Classified Employees

Access+ HMO plan
Trio ACO HMO plan
Shield Spectrum PPO plan
Santa Ana Unified School District  
Custom Access+ HMO Classified  
Benefit Summary (For groups of 101 and above)  
(Uniform Health Plan Benefits and Coverage Matrix)

Blue Shield of California  
Effective: July 1, 2017

THIS MATRIX IS INTENDED TO BE USED TO HELP YOU COMPARE COVERAGE BENEFITS AND IS A SUMMARY ONLY. THE EVIDENCE OF COVERAGE AND PLAN CONTRACT SHOULD BE CONSULTED FOR A DETAILED DESCRIPTION OF COVERAGE BENEFITS AND LIMITATIONS.

Highlights: A description of the prescription drug coverage is provided separately

<table>
<thead>
<tr>
<th>Coverage</th>
<th>Benefit Summary</th>
<th>Covered Services</th>
<th>Member Copayment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Calendar Year</td>
<td>None</td>
<td>None</td>
<td>None</td>
</tr>
<tr>
<td>Calendar Year Out-of-Pocket Maximum</td>
<td>$1,000 per individual / $2,000 per two persons / $3,000 per family</td>
<td>None</td>
<td>None</td>
</tr>
<tr>
<td>Lifetime Benefit Maximum</td>
<td>None</td>
<td>None</td>
<td>None</td>
</tr>
</tbody>
</table>

OUTPATIENT PROFESSIONAL SERVICES

Professional (Physician) Benefits

- Physician and specialist office visits (note: a woman may self-refer to an OB/GYN or family practice physician in her personal physician's medical group or IPA for OB/GYN services) $20 per visit
- Teladoc consultation $5 per consultation
- Outpatient diagnostic x-ray, imaging, pathology, laboratory and other testing services No Charge
- Radiological and nuclear imaging (CT scans, MRIs, MRAs, PET scans and cardiac diagnostic procedures utilizing nuclear medicine) No Charge

Access+ Specialist Benefits

- Office visit, examination or other consultation (self-referred office visits and consultations only) $30 per visit

Preventive Health Benefits

- Preventive health services (as required by applicable Federal and California law) No Charge

OUTPATIENT FACILITY SERVICES

- Outpatient surgery performed at a free-standing ambulatory surgery center No Charge
- Outpatient surgery performed in a hospital or a hospital affiliated ambulatory surgery center No Charge
- Outpatient services for treatment of illness or injury and necessary supplies (except as described under "Rehabilitation Benefits" and "Speech Therapy Benefits") No Charge
- Outpatient diagnostic x-ray, imaging, pathology, laboratory and other testing services No Charge
- Radiological and nuclear imaging (CT scans, MRIs, MRAs, PET scans and cardiac diagnostic procedures utilizing nuclear medicine) No Charge

HOSPITALIZATION SERVICES

Hospital Benefits (Facility Services)

- Inpatient physician services No Charge
- Inpatient non-emergency facility services (semi-private room and board, and medically necessary services and supplies, including subacute care) $250 per admission

Inpatient Skilled Nursing Benefits

(combined maximum of up to 100 days per benefit period; prior authorization is required; semi-private accommodations)

- Free-standing skilled nursing facility No Charge
- Skilled nursing unit of a hospital No Charge

EMERGENCY HEALTH COVERAGE

- Emergency room services not resulting in admission (copayment does not apply if the member is directly admitted to the hospital for inpatient services) $100 per visit
- Emergency room physician services No Charge

AMBULANCE SERVICES

- Emergency or authorized transport (ground or air) No Charge

PROSTHETICS/ORTHOTICS

- Prosthetic equipment and devices (separate office visit copayment may apply) No Charge
- Orthotic equipment and devices (separate office visit copayment may apply) No Charge

DURABLE MEDICAL EQUIPMENT

- Breast pump No Charge
- Other durable medical equipment (member share is based on allowed charges) No Charge
### MENTAL HEALTH AND SUBSTANCE USE DISORDER SERVICES

<table>
<thead>
<tr>
<th>Service</th>
<th>Cost</th>
</tr>
</thead>
<tbody>
<tr>
<td>Inpatient hospital services</td>
<td>No Charge</td>
</tr>
<tr>
<td>Residential care</td>
<td>No Charge</td>
</tr>
<tr>
<td>Inpatient physician services</td>
<td>No Charge</td>
</tr>
<tr>
<td>Routine outpatient mental health and substance use disorder services</td>
<td>$10 per visit</td>
</tr>
<tr>
<td>(includes professional/physician visits)</td>
<td></td>
</tr>
<tr>
<td>Non-routine outpatient mental health and substance use disorder services</td>
<td>No Charge</td>
</tr>
<tr>
<td>(includes behavioral health treatment, electroconvulsive therapy, intensive outpatient programs, office-based opioid treatment, partial hospitalization programs, psychological testing and transcranial magnetic stimulation)</td>
<td></td>
</tr>
</tbody>
</table>

