Summary of Benefits

Bronze 60 HDHP PPO

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). Please read both documents carefully for details.

Medical Provider Network: Exclusive PPO Network

This Plan uses a specific network of Health Care Providers, called the Exclusive 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.

Pharmacy Network: Rx Ultra

Drug Formulary: Standard Formulary

Calendar Year Deductibles (CYD)

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.

<table>
<thead>
<tr>
<th>Calendar Year Deductible</th>
<th>When using a Participating Provider</th>
<th>When using a Non-Participating Provider</th>
</tr>
</thead>
<tbody>
<tr>
<td>Individual coverage</td>
<td>$7,000</td>
<td>$14,000</td>
</tr>
<tr>
<td>Family coverage</td>
<td>$7,000: individual</td>
<td>$14,000: individual</td>
</tr>
<tr>
<td></td>
<td>$14,000: Family</td>
<td>$28,000: Family</td>
</tr>
</tbody>
</table>

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 Notes section at the end of this Summary of Benefits.

<table>
<thead>
<tr>
<th>When using a Participating Provider</th>
<th>When using a Non-Participating Provider</th>
</tr>
</thead>
<tbody>
<tr>
<td>Individual coverage</td>
<td>$7,000</td>
</tr>
<tr>
<td>Family coverage</td>
<td>$7,000: individual</td>
</tr>
<tr>
<td></td>
<td>$14,000: Family</td>
</tr>
<tr>
<td></td>
<td>$20,000: individual</td>
</tr>
<tr>
<td></td>
<td>$40,000: Family</td>
</tr>
</tbody>
</table>

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.
### Benefits

<table>
<thead>
<tr>
<th>Benefits</th>
<th>Your payment</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Preventive Health Services</strong></td>
<td></td>
</tr>
<tr>
<td>Preventive Health Services</td>
<td>$0</td>
</tr>
<tr>
<td>California Prenatal Screening Program</td>
<td>$0</td>
</tr>
<tr>
<td><strong>Physician services</strong></td>
<td></td>
</tr>
<tr>
<td>Primary care office visit</td>
<td>$0</td>
</tr>
<tr>
<td>Specialist care office visit</td>
<td>$0</td>
</tr>
<tr>
<td>Physician home visit</td>
<td>$0</td>
</tr>
<tr>
<td>Physician or surgeon services in an outpatient facility</td>
<td>$0</td>
</tr>
<tr>
<td>Physician or surgeon services in an inpatient facility</td>
<td>$0</td>
</tr>
<tr>
<td><strong>Other professional services</strong></td>
<td></td>
</tr>
<tr>
<td>Other practitioner office visit</td>
<td>$0</td>
</tr>
<tr>
<td>Includes nurse practitioners, physician assistants, and therapists.</td>
<td></td>
</tr>
<tr>
<td>Acupuncture services</td>
<td>$0</td>
</tr>
<tr>
<td>Chiropractic services</td>
<td>Not covered</td>
</tr>
<tr>
<td>Teladoc consultation</td>
<td>$0</td>
</tr>
<tr>
<td>Family planning</td>
<td></td>
</tr>
<tr>
<td>• Counseling, consulting, and education</td>
<td>$0</td>
</tr>
<tr>
<td>• Injectable contraceptive; diaphragm fitting, intrauterine device (IUD), implantable contraceptive, and related procedure.</td>
<td>$0</td>
</tr>
<tr>
<td>• Tubal ligation</td>
<td>$0</td>
</tr>
<tr>
<td>• Vasectomy</td>
<td>$0</td>
</tr>
<tr>
<td>• Infertility services</td>
<td>Not covered</td>
</tr>
<tr>
<td>Podiatric services</td>
<td>$0</td>
</tr>
<tr>
<td><strong>Pregnancy and maternity care</strong></td>
<td></td>
</tr>
<tr>
<td>Physician office visits: prenatal and initial postnatal</td>
<td>$0</td>
</tr>
<tr>
<td>Physician services for pregnancy termination</td>
<td>$0</td>
</tr>
<tr>
<td><strong>Emergency services</strong></td>
<td></td>
</tr>
<tr>
<td>Emergency room services</td>
<td>$0</td>
</tr>
</tbody>
</table>

