



Summary of Benefits

East West Bank  
Effective June 1, 2024  
PPO Plan

Blue Shield PPO

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.<sup>1</sup> Please read both documents carefully for details.

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)<sup>2</sup>

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 Participating <sup>3</sup> or Non-Participating <sup>4</sup> Provider |                     |                   |
|------------------------------------------------------------------------------------|---------------------|-------------------|
| Calendar Year medical Deductible                                                   | Individual coverage | \$250             |
|                                                                                    | Family coverage     | \$250: individual |
|                                                                                    |                     | \$500: Family     |

Calendar Year Out-of-Pocket Maximum<sup>5</sup>

An Out-of-Pocket Maximum is the most a Member will pay for Covered Services each Calendar Year. Any exceptions are listed in the Notes section at the end of this Summary of Benefits.

|                     | When using a Participating Provider <sup>3</sup> | When using any combination of Participating <sup>3</sup> or Non-Participating <sup>4</sup> Providers |
|---------------------|--------------------------------------------------|------------------------------------------------------------------------------------------------------|
| Individual coverage | \$2,250                                          | \$5,250                                                                                              |
| Family coverage     | \$2,250: individual                              | \$5,250: individual                                                                                  |
|                     | \$4,500: Family                                  | \$10,500: 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.

Benefits<sup>6</sup>

## Your payment

|                                                                                                                             | When using a Participating Provider <sup>3</sup> | CYD <sup>2</sup> applies | When using a Non-Participating Provider <sup>4</sup> | CYD <sup>2</sup> applies |
|-----------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------|--------------------------|------------------------------------------------------|--------------------------|
| <b>Preventive Health Services<sup>7</sup></b>                                                                               |                                                  |                          |                                                      |                          |
| Preventive Health Services                                                                                                  | \$0                                              |                          | 30%                                                  | ✓                        |
| <b>Physician services</b>                                                                                                   |                                                  |                          |                                                      |                          |
| Primary care office visit                                                                                                   | \$10/visit                                       |                          | 30%                                                  | ✓                        |
| Specialist care office visit                                                                                                | \$10/visit                                       |                          | 30%                                                  | ✓                        |
| Physician home visit                                                                                                        | \$10/visit                                       |                          | 30%                                                  | ✓                        |
| Physician or surgeon services in an Outpatient Facility                                                                     | 10%                                              | ✓                        | 30%                                                  | ✓                        |
| Physician or surgeon services in an inpatient facility                                                                      | 10%                                              | ✓                        | 30%                                                  | ✓                        |
| <b>Other professional services</b>                                                                                          |                                                  |                          |                                                      |                          |
| Other practitioner office visit<br><i>Includes nurse practitioners, physician assistants, and therapists.</i>               | \$10/visit                                       |                          | 30%                                                  | ✓                        |
| Acupuncture services<br><i>Up to 20 visits per Member, per Calendar Year.</i>                                               | \$10/visit                                       | ✓                        | 30%                                                  | ✓                        |
| Chiropractic services<br><i>Up to 20 visits per Member, per Calendar Year.</i>                                              | \$10/visit                                       | ✓                        | 30%                                                  | ✓                        |
| Teladoc consultation                                                                                                        | \$0                                              |                          | Not covered                                          |                          |
| Family planning                                                                                                             |                                                  |                          |                                                      |                          |
| • Counseling, consulting, and education                                                                                     | \$0                                              |                          | 30%                                                  | ✓                        |
| • Injectable contraceptive                                                                                                  | \$0                                              |                          | 30%                                                  | ✓                        |
| • Diaphragm fitting                                                                                                         | \$0                                              |                          | 30%                                                  | ✓                        |
| • Intrauterine device (IUD)                                                                                                 | \$0                                              |                          | 30%                                                  | ✓                        |
| • Insertion and/or removal of intrauterine device (IUD)                                                                     | \$0                                              |                          | 30%                                                  | ✓                        |
| • Implantable contraceptive                                                                                                 | \$0                                              |                          | 30%                                                  | ✓                        |
| • Tubal ligation                                                                                                            | \$0                                              |                          | 30%                                                  | ✓                        |
| • Vasectomy                                                                                                                 | 10%                                              | ✓                        | 30%                                                  | ✓                        |
| <b>Infertility Services</b>                                                                                                 |                                                  |                          |                                                      |                          |
| • Natural artificial inseminations limited to 6 per lifetime.<br>Without ovum [oocyte or ovarian tissue (egg)] stimulation. | 50%                                              |                          | Not covered                                          |                          |
| • Stimulated artificial inseminations limited to 3 per lifetime.<br>With ovum [oocyte or ovarian tissue (egg)] stimulation. | 50%                                              |                          | Not covered                                          |                          |