### HOME HEALTH SERVICES

<table>
<thead>
<tr>
<th>Service</th>
<th>Cost</th>
</tr>
</thead>
<tbody>
<tr>
<td>Home health care agency services (2) Coverage limited to 100 visits per member per calendar year.</td>
<td>$20 per visit</td>
</tr>
<tr>
<td>Home infusion/home injectable therapy and infusion nursing visits provided by a home infusion agency</td>
<td>No Charge</td>
</tr>
</tbody>
</table>

### HOSPICE PROGRAM BENEFITS

<table>
<thead>
<tr>
<th>Service</th>
<th>Cost</th>
</tr>
</thead>
<tbody>
<tr>
<td>Routine home care</td>
<td>No Charge</td>
</tr>
<tr>
<td>Inpatient respite care</td>
<td>No Charge</td>
</tr>
<tr>
<td>24-hour continuous home care</td>
<td>No Charge</td>
</tr>
<tr>
<td>Short-term inpatient care for pain and symptom management</td>
<td>No Charge</td>
</tr>
</tbody>
</table>

### PREGNANCY AND MATERNITY CARE BENEFITS

<table>
<thead>
<tr>
<th>Service</th>
<th>Cost</th>
</tr>
</thead>
<tbody>
<tr>
<td>Prenatal and postnatal physician office visits</td>
<td>No Charge</td>
</tr>
<tr>
<td>(may be billed as part of global maternity fee including hospital inpatient delivery services)</td>
<td></td>
</tr>
<tr>
<td>Abortion services (an additional facility copayment may apply when services are rendered in a hospital or outpatient surgery center)</td>
<td>No Charge</td>
</tr>
</tbody>
</table>

### FAMILY PLANNING AND INFERTILITY BENEFITS

<table>
<thead>
<tr>
<th>Service</th>
<th>Cost</th>
</tr>
</thead>
<tbody>
<tr>
<td>Counseling, consulting, and education (Includes insertion of IUD, as well as injectable and implantable contraceptives for women)</td>
<td>No Charge</td>
</tr>
<tr>
<td>Infertility services (member cost share is based upon allowed charges)</td>
<td>50%</td>
</tr>
<tr>
<td>(diagnosis and treatment of cause of infertility. Excludes in vitro fertilization, injectables for infertility, artificial insemination and GIFT)</td>
<td></td>
</tr>
<tr>
<td>Tubal ligation</td>
<td>No Charge</td>
</tr>
<tr>
<td>Vasectomy (an additional facility copayment may apply when services are rendered in a hospital or outpatient surgery center)</td>
<td>No Charge</td>
</tr>
</tbody>
</table>

### REHABILITATION AND HABILITATION BENEFITS

<table>
<thead>
<tr>
<th>Service</th>
<th>Cost</th>
</tr>
</thead>
<tbody>
<tr>
<td>Office location (an additional facility copayment may apply when services are rendered in a hospital or skilled nursing facility)</td>
<td>$20 per visit</td>
</tr>
</tbody>
</table>

### SPEECH THERAPY BENEFITS

<table>
<thead>
<tr>
<th>Service</th>
<th>Cost</th>
</tr>
</thead>
<tbody>
<tr>
<td>Office location (an additional facility copayment may apply when services are rendered in a hospital or skilled nursing facility)</td>
<td>$20 per visit</td>
</tr>
</tbody>
</table>

### DIABETES CARE BENEFITS

<table>
<thead>
<tr>
<th>Service</th>
<th>Cost</th>
</tr>
</thead>
<tbody>
<tr>
<td>Devices, equipment, and non-testing supplies (member share is based upon allowed charges; for testing supplies see Outpatient Prescription Drug Benefits)</td>
<td>No Charge</td>
</tr>
<tr>
<td>Diabetes self-management training</td>
<td>$20 per visit</td>
</tr>
</tbody>
</table>

### HEARING AID BENEFITS

<table>
<thead>
<tr>
<th>Service</th>
<th>Cost</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hearing aid instrument and ancillary equipment (plan payment maximum up to $2,000 every 24 months)</td>
<td>No Charge</td>
</tr>
<tr>
<td>Audiological exams</td>
<td>$20 per visit</td>
</tr>
</tbody>
</table>

### URGENT CARE BENEFITS

<table>
<thead>
<tr>
<th>Service</th>
<th>Cost</th>
</tr>
</thead>
<tbody>
<tr>
<td>Urgent care services outside your personal physician service area within California</td>
<td>$20 per visit</td>
</tr>
<tr>
<td>Urgent care services outside of California (BlueCard® Program)</td>
<td>$20 per visit</td>
</tr>
</tbody>
</table>

### OPTIONAL BENEFITS

Optional dental, vision, hearing aid, infertility, chiropractic or acupuncture benefits are available. If your employer purchased any of these benefits, a description of the benefit is provided separately.