*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.*
<table>
<thead>
<tr>
<th>Benefits</th>
<th>Your payment</th>
</tr>
</thead>
<tbody>
<tr>
<td>When using a Participating Provider²</td>
<td>When using a Non-Participating Provider⁴</td>
</tr>
<tr>
<td><strong>Urgent care center services</strong></td>
<td></td>
</tr>
<tr>
<td>$0</td>
<td>50%</td>
</tr>
<tr>
<td><strong>Ambulance services</strong></td>
<td></td>
</tr>
<tr>
<td>$0</td>
<td></td>
</tr>
<tr>
<td>This payment is for emergency or authorized transport.</td>
<td></td>
</tr>
<tr>
<td><strong>Outpatient facility services</strong></td>
<td></td>
</tr>
<tr>
<td>Ambulatory Surgery Center</td>
<td>$0</td>
</tr>
<tr>
<td>Outpatient Department of a Hospital: surgery</td>
<td>$0</td>
</tr>
<tr>
<td>Outpatient Department of a Hospital: treatment of illness or injury, radiation therapy, chemotherapy, and necessary supplies</td>
<td>$0</td>
</tr>
<tr>
<td>50% of up to $300/day plus 100% of additional charges</td>
<td></td>
</tr>
<tr>
<td>50% of up to $500/day plus 100% of additional charges</td>
<td></td>
</tr>
<tr>
<td><strong>Inpatient facility services</strong></td>
<td></td>
</tr>
<tr>
<td>Hospital services and stay</td>
<td>$0</td>
</tr>
<tr>
<td>50% of up to $500/day plus 100% of additional charges</td>
<td></td>
</tr>
<tr>
<td><strong>Transplant services</strong></td>
<td></td>
</tr>
<tr>
<td>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.</td>
<td></td>
</tr>
<tr>
<td>• Special transplant facility inpatient services</td>
<td>$0</td>
</tr>
<tr>
<td>• Physician inpatient services</td>
<td>$0</td>
</tr>
</tbody>
</table>
### Benefits

