

Summary of Benefits

Custom PPO Split Deductible 20-500 80/60

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 Participating Provider ³	When using a Non-Participating Provider ⁴
Calendar Year medical Deductible	<i>Individual coverage</i>	\$500	\$1,000
	<i>Family coverage</i>	\$500: individual	\$1,000: individual
		\$1,000: Family	\$2,000: 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
<i>Individual coverage</i>	\$3,500	\$11,000
<i>Family coverage</i>	\$3,500: individual	\$11,000: individual
	\$7,000: Family	\$22,000: Family

Benefits⁶

Your payment

	When using a Participating Provider³	CYD² applies	When using a Non-Participating Provider⁴	CYD² applies
Preventive Health Services⁷				
Preventive Health Services	\$0		Not covered	
California Prenatal Screening Program	\$0		\$0	
Physician services				
Primary care office visit	\$20/visit		40%	✓
Specialist care office visit	\$20/visit		40%	✓
Physician home visit	\$20/visit		40%	✓
Physician or surgeon services in an outpatient facility	20%	✓	40%	✓
Physician or surgeon services in an inpatient facility	20%	✓	40%	✓
Other professional services				
Other practitioner office visit <i>Includes nurse practitioners, physician assistants, and therapists.</i>	\$20/visit		40%	✓
Acupuncture services <i>Up to 20 visits per Member, per Calendar Year.</i>	\$20/visit	✓	40%	✓
Chiropractic services <i>Up to 30 visits per Member, per Calendar Year.</i>	\$20/visit	✓	40%	✓
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	
Podiatric services	\$20/visit		40%	✓
Pregnancy and maternity care⁷				
Physician office visits: prenatal and postnatal	20%	✓	40%	✓
Physician services for pregnancy termination	20%	✓	40%	✓

Benefits⁶

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 <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>	\$250/visit		\$250/visit	
Emergency room Physician services	20%	✓	20%	✓
Urgent care center services	\$20/visit		40%	✓
Ambulance services <i>This payment is for emergency or authorized transport.</i>	20%	✓	20%	✓
Outpatient facility services				
Ambulatory Surgery Center	\$150/surgery plus 20%	✓	40% of up to \$350/day plus 100% of additional charges	✓
Outpatient Department of a Hospital: surgery	\$250/surgery plus 20%	✓	40% of 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%	✓	40% of up to \$350/day plus 100% of additional charges	✓
Inpatient facility services				
Hospital services and stay	\$250/admission plus 20%	✓	40% of up to \$600/day plus 100% of additional charges	✓
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	\$250/admission plus 20%	✓	Not covered	
• Physician inpatient services	20%	✓	Not covered	

Benefits⁶

Your payment

	When using a Participating Provider³	CYD² applies	When using a Non-Participating Provider⁴	CYD² applies
<p>Bariatric surgery services, designated California counties</p> <p><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></p>				
Inpatient facility services	\$250/admission plus 20%	✓	Not covered	
Outpatient facility services	\$250/surgery plus 20%	✓	Not covered	
Physician services	20%	✓	Not covered	
<p>Diagnostic x-ray, imaging, pathology, and laboratory services</p> <p><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></p>				
<p>Laboratory services</p> <p><i>Includes diagnostic Papanicolaou (Pap) test.</i></p>				
<ul style="list-style-type: none"> Laboratory center 	\$20/visit	✓	40%	✓
<ul style="list-style-type: none"> Outpatient Department of a Hospital 	\$45/visit	✓	40% of up to \$350/day plus 100% of additional charges	✓
<p>X-ray and imaging services</p> <p><i>Includes diagnostic mammography.</i></p>				
<ul style="list-style-type: none"> Outpatient radiology center 	\$20/visit	✓	40%	✓
<ul style="list-style-type: none"> Outpatient Department of a Hospital 	\$45/visit	✓	40% of up to \$350/day plus 100% of additional charges	✓

