blue california

Summary of Benefits

City of Riverside
Effective January 1, 2027
PPO Savings Plan

Custom Full PPO Savings Two-Tier Embedded Deductible 1800/3500/3600

This Summary of Benefits shows the amount you will pay for Covered Benefits 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 Benefits 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: **Plus Formulary**

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 Benefits under the Plan. Blue Shield pays for some Covered Benefits 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*	$1,800
This Plan combines medical and pharmacy Deductibles into one Calendar Year Deductible	*Family coverage*	$3,500: individual $3,600: Family

Calendar Year Out-of-Pocket Maximum[5]

An Out-of-Pocket Maximum is the most a Member will pay for Covered Benefits 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	$4,500	$8,000
Family coverage	$4,500: individual $9,000: Family	$8,000: individual $16,000: Family

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 Benefits.

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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]				
Preventive Health Services	$0		Not covered	
California Prenatal Screening Program	$0		$0	
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	20%	✔	40%	✔
Includes nurse practitioners, physician assistants, therapists, and podiatrists.				
Acupuncture services	20%	✔	40%	✔
Up to 20 visits per Member, per Calendar Year.				
Chiropractic services	20%	✔	40%	✔
Up to 20 visits per Member, per Calendar Year.				
Teladoc Health consultation	$0		Not covered	
Family planning				
• Counseling, consulting, and education	$0		Not covered	
• Injectable contraceptive, diaphragm fitting, intrauterine device (IUD), implantable contraceptive, and related procedure.	$0		Not covered	
• Tubal ligation	$0		Not covered	
• Vasectomy	$0	✔	Not covered	
Medical nutrition therapy, not related to diabetes	20%	✔	40%	✔
Infertility Services				
Physician or surgeon services in an Outpatient Facility	20%	✔	40%	✔
Artificial Inseminations limited to 6 per lifetime	20%	✔	40%	✔
Oocyte (egg) retrieval limited to 3 per lifetime				
• Ambulatory Surgery Center	10%	✔	40% Subject to a Benefit maximum of $350/day	✔

Benefits[6]	Your payment			
	When using a Participating Provider[3]	CYD[2] applies	When using a Non-Participating Provider[4]	CYD[2] applies
• Outpatient Department of a Hospital	20%	✔	40% Subject to a Benefit maximum of $350/day	✔
In vitro fertilization (IVF)	20%	✔	40%	✔
Gamete Intrafallopian Transfer (GIFT) limited to 3 per lifetime				
• GIFT Ambulatory Surgery Center	10%	✔	40% Subject to a Benefit maximum of $350/day	✔
• Outpatient Department of a Hospital	20%	✔	40% Subject to a Benefit maximum of $350/day	✔
Zygote Intrafallopian Transfer (ZIFT) limited to 3 per lifetime				
• Ambulatory Surgery Center	10%	✔	40% Subject to a Benefit maximum of $350/day	✔
• Outpatient Department of a Hospital	20%	✔	40% Subject to a Benefit maximum of $350/day	✔
Embryo transfer				
• Ambulatory Surgery Center	10%	✔	40% Subject to a Benefit maximum of $350/day	✔
• Outpatient Department of a Hospital	20%	✔	40% Subject to a Benefit maximum of $350/day	✔
Cryopreservation limited to 1 year of storage per lifetime for each of the following: sperm, reproductive tissue, oocytes (eggs), and embryos	20%	✔	40%	✔
Pregnancy and maternity care				
Physician office visits: prenatal and postnatal	20%	✔	40%	✔
Abortion and abortion-related services	$0	✔	$0	✔

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%	✔	40%	✔
Ambulance services *This payment is for emergency or authorized transport.*	20%	✔	20%	✔
Outpatient Facility services				
Ambulatory Surgery Center	10%	✔	40% Subject to a Benefit maximum of $350/day	✔
Outpatient Department of a Hospital: surgery	20%	✔	40% Subject to a Benefit maximum of $350/day	✔
Outpatient Department of a Hospital: treatment of illness or injury, radiation therapy, chemotherapy, and necessary supplies	20%	✔	40% Subject to a Benefit maximum of $350/day	✔
Inpatient facility services				
Hospital services and stay	20%	✔	40% Subject to a Benefit maximum of $600/day	✔
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	20%	✔	Not covered	
• Physician inpatient services	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
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	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 Benefits that are diagnostic, non-Preventive Health Services, and diagnostic radiological procedures. For the payments for Covered Benefits that are considered Preventive Health Services, see Preventive Health Services.				
Laboratory and pathology services				
Includes diagnostic Papanicolaou (Pap) test.				
• Laboratory center	20%	✔	40%	✔
• Outpatient Department of a Hospital	30%	✔	40% Subject to a Benefit maximum of $350/day	✔
Basic imaging services				
Includes plain film X-rays, ultrasounds, and diagnostic mammography.				
• Outpatient radiology center	20%	✔	40%	✔
• Outpatient Department of a Hospital	30%	✔	40% Subject to a Benefit maximum of $350/day	✔