<table>
<thead>
<tr>
<th>Benefits</th>
<th>Your payment</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>When using a Participating Provider(^3)</td>
</tr>
<tr>
<td><strong>Bariatric surgery services, designated California counties</strong></td>
<td>$0</td>
</tr>
<tr>
<td>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.</td>
<td>$0</td>
</tr>
<tr>
<td></td>
<td>Outpatient facility services</td>
</tr>
<tr>
<td></td>
<td>Physician services</td>
</tr>
<tr>
<td><strong>Diagnostic x-ray, imaging, pathology, and laboratory services</strong></td>
<td>$0</td>
</tr>
<tr>
<td>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.</td>
<td>$0</td>
</tr>
<tr>
<td>Laboratory services</td>
<td></td>
</tr>
<tr>
<td>Includes diagnostic Papanicolaou (Pap) test.</td>
<td>$0</td>
</tr>
<tr>
<td>- Laboratory center</td>
<td>$0</td>
</tr>
<tr>
<td>- Outpatient Department of a Hospital</td>
<td>$0</td>
</tr>
<tr>
<td>X-ray and imaging services</td>
<td>$0</td>
</tr>
<tr>
<td>Includes diagnostic mammography.</td>
<td>$0</td>
</tr>
<tr>
<td>- Outpatient radiology center</td>
<td>$0</td>
</tr>
<tr>
<td>- Outpatient Department of a Hospital</td>
<td>$0</td>
</tr>
<tr>
<td>Benefits</td>
<td>Your payment</td>
</tr>
<tr>
<td>----------------------------------</td>
<td>--------------</td>
</tr>
<tr>
<td>Other outpatient diagnostic testing</td>
<td></td>
</tr>
<tr>
<td>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.</td>
<td></td>
</tr>
<tr>
<td>- Office location</td>
<td>$0</td>
</tr>
<tr>
<td>- Outpatient Department of a Hospital</td>
<td>$0</td>
</tr>
<tr>
<td>Radiological and nuclear imaging services</td>
<td></td>
</tr>
<tr>
<td>- Outpatient radiology center</td>
<td>$0</td>
</tr>
<tr>
<td>- Outpatient Department of a Hospital</td>
<td>$0</td>
</tr>
<tr>
<td>Rehabilitative and habilitative services</td>
<td></td>
</tr>
<tr>
<td>Includes physical therapy, occupational therapy, respiratory therapy, and speech therapy services. There is no visit limit for rehabilitative or habilitative services.</td>
<td></td>
</tr>
<tr>
<td>Office location</td>
<td>$0</td>
</tr>
<tr>
<td>- Outpatient Department of a Hospital</td>
<td>$0</td>
</tr>
<tr>
<td>Durable medical equipment (DME)</td>
<td></td>
</tr>
<tr>
<td>DME</td>
<td>$0</td>
</tr>
<tr>
<td>Breast pump</td>
<td>$0</td>
</tr>
<tr>
<td>Orthotic equipment and devices</td>
<td>$0</td>
</tr>
<tr>
<td>Prosthetic equipment and devices</td>
<td>$0</td>
</tr>
<tr>
<td>Benefits</td>
<td>Your payment</td>
</tr>
<tr>
<td>-----------</td>
<td>--------------</td>
</tr>
<tr>
<td><strong>Home health care services</strong></td>
<td></td>
</tr>
<tr>
<td></td>
<td>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.</td>
</tr>
<tr>
<td><strong>Home infusion and home injectable therapy services</strong></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Includes home infusion drugs and medical supplies.</td>
</tr>
<tr>
<td></td>
<td>Home visits by an infusion nurse</td>
</tr>
<tr>
<td></td>
<td>Hemophilia home infusion services</td>
</tr>
<tr>
<td></td>
<td>Includes blood factor products.</td>
</tr>
<tr>
<td><strong>Skilled Nursing Facility (SNF) services</strong></td>
<td></td>
</tr>
<tr>
<td></td>
<td>50% of up to $500/day plus 100% of additional charges</td>
</tr>
<tr>
<td></td>
<td>Hospital-based SNF</td>
</tr>
<tr>
<td><strong>Hospice program services</strong></td>
<td></td>
</tr>
<tr>
<td></td>
<td>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.</td>
</tr>
<tr>
<td><strong>Other services and supplies</strong></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Devices, equipment, and supplies</td>
</tr>
<tr>
<td></td>
<td>Self-management training</td>
</tr>
</tbody>
</table>
### Benefits

<table>
<thead>
<tr>
<th>Service</th>
<th>When using a Participating Provider³</th>
<th>CYD² applies</th>
<th>When using a Non-Participating Provider⁴</th>
<th>CYD² applies</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dialysis services</td>
<td>$0</td>
<td>✔</td>
<td>50% of up to $300/day plus 100% of additional charges</td>
<td>✔</td>
</tr>
<tr>
<td>PKU product formulas and special food products</td>
<td>$0</td>
<td>✔</td>
<td>$0</td>
<td>✔</td>
</tr>
<tr>
<td>Allergy serum billed separately from an office visit</td>
<td>$0</td>
<td>✔</td>
<td>50%</td>
<td>✔</td>
</tr>
</tbody>
</table>

### Mental Health and Substance Use Disorder Benefits

Mental health and substance use disorder Benefits are provided through Blue Shield’s Mental Health Service Administrator (MHSA).