**Benefits<sup>6</sup>**
**Your payment**

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | When using a Participating Provider <sup>3</sup> | CYD <sup>2</sup> applies | When using a Non-Participating Provider <sup>4</sup> | CYD <sup>2</sup> applies |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------|--------------------------|------------------------------------------------------|--------------------------|
| <ul style="list-style-type: none"> <li>Gamete intrafallopian transfer (GIFT) limited to 1 per lifetime.</li> <li>Zygote intrafallopian transfer (ZIFT) limited to 2 per lifetime.</li> <li>In-vitro fertilization (IVF) limited to 2 per lifetime.</li> <li>Intracytoplasmic sperm injection (ICSI) limited to 2 per lifetime.</li> <li>Cryopreservation of sperm, oocytes, embryos limited to one retrieval and three years of storage per lifetime.</li> </ul> | 50%                                              |                          | Not covered                                          |                          |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | 50%                                              |                          | Not covered                                          |                          |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | 50%                                              |                          | Not covered                                          |                          |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | 50%                                              |                          | Not covered                                          |                          |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | 50%                                              |                          | Not covered                                          |                          |
| Podiatric services                                                                                                                                                                                                                                                                                                                                                                                                                                               | \$10/visit                                       |                          | 30%                                                  | ✓                        |
| Medical nutrition therapy, not related to diabetes                                                                                                                                                                                                                                                                                                                                                                                                               | 10%                                              | ✓                        | 30%                                                  | ✓                        |
| <b>Pregnancy and maternity care</b>                                                                                                                                                                                                                                                                                                                                                                                                                              |                                                  |                          |                                                      |                          |
| Physician office visits: prenatal and postnatal                                                                                                                                                                                                                                                                                                                                                                                                                  | 10%                                              | ✓                        | 30%                                                  | ✓                        |
| Physician services for pregnancy termination                                                                                                                                                                                                                                                                                                                                                                                                                     | \$0                                              |                          | \$0                                                  |                          |
| <b>Emergency Services</b>                                                                                                                                                                                                                                                                                                                                                                                                                                        |                                                  |                          |                                                      |                          |
| Emergency room services                                                                                                                                                                                                                                                                                                                                                                                                                                          | \$100/visit                                      |                          | \$100/visit                                          |                          |
| <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                                                                                                                                                                                                                                                                                                                                                                                                                                | 10%                                              | ✓                        | 10%                                                  | ✓                        |
| <b>Urgent care center services</b>                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                  |                          |                                                      |                          |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | \$10/visit                                       |                          | 30%                                                  | ✓                        |
| <b>Ambulance services</b>                                                                                                                                                                                                                                                                                                                                                                                                                                        |                                                  |                          |                                                      |                          |
| <i>This payment is for emergency or authorized transport.</i>                                                                                                                                                                                                                                                                                                                                                                                                    | 10%                                              | ✓                        | 10%                                                  | ✓                        |
| <b>Outpatient Facility services</b>                                                                                                                                                                                                                                                                                                                                                                                                                              |                                                  |                          |                                                      |                          |
| Ambulatory Surgery Center                                                                                                                                                                                                                                                                                                                                                                                                                                        | 10%                                              | ✓                        | 30%<br>Subject to a Benefit maximum of \$350/day     | ✓                        |
| Outpatient Department of a Hospital: surgery                                                                                                                                                                                                                                                                                                                                                                                                                     | 10%                                              | ✓                        | 30%<br>Subject to a Benefit maximum of \$350/day     | ✓                        |
| Outpatient Department of a Hospital: treatment of illness or injury, radiation therapy, chemotherapy, and necessary supplies                                                                                                                                                                                                                                                                                                                                     | 10%                                              | ✓                        | 30%<br>Subject to a Benefit maximum of \$350/day     | ✓                        |

