

Summary of Benefits

PPO 200 80/60

This Summary of Benefits shows the amount you will pay for Covered Services under this Claims Administrator benefit plan. It is only a summary and it is included as part of the Benefit Booklet.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 Claims Administrator pays for Covered Services under the Plan. The Claims Administrator 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 | Family coverage |
|----------------------------------|---------------------|------------------------------------|
| | \$200 | \$200: individual \$400: 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.

When using any combination of Participating³ or Non-Participating⁴ Providers

| | |
|---------------------|--|
| Individual coverage | \$1,200 |
| Family coverage | \$1,200: individual \$2,400: Family |

No Annual or Lifetime Dollar Limit

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

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 | | 40% | ✓ |
| Physician services | | | | |
| Primary care office visit | 20% | ✓ | 40% | ✓ |
| Specialist care office visit | 20% | ✓ | 40% | ✓ |
| Physician home visit | 20% | ✓ | 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% | ✓ | 40% | ✓ |
| Acupuncture services | 20% | ✓ | 20% | ✓ |
| Chiropractic services <i>Up to 30 visits per Member, per Calendar Year.</i> | \$10/visit | ✓ | 50% of up to \$30/member /visit plus 100% of additional charges | ✓ |
| Teladoc consultation | \$40/consult | | Not covered | |
| Family planning | | | | |
| • Counseling, consulting, and education | \$0 | | 40% | ✓ |
| • Injectable contraceptive | \$0 | | Not covered | |
| • Diaphragm fitting | \$0 | | 40% | ✓ |
| • Intrauterine device (IUD) | \$0 | | Not covered | |
| • Insertion and/or removal of intrauterine device (IUD) | \$0 | | Not covered | |
| • Implantable contraceptive | \$0 | | Not covered | |
| • Tubal ligation | \$0 | | 40% | ✓ |
| • Vasectomy | 20% | ✓ | 40% | ✓ |
| Podiatric services | 20% | ✓ | 40% | ✓ |
| Pregnancy and maternity care | | | | |
| 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 | \$50/visit plus 20% | ✓ | \$50/visit plus 20% | ✓ |
| <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 | 20% | ✓ | 20% | ✓ |
| Urgent care center services | 20% | ✓ | 40% | ✓ |
| Ambulance services | 20% | ✓ | 20% | ✓ |
| <i>This payment is for emergency or authorized transport.</i> | | | | |
| Outpatient facility services | | | | |
| Ambulatory Surgery Center | 20% | ✓ | 40% of up to \$350/day plus 100% of additional charges | ✓ |
| Outpatient Department of a Hospital: surgery | 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 | 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 | 20% | ✓ | Not covered | |
| • Physician inpatient services | 20% | ✓ | Not covered | |

Benefits⁶

Your payment

| | When using a Participating Provider ³ | CYD ² applies | When using a Non-Participating Provider ⁴ | CYD ² applies |
|---|--|--------------------------|--|--------------------------|
| 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 | 20% | ✓ | 40% | ✓ |
| • Outpatient Department of a Hospital | 20% | ✓ | 40% of up to \$350/day plus 100% of additional charges | ✓ |
| X-ray and imaging services | | | | |
| <i>Includes diagnostic mammography.</i> | | | | |
| • Outpatient radiology center | 20% | ✓ | 40% | ✓ |
| • Outpatient Department of a Hospital | 20% | ✓ | 40% of up to \$350/day plus 100% of additional charges | ✓ |
| 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% | ✓ | 40% | ✓ |
| • Outpatient Department of a Hospital | 20% | ✓ | 40% of up to \$350/day plus 100% of additional charges | ✓ |
| Radiological and nuclear imaging services | | | | |
| • Outpatient radiology center | 20% | ✓ | 40% of up to \$800/day plus 100% of additional charges | ✓ |

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 | 20% | ✓ | 40% of up to \$350/day plus 100% of additional charges | ✓ |
| Rehabilitative and Habilitative Services | | | | |
| <i>Includes Physical Therapy, Occupational Therapy, and Respiratory Therapy.</i> | | | | |
| Office location | 20% | ✓ | 40% | ✓ |
| Outpatient Department of a Hospital | 20% | ✓ | 40% of up to \$350/day plus 100% of additional charges | ✓ |
| Speech Therapy services | | | | |
| Office location | 20% | ✓ | 40% | ✓ |
| Outpatient Department of a Hospital | 20% | ✓ | 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% | ✓ |
| Home health care services | | | | |
| 20% | | | | |
| <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 | 20% | ✓ | Not covered | |
| <i>Includes home infusion drugs and medical supplies.</i> | | | | |
| Home visits by an infusion nurse | 20% | ✓ | Not covered | |