<table>
<thead>
<tr>
<th>Service</th>
<th>When using a MHSA Participating Provider³</th>
<th>CYD² applies</th>
<th>When using a MHSA Non-Participating Provider⁴</th>
<th>CYD² applies</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Outpatient services</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Office visit, including Physician office visit</td>
<td>$0</td>
<td>✔</td>
<td>50%</td>
<td>✔</td>
</tr>
<tr>
<td>Teladoc behavioral health</td>
<td>$0</td>
<td>✔</td>
<td>Not covered</td>
<td></td>
</tr>
<tr>
<td>Other outpatient services, including intensive outpatient care,</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>electroconvulsive therapy, transcranial magnetic stimulation, Behavioral</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Health Treatment for pervasive developmental disorder or autism in an</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>office setting, home, or other non-institutional facility setting, and</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>office-based opioid treatment</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>$0</td>
<td></td>
<td>✔</td>
<td>50%</td>
<td>✔</td>
</tr>
<tr>
<td>Partial Hospitalization Program</td>
<td>$0</td>
<td>✔</td>
<td></td>
<td>✔</td>
</tr>
<tr>
<td>Psychological Testing</td>
<td>$0</td>
<td>✔</td>
<td>50%</td>
<td>✔</td>
</tr>
</tbody>
</table>

| **Inpatient services**                                                 |                                          |              |                                          |              |
| Physician inpatient services                                           | $0                                      | ✔            | 50% of up to $500/day plus 100% of       | ✔            |
|                                                                        |                                          |              | additional charges                      |              |
| Hospital services                                                      | $0                                      | ✔            | 50% of up to $500/day plus 100% of      | ✔            |
|                                                                        |                                          |              | additional charges                      |              |
| Residential care                                                       | $0                                      | ✔            | 50% of up to $500/day plus 100% of      | ✔            |
|                                                                        |                                          |              | additional charges                      |              |
### Prescription Drug Benefits

<table>
<thead>
<tr>
<th></th>
<th>Your payment</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>When using a Participating Pharmacy</td>
</tr>
<tr>
<td><strong>Retail pharmacy prescription Drugs</strong></td>
<td></td>
</tr>
<tr>
<td>Per prescription, up to a 30-day supply.</td>
<td></td>
</tr>
<tr>
<td>Contraceptive Drugs and devices</td>
<td>$0</td>
</tr>
<tr>
<td>Tier 1 Drugs</td>
<td>$0</td>
</tr>
<tr>
<td>Tier 2 Drugs</td>
<td>$0</td>
</tr>
<tr>
<td>Tier 3 Drugs</td>
<td>$0</td>
</tr>
<tr>
<td>Tier 4 Drugs</td>
<td>$0</td>
</tr>
<tr>
<td><strong>Mail service pharmacy prescription Drugs</strong></td>
<td></td>
</tr>
<tr>
<td>Per prescription, up to a 90-day supply.</td>
<td></td>
</tr>
<tr>
<td>Contraceptive Drugs and devices</td>
<td>$0</td>
</tr>
<tr>
<td>Tier 1 Drugs</td>
<td>$0</td>
</tr>
<tr>
<td>Tier 2 Drugs</td>
<td>$0</td>
</tr>
<tr>
<td>Tier 3 Drugs</td>
<td>$0</td>
</tr>
<tr>
<td>Tier 4 Drugs</td>
<td>$0</td>
</tr>
<tr>
<td><strong>Oral anticancer Drugs</strong></td>
<td></td>
</tr>
<tr>
<td>Per prescription, up to a 30-day supply.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>$0</td>
</tr>
</tbody>
</table>

### Pediatric Benefits

**Pediatric Benefits are available through the end of the month in which the Member turns 19.**

<table>
<thead>
<tr>
<th></th>
<th>Your payment</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>When using a Participating Dentist</td>
</tr>
<tr>
<td><strong>Pediatric dental</strong></td>
<td></td>
</tr>
<tr>
<td>Diagnostic and preventive services</td>
<td></td>
</tr>
<tr>
<td>- Oral exam</td>
<td>$0</td>
</tr>
<tr>
<td>- Preventive – cleaning</td>
<td>$0</td>
</tr>
<tr>
<td>- Preventive – x-ray</td>
<td>$0</td>
</tr>
<tr>
<td>- Sealants per tooth</td>
<td>$0</td>
</tr>
<tr>
<td>- Topical fluoride application</td>
<td>$0</td>
</tr>
<tr>
<td>- Space maintainers - fixed</td>
<td>$0</td>
</tr>
</tbody>
</table>
### Pediatric Benefits

Pediatric Benefits are available through the end of the month in which the Member turns 19.

