Benefit. Blue Shield pays for some prescription Drugs before the Calendar Year Pharmacy Deductible is met, as noted in the Prescription Drug Benefits chart below.

| Calendar Year Pharmacy Deductible | | When using a Participating ² or Non-Participating ³ Pharmacy | | |
|---|--|--|---|---------------------------|
| | | Per Member \$0 | | |
| Prescription Drug Benefits ^{4,5} | | Your payment | | |
| | When using a Participating Pharmacy ² | CYPD ¹ applies | When using a Non-Participating Pharmacy ³ | CYPD ¹ applies |
| Retail pharmacy prescription Drugs | | | | |
| <i>Per prescription, up to a 30-day supply.</i> | | | | |
| Contraceptive Drugs and devices | \$0 | | Applicable Tier 1, Tier 2, or Tier 3 Copayment | |
| Tier 1 Drugs | \$10/prescription | | 25% plus \$10/prescription | |
| Tier 2 Drugs | \$25/prescription | | 25% plus \$25/prescription | |
| Tier 3 Drugs | \$40/prescription | | 25% plus \$40/prescription | |
| Tier 4 Drugs | 30% up to \$250/prescription | | 30% up to \$250/prescription plus 25% of purchase price | |
| Retail pharmacy prescription Drugs | | | | |
| <i>Per prescription, up to a 90-day supply from a 90-day retail pharmacy.</i> | | | | |
| Contraceptive Drugs and devices | \$0 | | Not covered | |
| Tier 1 Drugs | \$30/prescription | | Not covered | |
| Tier 2 Drugs | \$75/prescription | | Not covered | |
| Tier 3 Drugs | \$120/prescription | | Not covered | |
| Tier 4 Drugs | 30% up to \$750/prescription | | Not covered | |

Prescription Drug Benefits^{4,5}

| Prescription Drug Benefits ^{4,5} | | Your payment | | |
|---|--|---------------------------|--|---------------------------|
| | When using a Participating Pharmacy ² | CYPD ¹ applies | When using a Non-Participating Pharmacy ³ | CYPD ¹ applies |
| Mail service pharmacy prescription Drugs | | | | |
| Per prescription, up to a 90-day supply. | | | | |
| Contraceptive Drugs and devices | \$0 | | Not covered | |
| Tier 1 Drugs | \$20/prescription | | Not covered | |
| Tier 2 Drugs | \$50/prescription | | Not covered | |
| Tier 3 Drugs | \$80/prescription | | Not covered | |
| Tier 4 Drugs | 30% up to \$500/prescription | | Not covered | |

Notes

1 Calendar Year Pharmacy Deductible (CYPD):

Calendar Year Pharmacy Deductible explained. A Calendar Year Pharmacy Deductible is the amount you pay each Calendar Year before Blue Shield pays for outpatient prescription Drugs under this Benefit.

If this Benefit has a Calendar Year Pharmacy Deductible, outpatient prescription Drugs subject to the Deductible are identified with a check mark (✓) in the Benefits chart above.

Any applicable Copayment, Coinsurance and CYPD you pay counts towards the Calendar Year Out-of-Pocket Maximum.

Outpatient prescription Drugs not subject to the Calendar Year Pharmacy Deductible. Some outpatient prescription Drugs received from Participating Pharmacies are paid by Blue Shield before you meet any Calendar Year Pharmacy Deductible. These outpatient prescription Drugs do not have a check mark (✓) next to them in the "CYPD applies" column in the Prescription Drug Benefits chart above.

2 Using Participating Pharmacies:

Participating Pharmacies have a contract to provide outpatient prescription Drugs to Members. When you obtain covered prescription Drugs from a Participating Pharmacy, you are only responsible for the Copayment or Coinsurance, once any Calendar Year Pharmacy Deductible has been met.

Participating Pharmacies and Drug Formulary. You can find a Participating Pharmacy and the Drug Formulary by visiting www.blueshieldca.com/pharmacy.

3 Using Non-Participating Pharmacies:

Non-Participating Pharmacies do not have a contract to provide outpatient prescription Drugs to Members. When you obtain prescription Drugs from a Non-Participating Pharmacy, you must pay all charges for the prescription, then submit a completed claim form for reimbursement. You will be reimbursed based on the price you paid for the Drug.

4 Outpatient Prescription Drug Coverage:

Medicare Part D-creditable coverage-

This prescription Drug coverage is on average equivalent to or better than the standard benefit set by the federal government for Medicare Part D (also called creditable coverage). Because this prescription Drug coverage is creditable, you do not have to enroll in Medicare Part D while you maintain this coverage; however, you should be aware that if you do not enroll in Medicare Part D within 63 days following termination of this coverage, you could be subject to Medicare Part D premium penalties.

5 Outpatient Prescription Drug Coverage:

Brand Drug coverage when a Generic Drug is available. If you select a Brand Drug when a Generic Drug equivalent is available, you are responsible for the difference between the cost to Blue Shield for the Brand Drug and its Generic Drug equivalent plus the Tier 1 Copayment or Coinsurance. This difference in cost will not count towards any Calendar Year Pharmacy Deductible, medical Deductible, or the Calendar Year Out-of-Pocket Maximum. If your Physician or Health Care Provider prescribes a Brand Drug and indicates that a Generic Drug equivalent should not be substituted, you pay your applicable tier Copayment or Coinsurance. If your Physician or Health Care Provider does not indicate that a Generic Drug equivalent should not be substituted, you may request a Medical Necessity Review. If approved, the Brand Drug will be covered at the applicable Drug tier Copayment or Coinsurance.

Short-Cycle Specialty Drug program. This program allows initial prescriptions for select Specialty Drugs to be filled for a 15-day supply with your approval. When this occurs, the Copayment or Coinsurance will be pro-rated.

Specialty Drugs. Specialty Drugs are only available from a Network Specialty Pharmacy, up to a 30-day supply.

Oral Anticancer Drugs. You pay up to \$250 for oral Anticancer Drugs from a Participating Pharmacy, up to a 30-day supply. Oral Anticancer Drugs from a Participating Pharmacy are not subject to any Deductible.

Benefit designs may be modified to ensure compliance with State and Federal requirements.