



Summary of Benefits

TriNet HR III, Inc
Effective October 1, 2026
PPO Plan

Custom PPO 500

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.

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 Provider ³	When using any combination of Participating ³ and Non-Participating ⁴ Providers
Calendar Year medical Deductible	Individual coverage	\$500	\$1,000
	Family coverage	\$500: individual \$1,500: Family	\$1,000: individual \$2,000: Family

Calendar Year Out-of-Pocket Maximum⁵

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.

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.

	When using a Participating Provider ³	When using any combination of Participating ³ or Non-Participating ⁴ Providers
Individual coverage	\$4,000	\$7,000
Family coverage	\$4,000: individual \$8,000: Family	\$7,000: individual \$14,000: Family

Blue Shield of California is an independent member of the Blue Shield Association

Benefits⁶

Your payment

	When using a Participating Provider ³	CYD ² applies	When using a Non-Participating Provider ⁴	CYD ² applies
Preventive Health Services⁷				
Preventive Health Services	\$0		35%	✓
California Prenatal Screening Program	\$0		\$0	
Physician services				
Primary care office visit	\$30/visit		35%	✓
Specialist care office visit	\$60/visit		35%	✓
Physician home visit	\$30/visit		35%	✓
Physician or surgeon services in an Outpatient Facility	15%	✓	35%	✓
Physician or surgeon services in an inpatient facility	15%	✓	35%	✓
Other professional services				
Other practitioner office visit <i>Includes nurse practitioners, physician assistants, therapists, and podiatrists.</i>	\$30/visit		35%	✓
Acupuncture services <i>Up to 20 visits per Member, per Calendar Year.</i>	\$25/visit		35%	✓
Chiropractic services <i>Up to 20 visits per Member, per Calendar Year.</i>	\$25/visit		35%	✓
Teladoc Health consultation	\$0		Not covered	
Family planning				
• Counseling, consulting, and education	\$0		35%	✓
• Injectable contraceptive, diaphragm fitting, intrauterine device (IUD), implantable contraceptive, and related procedure.	\$0		35%	✓
• Tubal ligation	\$0		35%	✓
• Vasectomy	\$0		35%	✓
Medical nutrition therapy, not related to diabetes	15%	✓	35%	✓
Infertility Services				
Physician or surgeon services in an Outpatient Facility	15%	✓	35%	✓
Artificial Inseminations limited to 6 per lifetime	15%	✓	35%	✓
Oocyte (egg) retrieval limited to 3 per lifetime				
• Ambulatory Surgery Center	15%	✓	35% Subject to a Benefit maximum of \$350/day	✓

Benefits⁶
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	15%	✓	35% Subject to a Benefit maximum of \$350/day	✓
In vitro fertilization (IVF) Embryo transfer	15%	✓	35%	✓
Ambulatory Surgery Center	15%	✓	35% Subject to a Benefit maximum of \$350/day	✓
Outpatient Department of a Hospital	15%	✓	35% 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	15%	✓	35%	✓
Pregnancy and maternity care				
Physician office visits: prenatal and postnatal	15%	✓	35%	✓
Abortion and abortion-related services	\$0		\$0	
Emergency Services				
Emergency room services	\$250/visit plus 15%		\$250/visit plus 15%	
<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	15%	✓	15%	✓
Urgent care center services				
	\$30/visit		35%	✓
Ambulance services				
<i>This payment is for emergency or authorized transport.</i>	\$250/transport	✓	\$250/transport	✓
Outpatient Facility services				
Ambulatory Surgery Center	15%	✓	35% Subject to a Benefit maximum of \$350/day	✓

Benefits⁶
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: surgery	15%	✓	35% Subject to a Benefit maximum of \$350/day	✓
Outpatient Department of a Hospital: treatment of illness or injury, radiation therapy, chemotherapy, and necessary supplies	15%	✓	35% Subject to a Benefit maximum of \$350/day	✓
Inpatient facility services				
Hospital services and stay	\$250/admission plus 15%	✓	35% Subject to a Benefit maximum of \$1,500/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	\$250/admission plus 15%	✓	Not covered	
• Physician inpatient services	15%	✓	Not covered	
Bariatric surgery services, designated California counties				
<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	\$250/admission plus 15%	✓	Not covered	
Outpatient Facility services	15%	✓	Not covered	
Physician services	15%	✓	Not covered	