<table>
<thead>
<tr>
<th>Service Description</th>
<th>When using a Participating Dentist(^2)</th>
<th>CYD(^2) applies</th>
<th>When using a Non-Participating Dentist(^3)</th>
<th>CYD(^2) applies</th>
</tr>
</thead>
<tbody>
<tr>
<td>Basic services</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Restorative procedures</td>
<td>20%</td>
<td></td>
<td>30%</td>
<td></td>
</tr>
<tr>
<td>• Periodontal maintenance</td>
<td>20%</td>
<td></td>
<td>30%</td>
<td></td>
</tr>
<tr>
<td>Major services</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Oral surgery</td>
<td>50%</td>
<td></td>
<td>50%</td>
<td></td>
</tr>
<tr>
<td>• Endodontics</td>
<td>50%</td>
<td></td>
<td>50%</td>
<td></td>
</tr>
<tr>
<td>• Periodontics (other than maintenance)</td>
<td>50%</td>
<td></td>
<td>50%</td>
<td></td>
</tr>
<tr>
<td>• Crowns and casts</td>
<td>50%</td>
<td></td>
<td>50%</td>
<td></td>
</tr>
<tr>
<td>• Prosthodontics</td>
<td>50%</td>
<td></td>
<td>50%</td>
<td></td>
</tr>
<tr>
<td>Orthodontics (Medically Necessary)</td>
<td>50%</td>
<td></td>
<td>50%</td>
<td></td>
</tr>
</tbody>
</table>

### Pediatric Benefits

Pediatric Benefits are available through the end of the month in which the Member turns 19.

<table>
<thead>
<tr>
<th>Service Description</th>
<th>When using a Participating Provider(^2)</th>
<th>CYD(^2) applies</th>
<th>When using a Non-Participating Provider(^3)</th>
<th>CYD(^2) applies</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pediatric vision(^1)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Comprehensive eye examination</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>One exam per Calendar Year</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Ophthalmologic visit</td>
<td>$0</td>
<td></td>
<td>All charges above $30</td>
<td></td>
</tr>
<tr>
<td>• Optometric visit</td>
<td>$0</td>
<td></td>
<td>All charges above $30</td>
<td></td>
</tr>
<tr>
<td>Eyewear/materials</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>One eyeglass frame and eyeglass lenses, or contact lenses instead of eyeglasses, up to the Benefit per Calendar Year. Any exceptions are noted below.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Contact lenses</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Non-elective (Medically Necessary) - hard or soft</td>
<td>$0</td>
<td></td>
<td>All charges above $225</td>
<td></td>
</tr>
<tr>
<td>Up to two pairs per eye per Calendar Year.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Elective (cosmetic/convenience)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Standard and non-standard, hard</td>
<td>$0</td>
<td></td>
<td>All charges above $75</td>
<td></td>
</tr>
<tr>
<td>Up to a 3 month supply for each eye per Calendar Year based on lenses selected.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
### Pediatric Benefits

Pediatric Benefits are available through the end of the month in which the Member turns 19.