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | When using a Participating Provider <sup>3</sup> | CYD <sup>2</sup> applies | When using a Non-Participating Provider <sup>4</sup> | CYD <sup>2</sup> applies |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------|--------------------------|------------------------------------------------------|--------------------------|
| <b>Inpatient facility services</b>                                                                                                                                                                                                                                                                                                                                                                                                                                        |                                                  |                          |                                                      |                          |
| Hospital services and stay                                                                                                                                                                                                                                                                                                                                                                                                                                                | 10%                                              | ✓                        | 30%<br>Subject to a Benefit maximum of \$600/day     | ✓                        |
| 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                                                                                                                                                                                                                                                                                                                                                                                                                          | 10%                                              | ✓                        | Not covered                                          |                          |
| • Physician inpatient services                                                                                                                                                                                                                                                                                                                                                                                                                                            | 10%                                              | ✓                        | Not covered                                          |                          |
| <b>Bariatric surgery services, designated California counties</b>                                                                                                                                                                                                                                                                                                                                                                                                         |                                                  |                          |                                                      |                          |
| <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> |                                                  |                          |                                                      |                          |
| Inpatient facility services                                                                                                                                                                                                                                                                                                                                                                                                                                               | 10%                                              | ✓                        | Not covered                                          |                          |
| Outpatient Facility services                                                                                                                                                                                                                                                                                                                                                                                                                                              | 10%                                              | ✓                        | Not covered                                          |                          |
| Physician services                                                                                                                                                                                                                                                                                                                                                                                                                                                        | 10%                                              | ✓                        | Not covered                                          |                          |
| <b>Diagnostic x-ray, imaging, pathology, and laboratory services</b>                                                                                                                                                                                                                                                                                                                                                                                                      |                                                  |                          |                                                      |                          |
| <i>This payment is for Covered Services that are diagnostic, non-Preventive Health Services, and diagnostic radiological procedures. For the payments for Covered Services that are considered Preventive Health Services, see Preventive Health Services.</i>                                                                                                                                                                                                            |                                                  |                          |                                                      |                          |
| Laboratory and pathology services                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                                  |                          |                                                      |                          |
| <i>Includes diagnostic Papanicolaou (Pap) test.</i>                                                                                                                                                                                                                                                                                                                                                                                                                       |                                                  |                          |                                                      |                          |
| • Laboratory center                                                                                                                                                                                                                                                                                                                                                                                                                                                       | 10%                                              | ✓                        | 30%                                                  | ✓                        |
| • Outpatient Department of a Hospital                                                                                                                                                                                                                                                                                                                                                                                                                                     | 10%                                              | ✓                        | 30%<br>Subject to a Benefit maximum of \$350/day     | ✓                        |

## Benefits<sup>6</sup>

## Your payment

|                                                                                                                                                                                                                                                                            | When using a Participating Provider <sup>3</sup> | CYD <sup>2</sup> applies | When using a Non-Participating Provider <sup>4</sup> | CYD <sup>2</sup> applies |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------|--------------------------|------------------------------------------------------|--------------------------|
| <b>Basic imaging services</b><br><i>Includes plain film X-rays, ultrasounds, and diagnostic mammography.</i>                                                                                                                                                               |                                                  |                          |                                                      |                          |
| • Outpatient radiology center                                                                                                                                                                                                                                              | 10%                                              | ✓                        | 30%                                                  | ✓                        |
| • Outpatient Department of a Hospital                                                                                                                                                                                                                                      | 10%                                              | ✓                        | 30%<br>Subject to a Benefit maximum of \$350/day     | ✓                        |
| <b>Other outpatient non-invasive diagnostic testing</b><br><i>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.</i> |                                                  |                          |                                                      |                          |
| • Office location                                                                                                                                                                                                                                                          | 10%                                              | ✓                        | 30%                                                  | ✓                        |
| • Outpatient Department of a Hospital                                                                                                                                                                                                                                      | 10%                                              | ✓                        | 30%<br>Subject to a Benefit maximum of \$350/day     | ✓                        |
| <b>Advanced imaging services</b><br><i>Includes diagnostic radiological and nuclear imaging such as CT scans, MRIs, MRAs, and PET scans.</i>                                                                                                                               |                                                  |                          |                                                      |                          |
| • Outpatient radiology center                                                                                                                                                                                                                                              | 10%                                              | ✓                        | 30%                                                  | ✓                        |
| • Outpatient Department of a Hospital                                                                                                                                                                                                                                      | 10%                                              | ✓                        | 30%                                                  | ✓                        |
| <b>Rehabilitative and Habilitative Services</b><br><i>Includes physical therapy, occupational therapy, and respiratory therapy.</i>                                                                                                                                        |                                                  |                          |                                                      |                          |
| Office location                                                                                                                                                                                                                                                            | \$10/visit                                       | ✓                        | 30%                                                  | ✓                        |
| Outpatient Department of a Hospital                                                                                                                                                                                                                                        | \$10/visit                                       | ✓                        | 30%<br>Subject to a Benefit maximum of \$350/day     | ✓                        |
| <b>Speech Therapy services</b>                                                                                                                                                                                                                                             |                                                  |                          |                                                      |                          |
| Office location                                                                                                                                                                                                                                                            | \$10/visit                                       | ✓                        | 30%                                                  | ✓                        |
| Outpatient Department of a Hospital                                                                                                                                                                                                                                        | \$10/visit                                       | ✓                        | 30%<br>Subject to a Benefit maximum of \$350/day     | ✓                        |