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1 To use this option, members must select a personal physician who is affiliated with a medical group or IPA that is an Access+ provider group, which offers the Access+ Specialist feature. Members should then select a specialist within that medical group or IPA.

2 For Plans with a facility deductible amount, services with a day or visit limit accrue to the calendar year day or visit limit maximum regardless of whether the plan deductible has been met.

3 Inpatient skilled nursing services are limited to 100 preauthorized days during a benefit period except when received through a hospice program provided by a participating hospice agency. This 100 preauthorized day maximum on inpatient skilled nursing services is a combined maximum between skilled nursing services provided in a hospital unit and skilled nursing services provided in a skilled nursing facility (SNF).

4 Mental health and substance use disorder services are accessed through Blue Shield's Mental Health Service Administrator (MHSA) - using MHSA participating providers.

5 Inpatient services for acute detoxification are covered under the medical benefit; see the Hospital Benefits (Facility Services) section of the Evidence of Coverage for benefit details. Services for acute medical detoxification are accessed through Blue Shield using Blue Shield's participating providers.

Plan designs may be modified to ensure compliance with state and Federal requirements.

A16205 (1/17) 20629 DC 050917
**Santa Ana Unified School District**  
**Custom Trio ACO HMO Classified**  
Benefit Summary (For groups of 101 and above)  
(Uniform Health Plan Benefits and Coverage Matrix)

**Blue Shield of California**  
Effective: July 1, 2017

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**Highlights:** A description of the prescription drug coverage is provided separately

This plan is available only in certain California counties and cities "Service Area" as described in the Evidence of Coverage. You must live and/or work in this select Service Area in order to enroll in this plan.

This HMO plan also utilizes an Accountable Care Organization (ACO) for its provider network. Except for Emergency Services, Urgent Services when the Member is out of the Service Area, or when prior authorized, all services must be obtained through the Member’s Personal Physician and within the ACO provider network to be covered.

This health plan uses the ACO HMO provider network.

<table>
<thead>
<tr>
<th>Calendar Year Medical Deductible</th>
<th>None</th>
</tr>
</thead>
<tbody>
<tr>
<td>Calendar Year Out-of-Pocket Maximum</td>
<td>$1,000 per individual / $2,000 per two persons / $3,000 per family</td>
</tr>
<tr>
<td>Lifetime Benefit Maximum</td>
<td>None</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Covered Services</th>
<th>Member Copayment</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>OUTPATIENT PROFESSIONAL SERVICES</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Professional (Physician) Benefits</strong></td>
<td></td>
</tr>
<tr>
<td>Physician and specialist office visits (note: a woman may self-refer to an OB/GYN or family practice physician in her personal physician's medical group or IPA for OB/GYN services)</td>
<td>$20 per visit</td>
</tr>
<tr>
<td>Teladoc consultation</td>
<td>$5 per consultation</td>
</tr>
<tr>
<td>Outpatient diagnostic x-ray, imaging, pathology, laboratory and other testing services</td>
<td>No Charge</td>
</tr>
<tr>
<td>Radiological and nuclear imaging (CT scans, MRIs, MRAs, PET scans and cardiac diagnostic procedures utilizing nuclear medicine)</td>
<td>No Charge</td>
</tr>
<tr>
<td><strong>Allergy Testing and Treatment Benefits</strong></td>
<td></td>
</tr>
<tr>
<td>Allergy testing, treatment and serum injections</td>
<td>$20 per visit</td>
</tr>
<tr>
<td><strong>Access+ Specialties™ Benefits</strong></td>
<td></td>
</tr>
<tr>
<td>Office visit, examination or other consultation (self-referred office visits and consultations only)</td>
<td>$30 per visit</td>
</tr>
<tr>
<td><strong>Preventive Health Benefits</strong></td>
<td></td>
</tr>
<tr>
<td>Preventive health services (as required by applicable Federal and California law)</td>
<td>No Charge</td>
</tr>
</tbody>
</table>

