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Benefit Modification for Members with

Full PPO Savings Two-Tier Embedded Deductible 2250/2700/4500 Effective January 1, 2019

This chart is a summary of specific benefit changes to your plan. For a list of legislative mandates and Blue Shield required changes, refer to the accompanying Contract and Benefit Changes list. Please contact your benefits administrator or call Customer Service for additional information regarding your plan.

	2018 Benefits	2019 Benefits
Calendar Year Out-of-Pocket Maximum An out-of-pocket maximum is the most a member will pay for covered services each calendar year. Any exceptions are listed in the EOC.	**Participating Providers**	**Participating Providers**
Individual coverage	$3,000	$3,500
Family coverage	$3,000: individual $6,000: family	$3,500: individual $7,000: family

Emergency services	**Participating Providers**	**Non-Participating Providers**	**Participating Providers**	**Non-Participating Providers**
Emergency room services	$100/visit	$100/visit	$150/visit	$150/visit

Outpatient facility services	**Participating Providers**	**Participating Providers**
Ambulatory surgery center	20%	10%

Benefits are subject to modification for subsequently enacted state or federal legislation.

Note: This document is only a summary for informational purposes. It is not a contract. Please refer to the *Evidence of Coverage* and the Plan Contract for the exact terms and conditions of coverage.

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Group Plan
PPO Savings Benefit Plan

Summary of Benefits

Full PPO Savings Two-Tier Embedded Deductible 2250/2700/4500

This Summary of Benefits shows the amount you will pay for Covered Services under this Blue Shield of California benefit Plan. It is only a summary and it is part of the contract for health care coverage, called the Evidence of Coverage (EOC).[1] Please read both documents carefully for details.

Provider Network: **Full PPO Network**

This benefit 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 benefit 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 Participating[3] or Non-Participating[4] Provider
Calendar Year medical and pharmacy Deductible	*Individual coverage*	$2,250
This Plan combines medical and pharmacy Deductibles into one Calendar Year Deductible	*Family Coverage*	$2,700: individual $4,500: Family

Calendar Year Out-of-Pocket Maximum[5]

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.

	When using a Participating Provider[3]	When using a Non-Participating Provider[4]
Individual coverage	$3,500	$6,000
Family Coverage	$3,500: individual $7,000: Family	$6,000: individual $12,000: Family

No Lifetime Benefit Maximum

Under this benefit Plan there is no dollar limit on the total amount Blue Shield will pay for Covered Services in a Member's lifetime.

Benefits[6]	Your payment			
	When using a Participating Provider[3]	CYD[2] applies	When using a Non-Participating Provider[4]	CYD[2] applies
Preventive Health Services[7]	$0		Not covered	
California Prenatal Screening Program	$0		$0	
Physician services				
Primary care office visit	20%	✔	50%	✔
Specialist care office visit	20%	✔	50%	✔
Physician home visit	20%	✔	50%	✔
Physician or surgeon services in an Outpatient Facility	20%	✔	50%	✔
Physician or surgeon services in an inpatient facility	20%	✔	50%	✔
Other professional services				
Other practitioner office visit *Includes nurse practitioners, physician assistants, and therapists.*	20%	✔	50%	✔
Acupuncture services *Up to 20 visits per Member, per Calendar Year.*	20%	✔	50%	✔
Chiropractic services *Up to 20 visits per Member, per Calendar Year.*	20%	✔	50%	✔
Teladoc consultation	$5/consult	✔	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	20%	✔	Not covered	
• Infertility services	Not covered		Not covered	
Podiatric services	20%	✔	50%	✔
Pregnancy and maternity care[7]				
Physician office visits: prenatal and postnatal	20%	✔	50%	✔
Physician services for pregnancy termination	20%	✔	50%	✔

Benefits[6]	Your payment			
	When using a Participating Provider[3]	CYD[2] applies	When using a Non-Participating Provider[4]	CYD[2] applies
Emergency services				
Emergency room services *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.*	$150/visit plus 20%	✔	$150/visit plus 20%	✔
Emergency room Physician services	20%	✔	20%	✔
Urgent care center services	20%	✔	50%	✔
Ambulance services *This payment is for emergency or authorized transport.*	20%	✔	20%	✔
Outpatient Facility services				
Ambulatory Surgery Center	10%	✔	50% up to $350/day plus 100% of additional charges	✔
Outpatient department of a Hospital: surgery	20%	✔	50% up to $350/day plus 100% of additional charges	✔
Outpatient department of a Hospital: treatment of illness or injury, radiation therapy, chemotherapy, and necessary supplies	20%	✔	50% up to $350/day plus 100% of additional charges	✔
Inpatient facility services				
Hospital services and stay	$100/admission plus 20%	✔	50% up to $600/day plus 100% of additional charges	✔
Transplant services *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.* • Special transplant facility inpatient services	$100/admission plus 20%	✔	Not covered	

