

Plan information



James Perse Enterprises LLC

Effective Date: 08/01/2026

- Trio HMO Zero Admit 20
- Access+ HMO® Zero Admit 30
- Local Access+ HMO® Zero Admit 20
- Full PPO Combined Deductible 25-250 90/60
- Full PPO Split Deductible 35-1000 80/60
- Smile (SM) Spectrum Premier Plus 50/1500/Ortho/U90
- Vision Deluxe 15/25/130
- CUSTOM 1 times salary to 200 000



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1.

Choose a plan

Start here. In this section you can explore your Blue Shield benefit options.

Summary of Benefits

**Group Plan
HMO Plan**

Trio HMO Zero Admit 20

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:

Trio ACO HMO Network

This Plan uses a specific network of Health Care Providers, called the Trio ACO HMO provider network. Medical Groups, Independent Practice Associations (IPAs), and Physicians in this network are called Participating Providers. You must select a Primary Care Physician from this network to provide your primary care and help you access services, but there are some exceptions. Please review your Evidence of Coverage for details about how to access care under this Plan. 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.

When using a Participating Provider³

Calendar Year medical Deductible	<i>Individual coverage</i>	\$0
	<i>Family coverage</i>	\$0: individual \$0: Family

Calendar Year Out-of-Pocket Maximum⁴

An Out-of-Pocket Maximum is the most a Member will pay for Covered Benefits each Calendar Year. Any exceptions are listed in the EOC.

When using a Participating Provider³

<i>Individual coverage</i>	\$1,500
<i>Family coverage</i>	\$1,500: individual \$3,000: Family

No Annual or Lifetime Dollar Limit

Under this Plan there is no annual or lifetime dollar limit on the amount Blue Shield will pay for Covered Benefits.

Benefits⁵

Your payment

	When using a Participating Provider³	CYD² applies
Preventive Health Services⁶		
Preventive Health Services	\$0	
California Prenatal Screening Program	\$0	
Physician services		
Primary care office visit	\$20/visit	
Trio+ specialist care office visit (self-referral)	\$20/visit	
Other specialist care office visit (referred by PCP)	\$20/visit	
Physician home visit	\$20/visit	
Physician or surgeon services in an Outpatient Facility	\$0	
Physician or surgeon services in an inpatient facility	\$0	
Other professional services		
Other practitioner office visit <i>Includes nurse practitioners, physician assistants, therapists, and podiatrists.</i>	\$20/visit	
Teladoc Health consultation	\$0	
Family planning		
<ul style="list-style-type: none"> Counseling, consulting, and education 	\$0	
<ul style="list-style-type: none"> Injectable contraceptive, diaphragm fitting, intrauterine device (IUD), implantable contraceptive, and related procedure. 	\$0	
<ul style="list-style-type: none"> Tubal ligation 	\$0	
<ul style="list-style-type: none"> Vasectomy 	\$0	
Medical nutrition therapy, not related to diabetes	\$0	
Infertility Services		
Physician or surgeon services in an Outpatient Facility	\$0	
Artificial Inseminations limited to 6 per lifetime	\$0	
Oocyte (egg) retrieval limited to 3 per lifetime		
<ul style="list-style-type: none"> Ambulatory Surgery Center 	\$0	
<ul style="list-style-type: none"> Outpatient Department of a Hospital 	\$0	
In vitro fertilization (IVF)	\$0	
Embryo transfer		
<ul style="list-style-type: none"> Ambulatory Surgery Center 	\$0	
<ul style="list-style-type: none"> Outpatient Department of a Hospital 	\$0	
Cryopreservation limited to 1 year of storage per lifetime for each of the following: sperm, reproductive tissue, oocytes (eggs), and embryos	\$0	

Benefits⁵

Your payment

	When using a Participating Provider³	CYD² applies
Pregnancy and maternity care		
Physician office visits: prenatal and postnatal	\$0	
Abortion and abortion-related services	\$0	
Emergency Services		
Emergency room services	\$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	\$0	
Urgent care center services		
	\$20/visit	
Ambulance services		
	\$100/transport	
<i>This payment is for emergency or authorized transport.</i>		
Outpatient Facility services		
Ambulatory Surgery Center	\$0	
Outpatient Department of a Hospital: surgery	\$0	
Outpatient Department of a Hospital: treatment of illness or injury, radiation therapy, chemotherapy, and necessary supplies	\$0	
Inpatient facility services		
Hospital services and stay	\$0	
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	\$0	
• Physician inpatient services	\$0	
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	\$0	
• Outpatient Department of a Hospital	\$0	