| **OUTPATIENT FACILITY SERVICES** |
|------------------|------------------|
| **Hospital Benefits (Facility Services)** |
| Inpatient physician services | No Charge |
| Inpatient non-emergency facility services (semi-private room and board, and medically necessary services and supplies, including subacute care) | $250 per admission |
| **Inpatient Skilled Nursing Benefits**  
(combined maximum of up to 100 days per benefit period; prior authorization is required; semi-private accommodations) |
| Free-standing skilled nursing facility | No Charge |
| Skilled nursing unit of a hospital | No Charge |
| **EMERGENCY HEALTH COVERAGE** |
| Emergency room services not resulting in admission (copayment does not apply if the member is directly admitted to the hospital for inpatient services) | $100 per visit |
| Emergency room physician services | No Charge |

| **AMBULANCE SERVICES** |
|------------------|------------------|
| Emergency or authorized transport (ground or air) | No Charge |
### Prosthetics/Orthotics
- Prosthetic equipment and devices (separate office visit copayment may apply): No Charge
- Orthotic equipment and devices (separate office visit copayment may apply): No Charge

### Durable Medical Equipment
- Breast pump: No Charge
- Other durable medical equipment (member share is based on allowed charges): No Charge

### Mental Health and Substance Use Disorder Services
1. **Inpatient Hospital Services**
   - No Charge
2. **Residential Care**
   - No Charge
3. **Inpatient Physician Services**
   - No Charge
4. **Routine Outpatient Mental Health and Substance Use Disorder Services** (includes professional/physician visits): $10 per visit
5. **Non-Routine Outpatient Mental Health and Substance Use Disorder Services** (includes behavioral health treatment, electroconvulsive therapy, intensive outpatient programs, office-based opioid treatment, partial hospitalization programs, psychological testing and transcranial magnetic stimulation): No Charge

### Home Health Services
1. **Home Health Care Agency Services**
   - Coverage limited to 100 visits per member per calendar year: $20 per visit
2. **Home Infusion/Inpatient Therapy and Infusion Nursing Visits Provided by a Home Infusion Agency**: No Charge

### Hospice Program Benefits
- **Routine Home Care**: No Charge
- **Inpatient Respite Care**: No Charge
- **24-Hour Continuous Home Care**: No Charge
- **Short-Term Inpatient Care for Pain and Symptom Management**: No Charge

### Pregnancy and Maternity Care Benefits
- **Prenatal and Postnatal Physician Office Visits** (may be billed as part of global maternity fee including hospital inpatient delivery services): No Charge
- **Abortion Services** (an additional facility copayment may apply when services are rendered in a hospital or outpatient surgery center): No Charge

### Family Planning and Infertility Benefits
- **Counseling, Consulting, and Education** (includes insertion of IUD, as well as injectable and implantable contraceptives for women): No Charge
- **Infertility Services** (member cost share is based upon allowed charges; diagnosis and treatment of cause of infertility. Excludes in vitro fertilization, injectables for infertility, artificial insemination and GIFT): 50%
- **Tubal Ligation**: No Charge
- **Vasectomy** (an additional facility copayment may apply when services are rendered in a hospital or outpatient surgery center): No Charge

### Rehabilitation and Habilitation Benefits (Physical, Occupational and Respiratory Therapy)
- **Office Location** (an additional facility copayment may apply when services are rendered in a hospital or skilled nursing facility): $20 per visit

### Speech Therapy Benefits
- **Office Location** (an additional facility copayment may apply when services are rendered in a hospital or skilled nursing facility): $20 per visit

### Diabetes Care Benefits
- **Devices, Equipment, and Non-Testing Supplies** (member share is based upon allowed charges; for testing supplies see Outpatient Prescription Drug Benefits): No Charge
- **Diabetes Self-Management Training**: $20 per visit

### Hearing Aid Benefits
- **Hearing Aid Instrument and Ancillary Equipment** (plan payment up to $2,000 every 24 months): No Charge
- **Audiological Exams**: $20 per visit

### Urgent Care Benefits
- **Urgent Care Services Outside Your Personal Physician Service Area Within California**: $20 per visit
- **Urgent Care Services Outside of California (BlueCard® Program)**: $20 per visit

### Optional Benefits
- Optional dental, vision, hearing aid, infertility, chiropractic or acupuncture benefits are available. If your employer purchased any of these benefits, a description of the benefit is provided separately.

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1. **Note:** To use this option, members must select a personal physician who is affiliated with a medical group or IPA that is an Access+ provider group, which offers the Access+ Specialist feature. Members should then select a specialist within that medical group or IPA.

2. **Note:** For Plans with a facility deductible amount, services with a day or visit limit accrue to the calendar year day or visit limit maximum regardless of whether the plan deductible has been met.

3. **Note:** Inpatient skilled nursing services are limited to 100 preauthorized days during a benefit period except when received through a hospice program provided by a participating hospice agency. This 100 preauthorized day maximum on inpatient skilled nursing services is a combined maximum between skilled nursing services provided in a hospital unit and skilled nursing services provided in a skilled nursing facility (SNF).