Benefits[6]	Your payment			
	When using a Participating Provider[3]	CYD[2] applies	When using a Non-Participating Provider[4]	CYD[2] applies
• Physician inpatient services	20%	✔	Not covered	
Bariatric surgery services, designated California counties				
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.				
Inpatient facility services	$100/admission plus 20%	✔	Not covered	
Outpatient Facility services	20%	✔	Not covered	
Physician services	20%	✔	Not covered	
Diagnostic x-ray, imaging, pathology, and laboratory services				
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.				
Laboratory services				
Includes diagnostic Papanicolaou (Pap) test.				
• Laboratory center	20%	✔	50%	✔
• Outpatient department of a Hospital	$25/visit plus 20%	✔	50% up to $350/day plus 100% of additional charges	✔
X-ray and imaging services				
Includes diagnostic mammography.				
• Outpatient radiology center	20%	✔	50%	✔
• Outpatient department of a Hospital	$25/visit plus 20%	✔	50% up to $350/day plus 100% of additional charges	✔

Benefits[6]	Your payment			
	When using a Participating Provider[3]	CYD[2] applies	When using a Non-Participating Provider[4]	CYD[2] applies
Other outpatient diagnostic testing *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.*				
• Office location	20%	✔	50%	✔
• Outpatient department of a Hospital	$25/visit plus 20%	✔	50% up to $350/day plus 100% of additional charges	✔
Radiological and nuclear imaging services				
• Outpatient radiology center	20%	✔	50%	✔
• Outpatient department of a Hospital	$100/visit plus 20%	✔	50% up to $350/day plus 100% of additional charges	✔
Rehabilitative and Habilitative Services *Includes Physical Therapy, Occupational Therapy, Respiratory Therapy, and Speech Therapy services.*				
Office location	20%	✔	50%	✔
Outpatient department of a Hospital	20%	✔	50% up to $350/day plus 100% of additional charges	✔
Durable medical equipment (DME)				
DME	20%	✔	50%	✔
Breast pump	$0		Not covered	
Orthotic equipment and devices	20%	✔	50%	✔
Prosthetic equipment and devices	20%	✔	50%	✔

Benefits[6]	Your payment			
	When using a Participating Provider[3]	CYD[2] applies	When using a Non-Participating Provider[4]	CYD[2] applies
Home health services				
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, except hemophilia and home infusion nursing visits.				
Home health agency services	20%	✔	Not covered	
Includes home visits by a nurse, Home Health Aide, medical social worker, physical therapist, speech therapist, or occupational therapist.				
Home visits by an infusion nurse	20%	✔	Not covered	
Home health medical supplies	20%	✔	Not covered	
Home infusion agency services	20%	✔	Not covered	
Hemophilia home infusion services	20%	✔	Not covered	
Includes blood factor products.				
Skilled Nursing Facility (SNF) services				
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.				
Freestanding SNF	20%	✔	20%	✔
Hospital-based SNF	20%	✔	50% up to $600/day plus 100% of additional charges	✔
Hospice program services	$0	✔	Not covered	
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.				
Other services and supplies				
Diabetes care services				
• Devices, equipment, and supplies	20%	✔	50%	✔
• Self-management training	20%	✔	50%	✔

Benefits[6]	Your payment			
	When using a Participating Provider[3]	CYD[2] applies	When using a Non-Participating Provider[4]	CYD[2] applies
Dialysis services	20%	✔	50% up to $350/day plus 100% of additional charges	✔
PKU product formulas and Special Food Products	20%	✔	20%	✔
Allergy serum	20%	✔	50%	✔