Benefits⁵

Your payment

	When using a Participating Provider³	CYD² applies
<p>Basic imaging services</p> <p><i>Includes plain film X-rays, ultrasounds, and diagnostic mammography.</i></p> <ul style="list-style-type: none"> • Outpatient radiology center \$0 • Outpatient Department of a Hospital \$0 <p>Other outpatient non-invasive diagnostic testing</p> <p><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></p> <ul style="list-style-type: none"> • Office location \$0 • Outpatient Department of a Hospital \$0 <p>Advanced imaging services</p> <p><i>Includes diagnostic radiological and nuclear imaging such as CT scans, MRIs, MRAs, and PET scans.</i></p> <ul style="list-style-type: none"> • Outpatient radiology center \$0 • Outpatient Department of a Hospital \$0 		
<p>Rehabilitative and Habilitative Services</p> <p><i>Includes physical therapy, occupational therapy, respiratory therapy, and speech therapy services.</i></p> <ul style="list-style-type: none"> Office location \$20/visit Outpatient Department of a Hospital \$20/visit 		
<p>Durable medical equipment (DME)</p> <ul style="list-style-type: none"> DME 20% Breast pump \$0 Orthotic equipment and devices \$0 Prosthetic equipment and devices \$0 		
<p>Home health care services</p> <p><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></p>	\$20/visit	
<p>Home infusion and home injectable therapy services</p> <ul style="list-style-type: none"> Home infusion agency services \$0 <p><i>Includes home infusion drugs, medical supplies, and visits by a nurse.</i></p> Hemophilia home infusion services \$0 <p><i>Includes blood factor products.</i></p> 		

Benefits⁵

Your payment

	When using a Participating Provider³	CYD² applies
Skilled Nursing Facility (SNF) services		
<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	\$0	
Hospital-based SNF	\$0	
Hospice program services		
<i>Includes pre-Hospice consultation, routine home care, 24-hour continuous home care, short-term inpatient care for pain and symptom management, and inpatient respite care.</i>		
Other services and supplies		
Diabetes care services		
<ul style="list-style-type: none"> • Devices, equipment, and supplies • Self-management training • Medical nutrition therapy 	<p>20%</p> <p>\$20/visit</p> <p>\$20/visit</p>	
Dialysis services	\$0	
PKU product formulas and special food products	\$0	
Allergy serum billed separately from an office visit	50%	

Mental Health or Substance Use Disorder Benefits

Your payment

	When using a Participating Provider³	CYD² applies
Outpatient services		
Office visit, including Physician office visit	\$20/visit	
Teladoc Health mental health	\$0	
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	\$0	
Partial Hospitalization Program	\$0	
Psychological Testing	\$0	
Inpatient services		
Physician inpatient services	\$0	
Hospital services	\$0	
Residential Care	\$0	

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.

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.

4 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 Allowed Charges 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, charges above the Allowed Charges, and charges for services above any Benefit maximum.

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.

5 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.

6 Preventive Health Services:

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

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



Outpatient Prescription Drug Rider

Group Rider
HMO/POS

Enhanced Rx \$10/25/40 with \$0 Pharmacy Deductible Summary of Benefits

This Summary of Benefits shows the amount you will pay for covered Drugs under this prescription Drug Benefit.

Pharmacy Network:

Rx Ultra

Drug Formulary:

Plus Formulary

Calendar Year Pharmacy Deductible(CYPD)¹

A Calendar Year Pharmacy Deductible (CYPD) is the amount a Member pays each Calendar Year before Blue Shield pays for covered Drugs under the outpatient prescription Drug Benefit. Blue Shield pays for some prescription Drugs before the Calendar Year Pharmacy Deductible is met, as noted in the Prescription Drug Benefits chart below.