4. **Note:** Mental health and substance use disorder services are accessed through Blue Shield’s Mental Health Service Administrator (MHSA) - using MHSA participating providers.

5. **Note:** Inpatient services for acute detoxification are accessed through Blue Shield using Blue Shield’s participating providers.

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Plan designs may be modified to ensure compliance with state and Federal requirements.

A47048 (1/17) 20632 DC051017
Santa Ana Unified School District
Chiropractic Benefits
Additional coverage for your HMO Plans

Blue Shield Chiropractic Care coverage lets you self-refer to a network of more than 4,000 licensed chiropractors. Benefits are provided through a contract with American Specialty Health Plans of California, Inc. (ASH Plans).

How the Program Works
You can visit any participating chiropractor from the ASH Plans network without a referral from your HMO or POS Personal Physician. Simply call a participating provider to schedule an initial exam.

At the time of your first visit, you’ll present your Blue Shield identification card and pay only your copayment. Because participating chiropractors bill ASH Plans directly, you’ll never have to file claim forms.

If you need further treatment, the participating chiropractor will submit a proposed treatment plan to ASH Plans and obtain the necessary authorization from ASH Plans to continue treatment up to the calendar year maximum of 30 visits.

What’s Covered
The plan covers medically necessary chiropractic services including:

- Initial and subsequent examinations
- Office visits and adjustments (subject to annual limits)
- Adjunctive therapies
- X-rays (chiropractic only)

Benefit Plan Design

<table>
<thead>
<tr>
<th>Covered Services</th>
<th>Member Copayment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Chiropractic Services</td>
<td>$10</td>
</tr>
</tbody>
</table>

Out-of-network Coverage None

1. Chiropractic appliances are covered up to a maximum of $50 in a calendar year as authorized by ASH Plans.
2. As authorized by ASH Plans, this allowance is applied toward the purchase of items determined necessary, such as supports, collars, pillows, heel lifts, ice packs, cushions, orthotics, rib belts and home traction units.

Friendly Customer Service

Helpful ASH Plans Member Services representatives are available at (800) 678-9133 Monday through Friday from 6 a.m. to 5 p.m. to answer questions, assist with problems, or help locate a participating chiropractor.

This document is only a summary for informational purposes. It is not a contract. Please refer to the Evidence of Coverage and the Group Health Service Agreement for the exact terms and conditions of coverage.
Santa Ana Unified School District  
Custom PPO Classified  
Benefit Summary (For groups of 101 and above)  
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Blue Shield of California  
Effective: July 1, 2017

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<table>
<thead>
<tr>
<th>Participating Providers</th>
<th>Non-Participating Providers</th>
</tr>
</thead>
<tbody>
<tr>
<td>Calendar Year Medical Deductible (participating and non-participating deductibles accrue separately)</td>
<td>$300 per individual / $1,500 per family</td>
</tr>
<tr>
<td>Calendar Year Out-of-Pocket Maximum (includes the calendar year medical deductible, Copayments or coinsurance for covered services from participating providers accrue to both the participating and non-participating provider calendar year out-of-pocket maximum amount)</td>
<td>$1,300 per individual / $2,600 per family</td>
</tr>
<tr>
<td>Lifetime Benefit Maximum</td>
<td>None</td>
</tr>
</tbody>
</table>

### Covered Services

#### OUTPATIENT PROFESSIONAL SERVICES

<table>
<thead>
<tr>
<th>Professional (Physician) Benefits</th>
<th>Participating Providers</th>
<th>Non-Participating Providers</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physician and specialist office visits</td>
<td>$20 per visit (not subject to the calendar year medical deductible)</td>
<td>30%</td>
</tr>
<tr>
<td>Teladoc consultation</td>
<td>$5 per consultation</td>
<td>Not Covered</td>
</tr>
<tr>
<td>Outpatient diagnostic x-ray, imaging, pathology, laboratory and other testing services</td>
<td>20%</td>
<td>30%</td>
</tr>
<tr>
<td>Radiological and nuclear imaging (CT scans, MRIs, MRAs, PET scans and cardiac diagnostic procedures utilizing nuclear medicine)</td>
<td>20%</td>
<td>30%</td>
</tr>
</tbody>
</table>

#### Allergy Testing and Treatment Benefits

| Allergy testing, treatment and serum injections (separate office visit copayment may apply) | 10% | 30% |

#### Preventive Health Benefits

| Preventive Health Services (as required by applicable Federal and California law) | No Charge (not subject to the calendar year medical deductible) | 30% |