<table>
<thead>
<tr>
<th>Pediatric Benefits</th>
<th>When using a Participating Provider</th>
<th>When using a Non-Participating Provider</th>
<th>CYD applies</th>
</tr>
</thead>
<tbody>
<tr>
<td>Standard and non-standard, soft</td>
<td>$0</td>
<td>All charges above $75</td>
<td></td>
</tr>
<tr>
<td>Up to a 6 month supply for each eye per Calendar Year based on lenses selected.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Eyeglass frames</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Collection frames</td>
<td>$0</td>
<td>All charges above $40</td>
<td></td>
</tr>
<tr>
<td>Non-collection frames</td>
<td>All charges above $150</td>
<td>All charges above $40</td>
<td></td>
</tr>
<tr>
<td><strong>Eyeglass lenses</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Lenses include choice of glass or plastic lenses, all lens powers (single vision, bifocal, trifocal, lenticular), fashion or gradient tint, scratch coating, oversized, and glass-grey #3 prescription sunglasses.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Single vision</td>
<td>$0</td>
<td>All charges above $25</td>
<td></td>
</tr>
<tr>
<td>Lined bifocal</td>
<td>$0</td>
<td>All charges above $35</td>
<td></td>
</tr>
<tr>
<td>Lined trifocal</td>
<td>$0</td>
<td>All charges above $45</td>
<td></td>
</tr>
<tr>
<td>Lenticular</td>
<td>$0</td>
<td>All charges above $45</td>
<td></td>
</tr>
<tr>
<td><strong>Optional eyeglass lenses and treatments</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ultraviolet protective coating (standard only)</td>
<td>$0</td>
<td>Not covered</td>
<td></td>
</tr>
<tr>
<td>Polycarbonate lenses</td>
<td>$0</td>
<td>Not covered</td>
<td></td>
</tr>
<tr>
<td>Standard progressive lenses</td>
<td>$0</td>
<td>Not covered</td>
<td></td>
</tr>
<tr>
<td>Premium progressive lenses</td>
<td>$95</td>
<td>Not covered</td>
<td></td>
</tr>
<tr>
<td>Anti-reflective lens coating (standard only)</td>
<td>$35</td>
<td>Not covered</td>
<td></td>
</tr>
<tr>
<td>Photochromic - glass lenses</td>
<td>$25</td>
<td>Not covered</td>
<td></td>
</tr>
<tr>
<td>Photochromic - plastic lenses</td>
<td>$0</td>
<td>Not covered</td>
<td></td>
</tr>
<tr>
<td>High index lenses</td>
<td>$30</td>
<td>Not covered</td>
<td></td>
</tr>
<tr>
<td>Polarized lenses</td>
<td>$45</td>
<td>Not covered</td>
<td></td>
</tr>
<tr>
<td><strong>Low vision testing and equipment</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Comprehensive low vision exam</td>
<td>$0</td>
<td>Not covered</td>
<td></td>
</tr>
<tr>
<td>Once every 5 Calendar Years.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Low vision devices</td>
<td>$0</td>
<td>Not covered</td>
<td></td>
</tr>
<tr>
<td>One aid per Calendar Year.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Diabetes management referral</td>
<td>$0</td>
<td>Not covered</td>
<td></td>
</tr>
</tbody>
</table>
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
- Hospice program services
- Some prescription Drugs (see bluessieldca.com/pharmacy)
- Inpatient facility services
- Pediatric vision non-elective contact lenses and low vision testing and equipment

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 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.

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. Any amount you have paid toward the individual Deductible will be applied to both the individual Deductible and the Family Deductible. 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. 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 or Benefit maximum, whichever is less.
Notes

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 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):

*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, 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 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. Any amount you have paid toward the individual OOPM will be applied to both the individual and the Family OOPM, except for Out-of-Network pediatric dental services. Cost sharing payments for pediatric dental services made by each individual child for Out-of-Network Covered Services do not accumulate to the Family Out-of-Pocket Maximum.

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-non-creditable coverage.*

This Plan’s prescription drug coverage provides less coverage on average than the standard benefit set by the federal government for Medicare Part D (also called non-creditable coverage). It is important to know that generally you may only enroll in a Part D plan when you are initially eligible for Medicare, and from October 15th through December 7th of each subsequent year. You may also be eligible for a special enrollment period with Medicare when you lose
creditable coverage. If you do not enroll in Medicare Part D when first eligible, you may be subject to payment of higher Part D premiums when you do enroll at a later date. For more information about this drug coverage, call the Customer Services telephone number on your Member identification card, Monday through Thursday, 8 a.m. to 5 p.m., or Friday 9 a.m. to 5 p.m.

9 Outpatient Prescription Drug Coverage:

**Brand Drug coverage when a Generic Drug is available.** If you, the Physician, or Health Care Provider, 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.

**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 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.

10 Pediatric Dental Coverage:

**Pediatric dental benefits are provided through Blue Shield’s Dental Plan Administrator (DPA).**

**Orthodontic Covered Services.** The Copayment or Coinsurance for Medically Necessary orthodontic Covered Services applies to a course of treatment even if it extends beyond a Calendar Year. This applies as long as the Member remains enrolled in the Plan.