When using a Participating² Pharmacy

Calendar Year Pharmacy Deductible *Per Member* \$0

Prescription Drug Benefits^{3,4}

Your payment

	When using a Participating Pharmacy ²	CYPD ¹ applies
Retail pharmacy prescription Drugs		
<i>Per prescription, up to a 30-day supply.</i>		
Contraceptive Drugs and devices	\$0	
Tier 1 Drugs	\$10/prescription	
Tier 2 Drugs	\$25/prescription	
Tier 3 Drugs	\$40/prescription	
Tier 4 Drugs	20% up to \$250/prescription	
Retail pharmacy prescription Drugs		
<i>Per prescription, for a 90-day supply.</i>		
Contraceptive Drugs and devices	\$0	
Tier 1 Drugs	\$30/prescription	
Tier 2 Drugs	\$75/prescription	
Tier 3 Drugs	\$120/prescription	
Tier 4 Drugs	20% up to \$750/prescription	
Mail service pharmacy prescription Drugs		
<i>Per prescription, for a 31-90-day supply.</i>		
Contraceptive Drugs and devices	\$0	
Tier 1 Drugs	\$20/prescription	

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

Prescription Drug Benefits^{3,4}

Your payment

	When using a Participating Pharmacy ²	CYPD ¹ applies
Tier 2 Drugs	\$50/prescription	
Tier 3 Drugs	\$80/prescription	
Tier 4 Drugs	20% up to \$500/prescription	

Notes

1 Calendar Year Pharmacy Deductible (CYPD):

Calendar Year Pharmacy Deductible explained. A Calendar Year Pharmacy Deductible is the amount you pay each Calendar Year before Blue Shield pays for outpatient prescription Drugs under this Benefit.

If this Benefit has a Calendar Year Pharmacy Deductible, outpatient prescription Drugs subject to the Deductible are identified with a check mark (✓) in the Benefits chart above.

Any applicable Copayment, Coinsurance and CYPD you pay counts towards the Calendar Year Out-of-Pocket Maximum.

Outpatient prescription Drugs not subject to the Calendar Year Pharmacy Deductible. Some outpatient prescription Drugs received from Participating Pharmacies are paid by Blue Shield before you meet any Calendar Year Pharmacy Deductible. These outpatient prescription Drugs do not have a check mark (✓) next to them in the "CYPD applies" column in the Prescription Drug Benefits chart above.

2 Using Participating Pharmacies:

Participating Pharmacies have a contract to provide outpatient prescription Drugs to Members. When you obtain covered prescription Drugs from a Participating Pharmacy, you are only responsible for the Copayment or Coinsurance, once any Calendar Year Pharmacy Deductible has been met.

Participating Pharmacies and Drug Formulary. You can find a Participating Pharmacy and the Drug Formulary by visiting <https://www.blueshieldca.com/wellness/drugs/formulary#heading2>.

Non-Participating Pharmacies. Drugs from Non-Participating Pharmacies are not covered except in emergency situations.

3 Outpatient Prescription Drug Coverage:

Medicare Part D-creditable coverage-

This prescription Drug coverage is on average equivalent to or better than the standard benefit set by the federal government for Medicare Part D (also called creditable coverage). Because this prescription Drug coverage is creditable, you do not have to enroll in Medicare Part D while you maintain this coverage; however, you should be aware that if you do not enroll in Medicare Part D within 63 days following termination of this coverage, you could be subject to Medicare Part D premium penalties.

4 Outpatient Prescription Drug Coverage:

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

Notes

your Physician believes a Brand Drug is Medically Necessary, either person may request a Medical Necessity Review. If approved, the Brand Drug will be covered at the applicable Drug tier Copayment or Coinsurance.

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

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

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

Oral Anticancer Drugs. You pay up to \$250 for oral Anticancer Drugs from a Participating Pharmacy, up to a 30-day supply. Oral Anticancer Drugs from a Participating Pharmacy are not subject to any Deductible.

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

Mail service Drugs. You pay the applicable 30-day retail pharmacy Copayment or Coinsurance for a 30-day supply or less from the mail service pharmacy.

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

Summary of Benefits

This Summary of Benefits shows the amount you will pay for Covered Benefits under this acupuncture and chiropractic services Benefit.

Benefits	Your Payment	
<i>Covered Benefits must be determined as Medically Necessary by American Specialty Health Plans of California, Inc. (ASH Plans).</i>		
<i>Up to 30 visits per Member, per Calendar Year. The 30 visit maximum is for acupuncture and chiropractic services combined.</i>	When using an ASH Participating Provider	When using a Non-Participating Provider
<i>Services are not subject to the Calendar Year Deductible and do count towards the Calendar Year Out-of-Pocket Maximum.</i>		
Acupuncture Services		
Office visit	\$10/visit	Not covered
Chiropractic Services		
Office visit	\$10/visit	Not covered
Chiropractic Appliances	All charges above \$50	Not covered

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

Introduction

In addition to the Benefits listed in your Evidence of Coverage, your rider provides coverage for acupuncture and chiropractic services as described in this supplement. The Benefits covered under this rider must be received from an American Specialty Health Plans of California, Inc. (ASH Plans) Participating Provider. These acupuncture and chiropractic Benefits are separate from your health Plan, but the general provisions, limitations, and exclusions described in your Evidence of Coverage do apply. A referral from your Primary Care Physician is not required.