Benefits⁶

Your payment

	When using a Participating Provider³	CYD² applies	When using a Non-Participating Provider⁴	CYD² applies
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	\$20/visit	✓	40%	✓
• Outpatient Department of a Hospital	\$45/visit	✓	40% of up to \$350/day plus 100% of additional charges	✓
Radiological and nuclear imaging services				
• Outpatient radiology center	20%	✓	40%	✓
• Outpatient Department of a Hospital	20%	✓	40% of up to \$350/day plus 100% of additional charges	✓
Rehabilitative and Habilitative Services				
<i>Includes Physical Therapy, Occupational Therapy, Respiratory Therapy, and Speech Therapy services.</i>				
Office location	\$20/visit	✓	40%	✓
Outpatient Department of a Hospital	\$20/visit	✓	40% of up to \$350/day plus 100% of additional charges	✓
Durable medical equipment (DME)				
DME	20%	✓	40%	✓
Breast pump	\$0		Not covered	
Orthotic equipment and devices	20%	✓	40%	✓
Prosthetic equipment and devices	20%	✓	40%	✓

Benefits⁶

Your payment

	When using a Participating Provider ³	CYD ² applies	When using a Non-Participating Provider ⁴	CYD ² applies
<p>Home health care services</p> <p><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></p>	20%	✓	Not covered	
<p>Home infusion and home injectable therapy services</p> <p>Home infusion agency services <i>Includes home infusion drugs and medical supplies.</i></p> <p>Home visits by an infusion nurse</p> <p>Hemophilia home infusion services <i>Includes blood factor products.</i></p>	20%	✓	Not covered	
<p>Skilled Nursing Facility (SNF) services</p> <p><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></p> <p>Freestanding SNF</p> <p>Hospital-based SNF</p>	20%	✓	20%	✓
<p>Hospice program services</p> <p><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></p>	\$0		Not covered	
<p>Other services and supplies</p> <p>Diabetes care services</p> <ul style="list-style-type: none"> Devices, equipment, and supplies Self-management training 	20%	✓	40%	✓
	\$20/visit		40%	✓

Benefits⁶

Your payment

	When using a Participating Provider³	CYD² applies	When using a Non-Participating Provider⁴	CYD² applies
Dialysis services	20%	✓	40% of up to \$350/day plus 100% of additional charges	✓
PKU product formulas and Special Food Products	20%	✓	20%	✓
Allergy serum billed separately from an office visit	20%	✓	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 Provider³	CYD² applies	When using a MHSA Non-Participating Provider⁴	CYD² applies
Outpatient services				
Office visit, including Physician office visit	\$20/visit		40%	✓
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	\$0	✓	40%	✓
Partial Hospitalization Program	\$0	✓	40% of up to \$350/day plus 100% of additional charges	✓
Psychological Testing	\$0	✓	40%	✓
Inpatient services				
Physician inpatient services	\$0	✓	40%	✓
Hospital services	\$250/admission plus 20%	✓	40% of up to \$600/day plus 100% of additional charges	✓
Residential Care	\$250/admission plus 20%	✓	40% of up to \$600/day plus 100% of additional charges	✓

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
- 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 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.

This Plan has a separate Participating Provider Deductible and Non-Participating Provider Deductible.

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.

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

- Coinsurance is calculated from the Allowable Amount or Benefit maximum, whichever is less.
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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

Notes

- any charges above the Allowable Amount, or
- any charges above the stated dollar amount, which is the Benefit maximum.

“Allowable Amount” is defined in the EOC. In addition:

- Coinsurance is calculated from the Allowable Amount or Benefit maximum, whichever is less.
- Charges above the Allowable Amount or Benefit maximum 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):

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 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.

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.

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

PENDING REGULATORY APPROVAL

Hearing Aid Services Rider

Summary of Benefits

This Summary of Benefits shows the amount you will pay for Covered Services under this Blue Shield of California hearing aid services Benefit.