11 Pediatric Vision Coverage:

**Pediatric vision benefits are provided through Blue Shield’s Vision Plan Administrator (VPA).**

**Covered Services from Non-Participating Providers.** There is no Copayment or Coinsurance up to the listed Allowable Amount. You pay all charges above the Allowable Amount.

**Coverage for frames.** If frames are selected that are more expensive than the Allowable Amount established for frames under this Benefit, you pay the difference between the Allowable Amount and the provider’s charge.

“Collection frames” are covered with no Member payment from Participating Providers. Retail chain Participating Providers do not usually display the frames as “collection,” but a comparable selection of frames is maintained.

“Non-collection frames” are covered up to an Allowable Amount of $150; however, if the Participating Provider uses:

- wholesale pricing, then the Allowable Amount will be up to $99.06.
- warehouse pricing, then the Allowable Amount will be up to $103.64.

Participating Providers using wholesale pricing are identified in the provider directory.

Plans may be modified to ensure compliance with State and Federal requirements.
Discrimination is against the law

Blue Shield of California complies with applicable state laws and federal civil rights laws, and does not discriminate on the basis of race, color, national origin, ancestry, religion, sex, marital status, gender, gender identity, sexual orientation, age, or disability. Blue Shield of California does not exclude people or treat them differently because of race, color, national origin, ancestry, religion, sex, marital status, gender, gender identity, sexual orientation, age, or disability.

Blue Shield of California:

• Provides aids and services at no cost to people with disabilities to communicate effectively with us such as:
  - Qualified sign language interpreters
  - Written information in other formats (including large print, audio, accessible electronic formats, and other formats)

• Provides language services at no cost to people whose primary language is not English such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, contact the Blue Shield of California Civil Rights Coordinator.

If you believe that Blue Shield of California has failed to provide these services or discriminated in another way on the basis of race, color, national origin, ancestry, religion, sex, marital status, gender, gender identity, sexual orientation, age, or disability, you can file a grievance with:

Blue Shield of California
Civil Rights Coordinator
P.O. Box 629007
El Dorado Hills, CA 95762-9007
Phone: (844) 831-4133 (TTY: 711)
Fax: (844) 696-6070
Email: BlueShieldCivilRightsCoordinator@blueshieldca.com

You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, our Civil Rights Coordinator is available to help you. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue SW.
Room 509F, HHH Building
Washington, DC 20201
(800) 368-1019; TTY: (800) 537-7697

Complaint forms are available at www.hhs.gov/ocr/office/file/index.html.
Notice of the Availability of Language Assistance Services
Blue Shield of California

IMPORTANT: Can you read this letter? If not, we can have somebody help you read it. You may also be able to get this letter written in your language. For help at no cost, please call right away at the Member/Customer Service telephone number on the back of your Blue Shield ID card, or (866) 346-7198.

IMPORTANTANTE: ¿Puede leer esta carta? Si no, podemos hacer que alguien le ayude a leerla. También puede recibir esta carta en su idioma. Para ayuda sin cargo, por favor llame inmediatamente al teléfono de Servicios al miembro/cliente que se encuentra al reverso de su tarjeta de identificación de Blue Shield o al (866) 346-7198. (Spanish)

重要通知：您能讀懂這封信嗎？如果不能，我們可以請人幫您閱讀。這封信也可以用您所講的語言書寫。如需免費幫助，請立即撥打登列在您的Blue Shield ID卡背面上的會員/客戶服務部的電話，或者撥打電話 (866) 346-7198。 (Chinese)

QUAN TRỌNG: Quý vị có thể đọc lậu này không? Nếu không, chúng tôi có thể nhận lậu này được viết bằng ngôn ngữ của quý vị. Để được hỗ trợ miễn phí, vui lòng gọi ngay đến Ban Dịch vụ Hội viên/Khách hàng theo số ở mặt sau thẻ ID Blue Shield của quý vị hoặc số (866) 346-7198. (Vietnamese)