All Covered Benefits, except for (1) the initial examination and treatment by an ASH Participating Provider; and (2) Emergency Services, must be determined as Medically Necessary by ASH Plans.

Note: ASH Plans will respond to all requests for Medical Necessity review within five business days from receipt of the request.

Covered Benefits received from providers who are not ASH Participating Providers will not be covered except for Emergency Services and in certain circumstances, in counties in California in which there are no ASH Participating Providers. If ASH Plans determines Covered Benefits from a provider other than a Participating Provider are Medically Necessary, you will be responsible for the Participating Provider Copayment amount.

Benefits

Acupuncture Services

Benefits are available for Medically Necessary acupuncture services for the treatment of Musculoskeletal and Related Disorders.

Benefits include an initial examination, acupuncture and adjunctive therapy, and subsequent office visits for the treatment of:

- headaches (tension-type and migraines);
- hip or knee joint pain associated with osteoarthritis (OA);
- other extremity joint pain associated with OA or mechanical irritation;
- other pain syndromes involving the joints and associated soft tissues;
- back and neck pain; and
- nausea associated with pregnancy, surgery, or chemotherapy.

Chiropractic Services

Benefits are available for Medically Necessary chiropractic services for the treatment of Musculoskeletal and Related Disorders.

Benefits include an initial examination, subsequent office visits and the following services:

- spinal and extra-spinal joint manipulation (adjustments);
- adjunctive therapy such as electrical muscle stimulation or therapeutic exercises;
- plain film x-ray services; and
- chiropractic supports and appliances.

Visits for acupuncture and chiropractic services are limited to a per Member per Calendar Year maximum as

shown on the Summary of Benefits. Benefits must be provided in an office setting. You will be referred to your Primary Care Physician for evaluation of conditions not related to a Musculoskeletal and Related Disorder and for other services not covered under this rider such as diagnostic imaging (e.g. CAT scans or MRIs).

Note: You should exhaust the Benefits covered under this rider before accessing the same services through the "Alternative Care Discount Program," which is a wellness discount program. For more information about the Alternative Care Discount Program, visit www.blueshieldca.com.

See the Grievance Process portion of your EOC for information on filing a grievance, your right to seek assistance from the Department of Managed Health Care, and your rights to independent medical review.

Member Services

For all acupuncture and chiropractic services, Blue Shield of California has contracted with ASH Plans to act as the Plan's acupuncture and chiropractic services administrator. Contact ASH Plans with questions about acupuncture and chiropractic services, ASH Participating Providers, or acupuncture and chiropractic Benefits.

Contact ASH Plans at:

1-800-678-9133
American Specialty Health Plans of California, Inc.
P.O. Box 509002
San Diego, CA 92150-9002

ASH Plans can answer many questions over the telephone.

Exclusions

Acupuncture services do not include:

- treatment of asthma;
- treatment of addiction (including without limitation smoking cessation); or
- vitamins, minerals, nutritional supplements (including herbal supplements), or other similar products.

See the Grievance Process portion of your EOC for information on filing a grievance, your right to seek assistance from the Department of Managed Health Care, and your rights to independent medical review.

Definitions

American Specialty Health Plans of California, Inc. (ASH Plans)	ASH Plans is a licensed, specialized health care service plan that has entered into an agreement with Blue Shield of California to arrange for the delivery of acupuncture and chiropractic services.
ASH Participating Provider	An acupuncturist or a chiropractor under contract with ASH Plans to provide Covered Benefits to Members.

Musculoskeletal and Related Disorders

Musculoskeletal and Related Disorders are conditions with signs and symptoms related to the nervous, muscular, and/or skeletal systems. Musculoskeletal and Related Disorders are conditions typically categorized as: structural, degenerative, or inflammatory disorders; or biomechanical dysfunction of the joints of the body and/or related components of the muscle or skeletal systems (muscles, tendons, fascia, nerves, ligaments/capsules, discs and synovial structures) and related manifestations or conditions. Musculoskeletal and Related Disorders include Myofascial/Musculoskeletal Disorders, Musculoskeletal Functional Disorders and subluxation.