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 non-invasive diagnostic testing *Testing to diagnose illness or injury such as vestibular function tests, EKG, cardiac monitoring, non-invasive vascular studies, sleep medicine testing, muscle and range of motion tests, EEG, and EMG.*				
• Office location	20%	✔	40%	✔
• Outpatient Department of a Hospital	30%	✔	40% Subject to a Benefit maximum of $350/day	✔
Advanced imaging services *Includes diagnostic radiological and nuclear imaging such as CT scans, MRIs, MRAs, and PET scans.*				
• Outpatient radiology center	20%	✔	40%	✔
• Outpatient Department of a Hospital	$100/visit plus 20%	✔	40% Subject to a Benefit maximum of $350/day	✔
Rehabilitative and Habilitative Services *Includes physical therapy, occupational therapy, respiratory therapy, and speech therapy services.*				
Office location	20%	✔	40%	✔
Outpatient Department of a Hospital	20%	✔	40% Subject to a Benefit maximum of $350/day	✔
Durable medical equipment (DME)				
DME	20%	✔	40%	✔
Breast pump	$0		Not covered	
Glucose monitor	20%		40%	✔
Peak Flow Meter	20%		40%	✔
Orthotic equipment and devices	20%	✔	40%	✔
Prosthetic equipment and devices	20%	✔	40%	✔

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 care 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. Includes home visits by a nurse, Home Health Aide, medical social worker, physical therapist, speech therapist, or occupational therapist, and medical supplies.*	20%	✔	Not covered	
Home infusion and home injectable therapy services				
Home infusion agency services *Includes home infusion drugs, medical supplies, and visits by a nurse.*	$45/visit	✔	Not covered	
Hemophilia home infusion services *Includes blood factor products.*	$45/visit	✔	Not covered	
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%	✔	40%	✔
Hospital-based SNF	20%	✔	40% Subject to a Benefit maximum of $600/day	✔
Hospice program services *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.*	$0	✔	Not covered	
Other services and supplies				
Diabetes care services				
• Devices, equipment, and supplies	20%	✔	40%	✔
• Self-management training	20%	✔	40%	✔
• Medical nutrition therapy	20%	✔	40%	✔
Dialysis services	20%	✔	40% Subject to a Benefit maximum of $350/day	✔
PKU product formulas and special food products	20%	✔	20%	✔

Benefits[6]	Your payment			
	When using a Participating Provider[3]	CYD[2] applies	When using a Non-Participating Provider[4]	CYD[2] applies
Allergy serum billed separately from an office visit	20%	✔	40%	✔

Mental Health or Substance Use Disorder Benefits	Your payment			
	When using a Participating Provider[3]	CYD[2] applies	When using a Non-Participating Provider[4]	CYD[2] applies
Outpatient services				
Office visit, including Physician office visit	20%	✔	40%	✔
Teladoc Health mental health	$0		Not covered	
Other outpatient services, including intensive outpatient care, electroconvulsive therapy, transcranial magnetic stimulation, Behavioral Health Treatment for pervasive developmental disorder or autism				
• Office location, clinic, home, or other non-institutional facility setting	20%	✔	40%	✔
• Outpatient Department of a Hospital	20%	✔	40% Subject to a Benefit maximum of $350/day	✔
Office-based opioid treatment	20%	✔	40%	✔
Partial Hospitalization Program	20%	✔	40% Subject to a Benefit maximum of $350/day	✔
Neuropsychological and Psychological Testing	20%	✔	40%	✔
Inpatient services				
Physician inpatient services	$0	✔	40%	✔
Hospital services	20%	✔	40% Subject to a Benefit maximum of $600/day	✔
Residential Care	20%	✔	40% Subject to a Benefit maximum of $600/day	✔