#### OUTPATIENT FACILITY SERVICES

| Outpatient surgery performed at a free-standing ambulatory surgery center | 10% | 30% up to $1,500 per day |
| Outpatient surgery performed in a hospital or a hospital affiliated ambulatory surgery center | 10% | 30% up to $1,500 per day |
| Outpatient services for treatment of illness or injury and necessary supplies (except as described under “Rehabilitation Benefits” and “Speech Therapy Benefits”) | 10% | 30% up to $1,500 per day |
| Outpatient diagnostic x-ray, imaging, pathology, laboratory and other testing services | 20% | 30% up to $1,500 per day |
| Radiological and nuclear imaging (CT scans, MRIs, MRAs, PET scans and cardiac diagnostic procedures utilizing nuclear medicine) | 20% | 30% up to $1,500 per day |
| Bariatric surgery (prior authorization is required; medically necessary surgery for weight loss, for morbid obesity only) | 10% | 30% up to $1,500 per day |

#### HOSPITALIZATION SERVICES

<table>
<thead>
<tr>
<th>Hospital Benefits (Facility Services)</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Inpatient physician services</td>
<td>10%</td>
</tr>
<tr>
<td>Inpatient non-emergency facility services (semi-private room and board, and medically necessary services and supplies, including subacute care)</td>
<td>10%</td>
</tr>
<tr>
<td>Bariatric surgery (prior authorization is required; medically necessary surgery for weight loss for morbid obesity only)</td>
<td>10%</td>
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</table>

<table>
<thead>
<tr>
<th>Inpatient Skilled Nursing Benefits</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Coverage limited to 100 days per members per benefit period combined with hospital/free-standing skilled nursing facility.</td>
<td></td>
</tr>
<tr>
<td>Free-standing skilled nursing facility</td>
<td>10%</td>
</tr>
<tr>
<td>Skilled nursing unit of a hospital</td>
<td>10%</td>
</tr>
</tbody>
</table>
EMERGENCY HEALTH COVERAGE

Emergency room services not resulting in admission (copayment does not apply if the member is directly admitted to the hospital for inpatient services)

- $100 per visit (not subject to the calendar year medical deductible)

Emergency room services resulting in admission (when the member is admitted directly from the ER)

- 10%

Emergency room physician services

- 10%

AMBULANCE SERVICES

Emergency or authorized transport (ground or air)

- 10%

PROSTHETICS/ORTHOTICS

Prosthetic equipment and devices (separate office visit copayment may apply)

- 10%

Orthotic equipment and devices (separate office visit copayment may apply)

- 10%

DURABLE MEDICAL EQUIPMENT

Breast pump

- No Charge (not subject to the calendar year medical deductible)

Other durable medical equipment

- 20%

MENTAL HEALTH AND SUBSTANCE USE DISORDER SERVICES

MHSA Participating Providers

- Inpatient hospital services: 10%
- Residential care: 10%
- Inpatient physician services: 10%
- Routine outpatient mental health and substance use disorder services (includes professional/physician visits): $10 per visit (not subject to the calendar year medical deductible)

MHSA Non-Participating Providers

- Inpatient hospital services: 30% up to $1,500 per day
- Residential care: 30% up to $1,500 per day
- Routine outpatient mental health and substance use disorder services (includes professional/physician visits): 30%

HOME HEALTH SERVICES

MHSA Participating Providers

- Home health care agency services: 20%
- Home infusion/home injectable therapy and infusion nursing visits provided by a home infusion agency: 20%

MHSA Non-Participating Providers

- Home health care agency services: Not Covered
- Home infusion/home injectable therapy and infusion nursing visits provided by a home infusion agency: Not Covered

HOSPICE PROGRAM BENEFITS

MHSA Participating Providers

- Routine home care: No Charge (not subject to the calendar year medical deductible)
- Inpatient respite care: No Charge (not subject to the calendar year medical deductible)
- 24-hour continuous home care: No Charge (not subject to the calendar year medical deductible)
- Short-term inpatient care for pain and symptom management: No Charge (not subject to the calendar year medical deductible)

MHSA Non-Participating Providers

- Routine home care: Not Covered
- Inpatient respite care: Not Covered
- 24-hour continuous home care: Not Covered
- Short-term inpatient care for pain and symptom management: Not Covered

CHIROPRACTIC BENEFITS

Chiropractic spinal manipulation Coverage limited to 50 visits per calendar year.