Benefits<sup>6</sup>

## Your payment

|                                                                                                                                                                                                                                                                                                                                                     | When using a Participating Provider <sup>3</sup> | CYD <sup>2</sup> applies | When using a Non-Participating Provider <sup>4</sup> | CYD <sup>2</sup> applies |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------|--------------------------|------------------------------------------------------|--------------------------|
| <b>Durable medical equipment (DME)</b>                                                                                                                                                                                                                                                                                                              |                                                  |                          |                                                      |                          |
| DME                                                                                                                                                                                                                                                                                                                                                 | 10%                                              | ✓                        | 30%                                                  | ✓                        |
| Breast pump                                                                                                                                                                                                                                                                                                                                         | \$0                                              |                          | Not covered                                          |                          |
| Orthotic equipment and devices                                                                                                                                                                                                                                                                                                                      | 10%                                              | ✓                        | 30%                                                  | ✓                        |
| Prosthetic equipment and devices                                                                                                                                                                                                                                                                                                                    | 10%                                              | ✓                        | 30%                                                  | ✓                        |
| <b>Home health care services</b>                                                                                                                                                                                                                                                                                                                    | 10%                                              | ✓                        | Not covered                                          |                          |
| <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> |                                                  |                          |                                                      |                          |
| <b>Home infusion and home injectable therapy services</b>                                                                                                                                                                                                                                                                                           |                                                  |                          |                                                      |                          |
| Home infusion agency services                                                                                                                                                                                                                                                                                                                       | 10%                                              | ✓                        | Not covered                                          |                          |
| <i>Includes home infusion drugs, medical supplies, and visits by a nurse.</i>                                                                                                                                                                                                                                                                       |                                                  |                          |                                                      |                          |
| Hemophilia home infusion services                                                                                                                                                                                                                                                                                                                   | 10%                                              | ✓                        | Not covered                                          |                          |
| <i>Includes blood factor products.</i>                                                                                                                                                                                                                                                                                                              |                                                  |                          |                                                      |                          |
| <b>Skilled Nursing Facility (SNF) services</b>                                                                                                                                                                                                                                                                                                      |                                                  |                          |                                                      |                          |
| <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>                                                                                              |                                                  |                          |                                                      |                          |
| Freestanding SNF                                                                                                                                                                                                                                                                                                                                    | 10%                                              | ✓                        | 10%                                                  | ✓                        |
|                                                                                                                                                                                                                                                                                                                                                     |                                                  |                          | 30%                                                  |                          |
| Hospital-based SNF                                                                                                                                                                                                                                                                                                                                  | 10%                                              | ✓                        | Subject to a Benefit maximum of \$600/day            | ✓                        |
| <b>Hospice program services</b>                                                                                                                                                                                                                                                                                                                     |                                                  |                          |                                                      |                          |
| Pre-Hospice consultation                                                                                                                                                                                                                                                                                                                            | \$0                                              |                          | Not covered                                          |                          |
| Routine home care                                                                                                                                                                                                                                                                                                                                   | \$0                                              |                          | Not covered                                          |                          |
| 24-hour continuous home care                                                                                                                                                                                                                                                                                                                        | \$0                                              |                          | Not covered                                          |                          |
| Short-term inpatient care for pain and symptom management                                                                                                                                                                                                                                                                                           | \$0                                              |                          | Not covered                                          |                          |
| Inpatient respite care                                                                                                                                                                                                                                                                                                                              | \$0                                              |                          | Not covered                                          |                          |