Prescription Drug Benefits[8,9]	Your payment			
	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.				
Contraceptive Drugs and devices	$0		Applicable Tier 1, Tier 2, or Tier 3 Copayment	
Tier 1 Drugs	$10/prescription	✔	25% plus $10/prescription	✔
Tier 2 Drugs	$25/prescription	✔	25% plus $25/prescription	✔
Tier 3 Drugs	$40/prescription	✔	25% plus $40/prescription	✔
Tier 4 Drugs	30% up to $250/prescription	✔	30% up to $250/prescription plus 25% of purchase price	✔
Retail pharmacy prescription Drugs				
Per prescription, for a 90-day supply.				
Contraceptive Drugs and devices	$0		Not covered	
Tier 1 Drugs	$30/prescription	✔	Not covered	
Tier 2 Drugs	$75/prescription	✔	Not covered	
Tier 3 Drugs	$120/prescription	✔	Not covered	
Tier 4 Drugs	30% up to $750/prescription	✔	Not covered	
Home delivery pharmacy prescription Drugs				
Per prescription, for a 31-90-day supply.				
Contraceptive Drugs and devices	$0		Not covered	
Tier 1 Drugs	$20/prescription	✔	Not covered	
Tier 2 Drugs	$50/prescription	✔	Not covered	
Tier 3 Drugs	$80/prescription	✔	Not covered	
Tier 4 Drugs	30% up to $500/prescription	✔	Not covered	

Prior Authorization

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

- Advanced imaging services
- Outpatient mental health services, except office visits and office-based opioid treatment
- Inpatient facility services
- 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 Plan. Please review the EOC for more details of coverage outlined in this Summary of Benefits. You can request a copy of the EOC at any time.

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

2 Calendar Year Deductible (CYD):

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

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

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

This Plan has a combined Participating Provider and Non-Participating Provider Calendar Year 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. 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 Benefits 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.

4 Using Non-Participating Providers:

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

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

- any charges above the Allowable Amount.

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

- Coinsurance is calculated from the Allowable Amount, which is subject to any stated Benefit maximum.
- Charges above the Allowable Amount do not count towards the Deductible or 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 Benefits in a Calendar Year. Once you reach your Out-of-Pocket Maximum, Blue Shield will pay 100% of the Allowable Amount for Covered Benefits for the rest of the Calendar Year.

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

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

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

Covered Drugs obtained at Non-Participating Pharmacies. Any amounts you pay for Covered Drugs at Non-Participating Pharmacies count towards the 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 Benefits are Received:

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

7 Preventive Health Services:

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

9 Outpatient Prescription Drug Coverage:

Brand Drug coverage when a Generic or Biosimilar Drug is available. If you, the Physician, or Health Care Provider, select a Brand Drug when a Generic Drug equivalent or Biosimilar Drug is available, you are responsible for the difference between the cost to Blue Shield for the Brand Drug and its Generic Drug equivalent or Biosimilar Drug plus the applicable tier Copayment or Coinsurance of the Brand Drug. This difference in cost will not count towards any

Notes

Calendar Year pharmacy Deductible, medical Deductible, or the Calendar Year Out-of-Pocket Maximum. 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.

See the Obtaining outpatient prescription Drugs at a Participating Pharmacy section of the EOC for more information about how a brand contraceptive may be covered without a Copayment or Coinsurance.

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

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

Oral Anticancer Drugs. After the Deductible is met, you pay up to $250 for oral Anticancer Drugs from a Participating Pharmacy, up to a 30-day supply.

High Deductible Health Plan (HDHP) preventive Drugs. HDHP preventive Drugs obtained from a Participating Pharmacy are covered at the applicable Drug tier Copayment but are not subject to the Deductible. HDHP preventive Drugs do not include those preventive Drugs that are required by Health Care Reform to be covered at no charge. Visit blueshieldca.com/pharmacy for lists of these Drugs.

Retail pharmacy. You may receive up to a 90-day supply for maintenance Drugs at a Participating Pharmacy when you pay the applicable Copayment or Coinsurance for each 30-day supply.

Home delivery. You pay the applicable 30-day retail pharmacy Copayment or Coinsurance for a 30-day supply or less from the home delivery pharmacy.

Insulin. You will not pay more than $35 for a 30-day supply of Formulary insulin Prescription Drugs from a Participating Pharmacy.

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

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Hearing Aid Services Rider

Group Rider
Effective January 1, 2027
PSP

Custom PSP Hearing Aid and Ancillary Equipment Benefit Summary of Benefits

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

Benefits	Your Payment
Up to a $5,000 maximum per Member in any 24-month period. Covers 2 hearing aids per member per 24 months. Services are subject to the Calendar Year Deductible and count towards the Calendar Year Out-of-Pocket Maximum.	**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	20% of up to $5,000 per member per 24 months plus 100% of additional charges

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

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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 up to the number of hearing aids per Member in any period, are subject to the Calendar Year Deductible.

Blue Shield will reimburse you for Covered Benefits 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.