Benefits⁶

Your payment

	When using a Participating Provider ³	CYD ² applies	When using a Non-Participating Provider ⁴	CYD ² applies
Diagnostic x-ray, imaging, pathology, and laboratory services				
<i>This payment is for Covered 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.</i>				
Laboratory and pathology services				
<i>Includes diagnostic Papanicolaou (Pap) test.</i>				
• Laboratory center	\$30/visit		35%	✓
• Outpatient Department of a Hospital	\$30/visit		35% Subject to a Benefit maximum of \$350/day	✓
Basic imaging services				
<i>Includes plain film X-rays, ultrasounds, and diagnostic mammography.</i>				
• Outpatient radiology center	\$30/visit		35%	✓
• Outpatient Department of a Hospital	\$30/visit		35% Subject to a Benefit maximum of \$350/day	✓
Other outpatient non-invasive diagnostic testing				
<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	\$30/visit		35%	✓
• Outpatient Department of a Hospital	\$30/visit		35% Subject to a Benefit maximum of \$350/day	✓
Advanced imaging services				
<i>Includes diagnostic radiological and nuclear imaging such as CT scans, MRIs, MRAs, and PET scans.</i>				
• Outpatient radiology center	15%	✓	35%	✓
• Outpatient Department of a Hospital	15%	✓	35% Subject to a Benefit maximum of \$350/day	✓

Benefits⁶
Your payment

	When using a Participating Provider ³	CYD ² applies	When using a Non-Participating Provider ⁴	CYD ² applies
Rehabilitative and Habilitative Services				
<i>Includes physical therapy, occupational therapy, respiratory therapy, and speech therapy services.</i>				
Office location	\$30/visit		35%	✓
Outpatient Department of a Hospital	\$30/visit		35% Subject to a Benefit maximum of \$350/day	✓
Durable medical equipment (DME)				
DME	15%	✓	35%	✓
Breast pump	\$0		35%	✓
Orthotic equipment and devices	15%	✓	35%	✓
Prosthetic equipment and devices	15%	✓	35%	✓
Home health care services				
	15%	✓	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>				
Home infusion and home injectable therapy services				
Home infusion agency services	15%	✓	Not covered	
<i>Includes home infusion drugs, medical supplies, and visits by a nurse.</i>				
Hemophilia home infusion services	15%	✓	Not covered	
<i>Includes blood factor products.</i>				
Skilled Nursing Facility (SNF) services				
<i>Up to 120 days per Member, per benefit period, except when provided as part of a Hospice program. All days count towards the limit, including days during any applicable Deductible period and days in different SNFs during the Calendar Year.</i>				
Freestanding SNF	15%	✓	15% 35%	✓
Hospital-based SNF	15%	✓	Subject to a Benefit maximum of \$1,500/day	✓

Benefits⁶

Your payment

	When using a Participating Provider ³	CYD ² applies	When using a Non-Participating Provider ⁴	CYD ² applies
Hospice program services				
Pre-Hospice consultation	\$0	✓	Not covered	
Routine home care	\$0	✓	Not covered	
24-hour continuous home care	15%	✓	Not covered	
Short-term inpatient care for pain and symptom management	15%	✓	Not covered	
Inpatient respite care	\$0	✓	Not covered	
Other services and supplies				
Diabetes care services				
• Devices, equipment, and supplies	15%	✓	35%	✓
• Self-management training	\$30/visit		35%	✓
• Medical nutrition therapy	\$30/visit		35%	✓
			35%	
Dialysis services	15%	✓	Subject to a Benefit maximum of \$350/day	✓
PKU product formulas and special food products	15%	✓	15%	✓
Allergy serum billed separately from an office visit	15%	✓	35%	✓
Accidental Dental Injury				
• Hospital and professional services	15%	✓	15% of billed charges	✓
<i>Up to \$40,000 per injury.</i>				

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	\$30/visit		35%	✓
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 in an office setting, home, or other non-institutional facility setting, and office-based opioid treatment	15%	✓	35%	✓

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
Partial Hospitalization Program	15%	✓	35% Subject to a Benefit maximum of \$350/day	✓
Psychological Testing	15%	✓	35%	✓
Inpatient services				
Physician inpatient services	\$0	✓	35%	✓
Hospital services	\$250/admission plus 15%	✓	35% Subject to a Benefit maximum of \$1,500/day	✓
Residential Care	\$250/admission plus 15%	✓	35% Subject to a Benefit maximum of \$1,500/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 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 medical Deductible. Some Covered Benefits received from Participating Providers are paid by Blue Shield before you meet any Calendar Year medical 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 Participating Provider Calendar Year Deductible as well as a combined Participating Provider and Non-Participating Provider Calendar Year Deductible. This means that any amounts you pay towards your Participating Provider Calendar Year Deductible also count towards your combined Participating 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 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 medical 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 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 by a Participating Provider. 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.

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