## Benefits<sup>6</sup>

## Your payment

|                                                      | When using a Participating Provider <sup>3</sup> | CYD <sup>2</sup> applies | When using a Non-Participating Provider <sup>4</sup> | CYD <sup>2</sup> applies |
|------------------------------------------------------|--------------------------------------------------|--------------------------|------------------------------------------------------|--------------------------|
| <b>Other services and supplies</b>                   |                                                  |                          |                                                      |                          |
| Diabetes care services                               |                                                  |                          |                                                      |                          |
| • Devices, equipment, and supplies                   | 10%                                              | ✓                        | 30%                                                  | ✓                        |
| • Self-management training                           | \$10/visit                                       |                          | 30%                                                  | ✓                        |
| • Medical nutrition therapy                          | \$10/visit                                       |                          | 30%                                                  | ✓                        |
| Dialysis services                                    | 10%                                              | ✓                        | 30%<br>Subject to a Benefit maximum of \$350/day     | ✓                        |
| PKU product formulas and special food products       | 10%                                              | ✓                        | 10%                                                  | ✓                        |
| Allergy serum billed separately from an office visit | 10%                                              | ✓                        | 30%                                                  | ✓                        |

## Mental Health and Substance Use Disorder Benefits

## Your payment

|                                                                        | When using a Participating Provider <sup>3</sup> | CYD <sup>2</sup> applies | When using a Non-Participating Provider <sup>4</sup> | CYD <sup>2</sup> applies |
|------------------------------------------------------------------------|--------------------------------------------------|--------------------------|------------------------------------------------------|--------------------------|
| <b>Outpatient services</b>                                             |                                                  |                          |                                                      |                          |
| Office visit, including Physician office visit                         | \$10/visit                                       |                          | 30%                                                  | ✓                        |
| Teladoc mental health                                                  | \$0                                              |                          | Not covered                                          |                          |
| Intensive outpatient care                                              | 10%                                              | ✓                        | 30%                                                  | ✓                        |
| Behavioral Health Treatment in an office setting                       | 10%                                              | ✓                        | 30%                                                  | ✓                        |
| Behavioral Health Treatment in home or other non-institutional setting | 10%                                              | ✓                        | 30%                                                  | ✓                        |
| Office-based opioid treatment                                          | 10%                                              | ✓                        | 30%                                                  | ✓                        |
| Partial Hospitalization Program                                        | 10%                                              | ✓                        | 30%<br>Subject to a Benefit maximum of \$350/day     | ✓                        |
| Psychological Testing                                                  | 10%                                              | ✓                        | 30%                                                  | ✓                        |
| <b>Inpatient services</b>                                              |                                                  |                          |                                                      |                          |
| Physician inpatient services                                           | 10%                                              | ✓                        | 30%                                                  | ✓                        |
| Hospital services                                                      | 10%                                              | ✓                        | 30%<br>Subject to a Benefit maximum of \$600/day     | ✓                        |

## Mental Health and Substance Use Disorder Benefits

## Your payment

|                  | When using a Participating Provider <sup>3</sup> | CYD <sup>2</sup> applies | When using a Non-Participating Provider <sup>4</sup> | CYD <sup>2</sup> applies |
|------------------|--------------------------------------------------|--------------------------|------------------------------------------------------|--------------------------|
| Residential Care | 10%                                              | ✓                        | 30%<br>Subject to a Benefit maximum of \$600/day     | ✓                        |

## 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

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 Calendar Year 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.

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.



### 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 consultations are provided through Teladoc.

"Allowable Amount" is defined in the Benefit Booklet. 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 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.

"Allowable Amount" is defined in the Benefit Booklet. 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 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 and charges above the Allowable Amount.

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 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 by a Participating Provider. 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.