Please be sure to retain this document. It is not a contract but is a part of your EOC.

Summary of Benefits

**Group Plan
HMO Plan**

Access+ HMO® Zero Admit 30

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:

Access+ HMO Network

This Plan uses a specific network of Health Care Providers, called the Access+ HMO provider network. Medical Groups, Independent Practice Associations (IPAs), and Physicians in this network are called Participating Providers. You must select a Primary Care Physician from this network to provide your primary care and help you access services, but there are some exceptions. Please review your Evidence of Coverage for details about how to access care under this Plan. 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.

When using a Participating Provider³

Calendar Year medical Deductible	<i>Individual coverage</i>	\$0
	<i>Family coverage</i>	\$0: individual \$0: Family

Calendar Year Out-of-Pocket Maximum⁴

An Out-of-Pocket Maximum is the most a Member will pay for Covered Benefits each Calendar Year. Any exceptions are listed in the EOC.

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 Provider³

<i>Individual coverage</i>	\$1,500
<i>Family coverage</i>	\$1,500: individual \$3,000: Family

Benefits⁵

Your payment

	When using a Participating Provider³	CYD² applies
Preventive Health Services⁶		
Preventive Health Services	\$0	
California Prenatal Screening Program	\$0	
Physician services		
Primary care office visit	\$30/visit	
Access+ specialist care office visit (self-referral)	\$45/visit	
Other specialist care office visit (referred by PCP)	\$30/visit	
Physician home visit	\$30/visit	
Physician or surgeon services in an Outpatient Facility	\$0	
Physician or surgeon services in an inpatient facility	\$0	
Other professional services		
Other practitioner office visit <i>Includes nurse practitioners, physician assistants, therapists, and podiatrists.</i>	\$30/visit	
Teladoc Health consultation	\$0	
Family planning		
• Counseling, consulting, and education	\$0	
• Injectable contraceptive, diaphragm fitting, intrauterine device (IUD), implantable contraceptive, and related procedure.	\$0	
• Tubal ligation	\$0	
• Vasectomy	\$0	
Medical nutrition therapy, not related to diabetes	\$0	
Infertility Services		
Physician or surgeon services in an Outpatient Facility	\$0	
Artificial Inseminations limited to 6 per lifetime	\$0	
Oocyte (egg) retrieval limited to 3 per lifetime		
• Ambulatory Surgery Center	\$0	
• Outpatient Department of a Hospital	\$0	
In vitro fertilization (IVF)	\$0	
Embryo transfer		
• Ambulatory Surgery Center	\$0	
• Outpatient Department of a Hospital	\$0	
Cryopreservation limited to 1 year of storage per lifetime for each of the following: sperm, reproductive tissue, oocytes (eggs), and embryos	\$0	

Benefits⁵

Your payment

	When using a Participating Provider³	CYD² applies
Pregnancy and maternity care		
Physician office visits: prenatal and postnatal	\$0	
Abortion and abortion-related services	\$0	
Emergency Services		
Emergency room services	\$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	\$0	
Urgent care center services		
	\$30/visit	
Ambulance services		
	\$100/transport	
<i>This payment is for emergency or authorized transport.</i>		
Outpatient Facility services		
Ambulatory Surgery Center	\$0	
Outpatient Department of a Hospital: surgery	\$0	
Outpatient Department of a Hospital: treatment of illness or injury, radiation therapy, chemotherapy, and necessary supplies	\$0	
Inpatient facility services		
Hospital services and stay	\$0	
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	\$0	
• Physician inpatient services	\$0	
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	\$0	
• Outpatient Department of a Hospital	\$0	