Benefits

Your Payment

*Up to a \$2,000 maximum per Member in any 24-month period.
Services are not subject to the Calendar Year Deductible.*

When using any provider

Hearing Aid Services

Hearing aid examinations for the appropriate type of hearing aid and/or for fittings, counseling and adjustments

Hearing aid device checks

Electroacoustic evaluations for hearing aids

Hearing aid instrument, monaural or binaural, including ear mold(s) and the initial battery and cords

All charges above \$2,000

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

PENDING REGULATORY APPROVAL

Introduction

In addition to the Benefits listed in your Evidence of Coverage, your rider provides coverage for hearing aid services, as described in this supplement. These hearing aid services Benefits are separate from your health Plan, but the general provisions, limitations, and exclusions described in your Evidence of Coverage do apply.

Because Blue Shield does not maintain a network of contracted providers for these services, the Benefits covered under this supplement can be received from any provider and you may submit a claim to Blue Shield for reimbursement.

Benefits

Benefits are available for hearing aid services as shown on the Summary of Benefits. Services are limited to a maximum payment per Member in any 24-month period, are not subject to the Calendar Year Deductible.

Blue Shield will reimburse you for Covered Services up to the maximum shown on the Summary of Benefits.

Submitting a Claim Form

Blue Shield will pay Members directly for services rendered. Claims for payment must be submitted to Blue Shield within one year after the month services were provided. Blue Shield will notify the Member of its determination within 30 days after receipt of the claim.

To submit a claim for payment, send a copy of the itemized bill, along with a completed Blue Shield claim form to:

Blue Shield
P.O. Box 272540
Chico, CA 95927-2540

Claim forms are available online at www.blueshieldca.com or Members may call Blue Shield Customer Service to obtain a form. At a minimum, each claim submission must contain the Subscriber's name, home address, group contract number, Subscriber number, a copy of the provider's bill showing the services rendered, dates of treatment and the patient's name.

Blue Shield provides an Explanation of Benefits to describe how the claim was processed and to inform the Member of any financial responsibility.

Exclusions

Benefits do not include:

- surgically implanted hearing devices;
- spare hearing aids;
- assisted listening devices or amplification devices;
- purchase of batteries or other equipment, except those covered under the terms of the initial hearing aid purchase;
- charges for a hearing aid that exceed specifications prescribed for correction of a hearing loss; or
- replacement parts for hearing aids, repair of hearing aids after the covered warranty period, and replacement of hearing aids more than once in any 24-month period.

See the Grievance Process portion of your EOC for information on filing a grievance, your right to seek assistance from the Department of Managed Health Care, and your rights to independent medical review.

Please be sure to retain this document. It is not a contract but is a part of your EOC.

Enhanced Rx \$15/30/50% \$100 max 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.

**When using a Participating² or
Non-Participating³ Pharmacy**

Per Member \$0

**Calendar Year Pharmacy Deductible
Prescription Drug Benefits^{4,5}**

Your payment

	When using a Participating Pharmacy²	CYPD¹ applies	When using a Non-Participating Pharmacy³	CYPD¹ 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	\$15/prescription		25% plus \$15/prescription	
Tier 2 Drugs	\$30/prescription		25% plus \$30/prescription	
Tier 3 Drugs	50% up to \$100/prescription		50% up to \$100/prescription plus 25% of purchase price	
Tier 4 Drugs (excluding Specialty Drugs)	30% up to \$200/prescription		30% up to \$200/prescription plus 25% of purchase price	
Mail service pharmacy prescription Drugs <i>Per prescription, up to a 90-day supply.</i>				
Contraceptive Drugs and devices	\$0		Not covered	
Tier 1 Drugs	\$30/prescription		Not covered	
Tier 2 Drugs	\$60/prescription		Not covered	
Tier 3 Drugs	50% up to \$200/prescription		Not covered	
Tier 4 Drugs (excluding Specialty Drugs)	30% up to \$400/prescription		Not covered	

Network Specialty Pharmacy Drugs <i>Per prescription, up to a 30-day supply.</i> Tier 4 Specialty Drugs	30% up to \$200/prescription	Not covered	
Oral anticancer Drugs <i>Per prescription, up to a 30-day supply.</i>	30% up to \$200/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.

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/wellness/drugs/formulary#heading2.

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,

Notes

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.

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

PENDING REGULATORY APPROVAL