Mental Health and Substance Use Disorder Benefits	Your payment			
Mental health and substance use disorder Benefits are provided through Blue Shield's Mental Health Services Administrator (MHSA).	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	20%	✔	50%	✔
Other outpatient services, including intensive outpatient care, 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	20%	✔	50%	✔
Partial Hospitalization Program	20%	✔	50% up to $350/day plus 100% of additional charges	✔
Psychological Testing	20%	✔	50%	✔
Inpatient services				
Physician inpatient services	$0	✔	50%	✔
Hospital services	$100/admission plus 20%	✔	50% up to $600/day plus 100% of additional charges	✔
Residential Care	$100/admission plus 20%	✔	50% up to $600/day plus 100% of additional charges	✔

Prescription Drug Benefits[8,9]	**Your payment**			
Pharmacy Network: *Rx Ultra* ***Drug Formulary***: *Plus Formulary*	**When using a Participating Pharmacy**[3]	**CYD**[2] **applies**	**When using a Non-Participating Pharmacy**[4]	**CYD**[2] **applies**
Retail pharmacy prescription Drugs *Per prescription, up to a 30-day supply.*				
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 (excluding Specialty Drugs)	30% up to $200/prescription	✔	25% of purchase price plus 30% up to $200/prescription	✔
Contraceptive Drugs and devices	$0		25% of purchase price plus Tier 1, Tier 2, or Tier 3 Copayment	✔
Mail service pharmacy prescription Drugs *Per prescription, up to a 90-day supply.*				
Tier 1 Drugs	$20/prescription	✔	Not covered	
Tier 2 Drugs	$50/prescription	✔	Not covered	
Tier 3 Drugs	$80/prescription	✔	Not covered	
Tier 4 Drugs (excluding Specialty Drugs)	30% up to $400/prescription	✔	Not covered	
Contraceptive Drugs and devices	$0		Not covered	
Specialty Drugs *Per prescription. Specialty Drugs are covered at tier 4 and only when dispensed by a Network Specialty Pharmacy. Specialty Drugs from Non-Participating Pharmacies are not covered except in emergency situations.*	30% up to $200/prescription	✔	Not covered	
Oral Anticancer Drugs *Per prescription, up to a 30-day supply.*	30% up to $200/prescription	✔	Not covered	

Prior Authorization

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

- Radiological and nuclear imaging services
- Inpatient facility services
- Home health services from Non-Participating Providers
- Mental health services, except outpatient office visits, electroconvulsive therapy, and Psychological Testing
- Hospice program services
- Some prescription Drugs (see blueshieldca.com/pharmacy)

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 benefit 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.

Defined terms are 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 Deductible is the amount you pay each Calendar Year before Blue Shield pays for Covered Services under the benefit Plan.

If this benefit 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 combined medical and pharmacy Deductible. Some Covered Services received from Participating Providers are paid by Blue Shield before you meet any Calendar Year combined medical and pharmacy 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.

Your payment for services from "Other Providers." You will pay the Copayment or Coinsurance applicable to Participating Providers for Covered Services received from Other Providers. However, Other Providers do not have a contract to provide health care services to Members and so are not Participating Providers. Therefore, you will also pay all charges above the Allowable Amount. This out-of-pocket expense can be significant.

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 both:

- the Copayment or Coinsurance (once any Calendar Year Deductible has been met), and

- any charges above the Allowable Amount (which can be significant).

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

- Any Coinsurance is determined from the Allowable Amount.
- Any charges above the Allowable Amount are not covered, 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.
- Some Benefits from Non-Participating Providers have the Allowable Amount listed in the Benefits chart as a specific dollar ($) amount. You are responsible for any charges above the Allowable Amount, whether or not an amount is listed in the Benefits chart.

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

Your payment after you reach the Calendar Year OOPM. You will continue to pay all charges above a Benefit maximum.

Essential health benefits count towards the OOPM.

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 benefit Plan has a separate Participating Provider OOPM and Non-Participating Provider OOPM.

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 Copayment in addition to an allergy serum Copayment 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.

8 Outpatient Prescription Drug Coverage:

Medicare Part D-creditable coverage-

This benefit Plan's 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 benefit plan's 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 have a later break in this coverage of 63 days or more before enrolling in Medicare Part D you could be subject to payment of higher Medicare Part D premiums.

9 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

Notes

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.

Request for Medical Necessity Review. If you or your Physician believes a Brand Drug is Medically Necessary, either person may request a Medical Necessity Review. If approved, the Brand Drug will be covered at the applicable Drug tier Member payment.

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

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

PENDING REGULATORY APPROVAL