- 20%

ACUPUNCTURE BENEFITS

Acupuncture services

- 20%

REHABILITATION AND HABILITATION BENEFITS (Physical, Occupational and Respiratory Therapy)

Office location (an additional facility copayment may apply when services are rendered in a hospital or skilled nursing facility)

- 20%

SPEECH THERAPY BENEFITS

Office location (an additional facility copayment may apply when services are rendered in a hospital or skilled nursing facility)

- 20%

PREGNANCY AND MATERNITY CARE BENEFITS

Prenatal and postnatal physician office visits (may be billed as part of global maternity fee including hospital inpatient delivery services)

- 10%

Abortion services (an additional facility copayment may apply when services are rendered in a hospital or outpatient surgery center)

- 10%

FAMILY PLANNING BENEFITS

Counseling, consulting, and education (includes injectable and implantable contraceptives for women)

- No Charge (not subject to the calendar year medical deductible)

Intrauterine Device (Insertion and removal of IUD)

- No Charge (not subject to the calendar year medical deductible)

Tubal ligation

- No Charge (not subject to the calendar year medical deductible)

Vasectomy (an additional facility copayment may apply when services are rendered in a hospital or outpatient surgery center)

- 10%
**DIABETES CARE BENEFITS**  
<table>
<thead>
<tr>
<th>Benefit Description</th>
<th>Cost Share</th>
<th>Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>Devices, equipment, and non-testing supplies (for testing supplies see Outpatient Prescription Drug Benefits)</td>
<td>20%</td>
<td></td>
</tr>
<tr>
<td>Diabetes self-management training</td>
<td>$20 per visit (not subject to the calendar year medical deductible)</td>
<td></td>
</tr>
</tbody>
</table>

**HEARING AIDS BENEFITS**  
<table>
<thead>
<tr>
<th>Benefit Description</th>
<th>Cost Share</th>
<th>Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hearing aid instrument and ancillary equipment (plan payment up to $2,000 every 24 months)</td>
<td>No Charge (not subject to the calendar year medical deductible)</td>
<td></td>
</tr>
<tr>
<td>Audioligical exams</td>
<td>$20 per visit (not subject to the calendar year medical deductible)</td>
<td></td>
</tr>
</tbody>
</table>

**CARE OUTSIDE OF CALIFORNIA**  
Benefits provided through the BlueCard® Program are paid at the participating level. Member’s cost share will be either a copayment or coinsurance based on the lower of billed charges or the negotiated allowable amount for participating providers as agreed upon with the local Blue’s Plan.

**Optional Dental, Vision, Infertility, and Hearing Aid Benefits**  
Optional benefits are available. If your employer purchased any of these benefits, a description of the benefit is provided separately.

1. Unless otherwise specified, copayments/coinsurance are calculated based on allowable amounts. After the calendar year medical deductible is met, the member is responsible for copayments/coinsurance for covered services from participating providers. Participating providers agree to accept Blue Shield's allowable amount plus any applicable member copayment or coinsurance as full payment for covered services.

2. Non-participating providers can charge more than Blue Shield's allowable amounts. When members use non-participating providers, they must pay the applicable deductibles, copayments or coinsurance plus any amount that exceeds Blue Shield's allowable amount. Charges above the allowable amount do not count toward the calendar year deductible or out-of-pocket maximum.

3. Preventive Health Services, including an annual preventive care or well-baby care office visit, are not subject to the calendar year medical deductible. Other covered non-preventive services received during, or in connection with, the preventive care or well-baby care office visit are subject to the calendar year medical deductible and applicable member copayment/coinsurance.

4. The maximum allowed charges for non-emergency surgery and services performed in a non-participating ambulatory surgery center or outpatient unit of a non-participating hospital is $1,500 per day. Members are responsible for 30% of this $1,500 per day, and all charges in excess of $1,500 per day. Amounts that exceed the benefit maximums do not count toward the calendar year out-of-pocket maximum and continue to be the member’s responsibility after the calendar year maximums are reached.

5. Bariatric surgery is covered when prior authorized by Blue Shield; however, for members residing in Imperial, Kern, Los Angeles, Orange, Riverside, San Bernardino, San Diego, Santa Barbara and Ventura counties (“Designated Counties”), bariatric surgery services are covered only when performed at designated contracting bariatric surgery facilities and by designated contracting surgeons. Coverage is not available for bariatric services from any other participating provider and there is no coverage for bariatric services from non-participating providers. In addition, if prior authorized by Blue Shield, a member in a Designated County who is required to travel more than 50 miles to a designated bariatric surgery facility will be eligible for limited reimbursement for specified travel expenses for the member and one companion. Refer to the Evidence of Coverage for further details.

6. The maximum allowed charges for non-emergency hospital services received from a non-participating hospital is $1,500 per day. Members are responsible for 30% of this $1,500 per day, and all charges in excess of $1,500 per day. Amounts that exceed the benefit maximum do not count toward the calendar year out-of-pocket maximum and continue to be the member’s responsibility after the calendar year maximums are reached.

7. For plans with a calendar year medical deductible amount, services with a day or visit limit accrue to the calendar year day or visit limit maximum regardless of whether the plan calendar year medical deductible has been met.