Baa’ ákwihwëndzindoogií: Díí naaltsoosish yíníłta? Doo bínígahgoó éí, naaltsoos nich’jí yidóoltahígi la’ nihee hóló. Díí naaltsoos aldó tu Díné k’chíi ádoolníil nínîzingo bígah. Doo báa’ illiniigo shiká adowoow nínîzingo niich’i bée budi heidi-níión doó námboo éí díí Blue Shield bee néího’dilzínígí bine’déé bikáa’ éí doodagó éí (866) 346-7198 jí’ hodi-níinígí. (Navajo)

 중요: 이 서신을 읽을 수 있습니까? 읽을 수 없을 경우, 도움을 드릴 수 있는 사람이 있습니다. 또한 다른 언어로 작성된 이 서신을 받으실 수도 있습니다. 무료로 도움을 받으시려면 Blue Shield ID 카드 뒷면의 회원/고객 서비스 전화번호 또는 (866) 346-7198로 지금 전화하세요. (Korean)

ՎԱՀՆՈՒՄ. Շարունակենք թե դուք կկարողանան ես դիտել այս գրքը; եթե չի, մենք կիրառենք օգտակար նախշ՝ քննարկենք դեր կատարենք կատարենք այնքան արագ, որպեսզանք են՝ թույլ տալիս մենք կատարենք այնքան արագ, որպեսզանք են՝ թույլ տալիս մենք կատարենք այնքան արագ, որպեսզանք են՝ թույլ տալիս մենք կատարենք այնքան արագ, որպեսզանք են՝ թույլ տալիս մենք կատարենք այնքան արագ, որպեսզանք են՝ թույլ տալիս մենք կատարենք այնքան արագ, որպեսզանք են՝ թույլ տալիս մենք կատարենք այնքան արագ, որպեսզանք են՝ թույլ տալիս մենք կատարենք այնքան արագ (Armenian)

ВАЖНО: Не можете прочесть данное письмо? Мы поможем вам, если необходимо. Вы также можете получить это письмо написанное на вашем родном языке. Позвоните в Службу клиентской/членской поддержки прямо сейчас по телефону, указанному сзади идентификационной карты Blue Shield, или по телефону (866) 346-7198, и вам помогут совершенно бесплатно. (Russian)

重要：お客様は、この手紙を読むことができますか？もし読むことができない場合、弊社が、お客様をサポートする人物を手配いたします。また、お客様の母国語で書かれた手紙をお送りすることも可能です。無料のサポートを希望される場合は、Blue Shield IDカードの裏面に記載されている会員/お客様サービスの電話番号、または、(866) 346-7198にお電話をおかけください。 (Japanese)
MARCHUPLUK: If you have questions about a Blue Shield ID card or the Blue Shield number in your ID card, call (866) 346-7198 (Punjabi)

TSEEM CEEB: Koj pos tuaj yeem ngeem tawv no? Yog hais tias nyeem tsis tau, peb tuaj yeem nrhiav ib tug neeg los pace ngeem nru koi. Tej zum koj kuj yuav taox tais muab tsab ntawv no nau ua koi hom lus. Rau kev pab txhais dawb, thov hu kiag rau tus xov tooj Kev Pab Cuam Tub Koom Xeeb/Tub Lag Luam uas nyob rau sab nraum nrob qaum ntawm koj daim npav Blue Shield ID, los yong hau rau tus xov tooj (866) 346-7198. (Hmong)

SOKH: Tan deuam xiyab neua tiab vai vai nia bai loo. Taup vai tai, thiab xiyab tsiab xaybes xiyas tsa bai yam. Taup vai thiaj xiyas tsiab xaybes bai yam, xawm kow bai loo. Taup vai thiaj xiyas tsiab xaybes bai yam, xawm kow bai loo. (Hmong)

SANSAASI: TAN drag shde ast wi az teepg shmar TELFHN 7198-346 (866) ba hfmnmtm tuam/mtl hmr Blue Shield biy ga. (Persian)