Benefits⁶

Your payment

| | When using a Participating Provider³ | CYD² applies | When using a Non-Participating Provider⁴ | CYD² applies |
|--|--|--------------------------------|--|--------------------------------|
| Hemophilia home infusion services <i>Includes blood factor products.</i> | 20% | ✓ | Not covered | |
| Skilled Nursing Facility (SNF) services | | | | |
| <i>Up to 120 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 | 20% | ✓ | 20% | ✓ |
| Hospital-based SNF | 20% | ✓ | 40% of up to \$600/day plus 100% of additional charges | ✓ |
| Hospice program services | | | | |
| Pre-Hospice consultation | 20% | ✓ | Not covered | |
| Routine home care | 20% | ✓ | Not covered | |
| 24-hour continuous home care | 20% | ✓ | Not covered | |
| Short-term inpatient care for pain and symptom management | 20% | ✓ | Not covered | |
| Inpatient respite care | 20% | ✓ | Not covered | |
| Other services and supplies | | | | |
| Diabetes care services | | | | |
| • Devices, equipment, and supplies | 20% | ✓ | 40% | ✓ |
| • Self-management training | 20% | ✓ | 40% | ✓ |
| Dialysis services | 20% | ✓ | 40% of up to \$300/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% | ✓ |
| Hearing services | | | | |
| • Hearing aids and equipment <i>Up to \$1,200 combined maximum per Member, per 24-month.</i> | 20% | ✓ | 20% | ✓ |
| • Audiological evaluations | 20% | ✓ | 40% | ✓ |
| Learning impairment evaluation tests | 20% | ✓ | 40% | ✓ |

Benefits⁶

Your payment

| | When using a Participating Provider³ | CYD² applies | When using a Non-Participating Provider⁴ | CYD² applies |
|---|--|--------------------------------|--|--------------------------------|
| <i>Up to \$200 combined maximum per Member, per lifetime.</i> | | | | |

Mental Health and Substance Use Disorder Benefits

Your payment

| | When using a Participating Provider³ | CYD² applies | When using a Non-Participating Provider⁴ | CYD² applies |
|--|--|--------------------------------|--|--------------------------------|
| Outpatient services | | | | |
| Office visit, including Physician office visit | 20% | ✓ | 40% | ✓ |
| Teladoc behavioral health | \$40/consult | | Not covered | |
| Intensive outpatient care | 20% | ✓ | 40% | ✓ |
| Behavioral Health Treatment in an office setting | 20% | ✓ | 40% | ✓ |
| Behavioral Health Treatment in home or other non-institutional setting | 20% | ✓ | 40% | ✓ |
| Office-based opioid treatment | 20% | ✓ | 40% | ✓ |
| Partial Hospitalization Program | 20% | ✓ | 40% of up to \$350/day plus 100% of additional charges | ✓ |
| Psychological Testing | 20% | ✓ | 40% | ✓ |
| Inpatient services | | | | |
| Physician inpatient services | 20% | ✓ | 40% | ✓ |
| Hospital services | 20% | ✓ | 40% of up to \$600/day plus 100% of additional charges | ✓ |
| Residential Care | 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 Benefit Booklet for more about Benefits that require prior authorization.

Notes

1 Benefit Booklet:

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

Capitalized terms are defined in the Benefit Booklet. Refer to the Benefit Booklet 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 the Claims Administrator 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 the Claims Administrator 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. Once the individual Deductible or Family Deductible is reached, cost sharing applies until the Out-of-Pocket Maximum is reached.

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 (behavioral health) consultations are provided through Teladoc.

"Allowable Amount" is defined in the Benefit Booklet. 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
- 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 Benefit Booklet. 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):

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, the Claims Administrator 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, charges above the Allowable Amount, and charges for services above any Benefit maximum.

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 combined Participating Provider 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 Federal requirements.

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