8. Services may require prior authorization. When services are prior authorized, members pay the participating provider amount.

9. Mental health and substance use disorder services are accessed through Blue Shield’s Mental Health Service Administrator (MHSA) - using MHSA participating and MHSA non-participating providers. Only mental health and substance use disorder services rendered by MHSA participating providers are administered by the MHSA. Mental health and substance use disorder services rendered by non-MHSA participating providers are administered by Blue Shield.

10. Inpatient services for acute detoxification are covered under the medical benefit; see the Hospital Benefits (Facility Services) section of the Evidence of Coverage for benefit details. Services for acute medical detoxification are accessed through Blue Shield using Blue Shield’s participating providers or non-participating providers.

11. Services from non-participating providers for home health care and hospice services are not covered unless prior authorized. When these services are prior authorized, the member’s copayment or coinsurance will be calculated at the participating provider level, based upon the agreed upon rate between Blue Shield and the agency.

Plan designs may be modified to ensure compliance with state and Federal requirements.

A44629 (1/17) 20638 DC051017
Notice of the Availability of Language Assistance Services

Blue Shield of California

IMPORTANT: If you can read this letter, you may not need to call us for help. This is the English version of the Notice of the Availability of Language Assistance Services.

IMPORTANT: Can you read this letter? If not, we can have somebody help you read it. Please call right away at the Member/Customer Service telephone number on the back page of your Blue Shield ID card, or (866) 346-7198.

QUANG TRỌNG: Quý vị có thể đọc được thư này không? Nếu không, chúng tôi có thể nhờ người giúp quý vị đọc thư. Quý vị cũng có thể nhận thư này được viết bằng ngôn ngữ của quý vị. Để được hỗ trợ miễn phí, vui lòng gọi ngay đến Ban Dịch vụ Khách hàng (866) 346-7198.

MAHALAGA: Nababasa mo ba ang sulat na ito? Kung hindi, maari kaming kumuha ng isang tao upang matulungan ka umpang mabasa ito. Maari ka ring makakuhang sulat na ito na nakasulat sa iyong wika. Para sa libreng tulong, mangyaring tumawag kaagad sa numerong telepono ng Miyembro/Customer Service sa likod ng iyong Blue Shield ID kard, o (866) 346-7198. (Tagalog)

Baa’ akowiingzindoogii: Díi naaltsoos áh niich’8’ b44sh bee hod7ilnih d00 n1mboo d77 naaltsoos7sh y77ni[ta’go b77n7ghah? Doo b77n7ghahgóó é7, naaltsoos nich’8’ yiid0o[tah7g77 [a’ nihee hól=. D77 naaltsoos a[d0’ t’11 Din4 k’ehj7 1dooln77[ n7n7zingo b77ighah. Doo b22h 7l7n7g0 sh7k1’ adoowo[ n7n7zing0 nihich’8’ b44sh bee hod7ilnih d00 n1mboo 47 d77 Blue Shield bee n47ho’d7lzin7g7 bine’d44’ bik11’ 47 doodag0 47

MAHAMBA: Who can read this letter? If not, we can have someone help you read it. You may also be able to get this letter written in your language. To get free help, please call now at Member/Service telephone number on the back of your Blue Shield ID card, or (866) 346-7198. (Hindi)

重要: 您能讀懂這封信嗎？如果不，我們可以請人幫您閱讀。這封信也可以用您所講的語言寫。如需免費幫助，請立即撥打在您的 Blue Shield ID 卡背面的 參考/客戶服務電話，或者撥打電話 (866) 346-7198. (Chinese)

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

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Blue Shield of California is an independent member of the Blue Shield Association. blueshieldca.com
Notice Informing Individuals about Nondiscrimination and Accessibility Requirements

Discrimination is against the law

Blue Shield of California complies with applicable federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability or sex. Blue Shield of California does not exclude people or treat them differently because of race, color, national origin, age, disability or sex.

Blue Shield of California:
• Provides aids and services at no cost to people with disabilities to communicate effectively with us such as:
  - Qualified sign language interpreters
  - Written information in other formats (including large print, audio, accessible electronic formats and other formats)
• Provides language services at no cost to people whose primary language is not English such as:
  - Qualified interpreters
  - Information written in other languages

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

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

Blue Shield of California Civil Rights Coordinator
P.O. Box 629007
El Dorado Hills, CA 95762-9007
Phone: (844) 831-4133 (TTY: 711)
Fax: (916) 350-7405
Email: BlueShieldCivilRightsCoordinator@blueshieldca.com

You can file a grievance in person or by mail, fax or email. If you need help filing a grievance, our Civil Rights Coordinator is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

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

Complaint forms are available at www.hhs.gov/ocr/office/file/index.html.