Benefits⁵

Your payment

	When using a Participating Provider³	CYD² applies
<p>Basic imaging services</p> <p><i>Includes plain film X-rays, ultrasounds, and diagnostic mammography.</i></p> <ul style="list-style-type: none"> • Outpatient radiology center \$0 • Outpatient Department of a Hospital \$0 <p>Other outpatient non-invasive diagnostic testing</p> <p><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></p> <ul style="list-style-type: none"> • Office location \$0 • Outpatient Department of a Hospital \$0 <p>Advanced imaging services</p> <p><i>Includes diagnostic radiological and nuclear imaging such as CT scans, MRIs, MRAs, and PET scans.</i></p> <ul style="list-style-type: none"> • Outpatient radiology center \$0 • Outpatient Department of a Hospital \$0 		
<p>Rehabilitative and Habilitative Services</p> <p><i>Includes physical therapy, occupational therapy, respiratory therapy, and speech therapy services.</i></p> <ul style="list-style-type: none"> Office location \$30/visit Outpatient Department of a Hospital \$30/visit 		
<p>Durable medical equipment (DME)</p> <ul style="list-style-type: none"> DME 20% Breast pump \$0 Orthotic equipment and devices \$0 Prosthetic equipment and devices \$0 		
<p>Home health care services</p> <p><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></p>	\$30/visit	
<p>Home infusion and home injectable therapy services</p> <ul style="list-style-type: none"> Home infusion agency services \$0 <p><i>Includes home infusion drugs, medical supplies, and visits by a nurse.</i></p> Hemophilia home infusion services \$0 <p><i>Includes blood factor products.</i></p> 		

Benefits⁵

Your payment

	When using a Participating Provider³	CYD² applies
Skilled Nursing Facility (SNF) services		
<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	\$0	
Hospital-based SNF	\$0	
Hospice program services		
<i>Includes pre-Hospice consultation, routine home care, 24-hour continuous home care, short-term inpatient care for pain and symptom management, and inpatient respite care.</i>		
Other services and supplies		
Diabetes care services		
<ul style="list-style-type: none"> • Devices, equipment, and supplies • Self-management training • Medical nutrition therapy 	<p>20%</p> <p>\$30/visit</p> <p>\$30/visit</p>	
Dialysis services	\$0	
PKU product formulas and special food products	\$0	
Allergy serum billed separately from an office visit	50%	

Mental Health or Substance Use Disorder Benefits

Your payment

	When using a Participating Provider³	CYD² applies
Outpatient services		
Office visit, including Physician office visit	\$30/visit	
Teladoc Health mental health	\$0	
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	\$0	
Partial Hospitalization Program	\$0	
Psychological Testing	\$0	
Inpatient services		
Physician inpatient services	\$0	
Hospital services	\$0	
Residential Care	\$0	

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.

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.

4 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 Allowed Charges 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, charges above the Allowed Charges, and charges for services above any Benefit maximum.

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.

5 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.

6 Preventive Health Services:

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

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

Enhanced Rx \$10/25/40 with \$0 Pharmacy Deductible
Summary of Benefits

This Summary of Benefits shows the amount you will pay for covered Drugs under this prescription Drug Benefit.

Pharmacy Network:

Rx Ultra

Drug Formulary:

Plus Formulary

Calendar Year Pharmacy Deductible(CYPD)¹

A Calendar Year Pharmacy Deductible (CYPD) is the amount a Member pays each Calendar Year before Blue Shield pays for covered Drugs under the outpatient prescription Drug Benefit. Blue Shield pays for some prescription Drugs before the Calendar Year Pharmacy Deductible is met, as noted in the Prescription Drug Benefits chart below.

When using a Participating² Pharmacy

Calendar Year Pharmacy Deductible *Per Member* \$0

Prescription Drug Benefits^{3,4}

Your payment

	When using a Participating Pharmacy²	CYPD¹ applies
Retail pharmacy prescription Drugs		
<i>Per prescription, up to a 30-day supply.</i>		
Contraceptive Drugs and devices	\$0	
Tier 1 Drugs	\$10/prescription	
Tier 2 Drugs	\$25/prescription	
Tier 3 Drugs	\$40/prescription	
Tier 4 Drugs	20% up to \$250/prescription	
Retail pharmacy prescription Drugs		
<i>Per prescription, for a 90-day supply.</i>		
Contraceptive Drugs and devices	\$0	
Tier 1 Drugs	\$30/prescription	
Tier 2 Drugs	\$75/prescription	
Tier 3 Drugs	\$120/prescription	
Tier 4 Drugs	20% up to \$750/prescription	
Mail service pharmacy prescription Drugs		
<i>Per prescription, for a 31-90-day supply.</i>		
Contraceptive Drugs and devices	\$0	
Tier 1 Drugs	\$20/prescription	

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

Prescription Drug Benefits^{3,4}

Your payment

	When using a Participating Pharmacy ²	CYPD ¹ applies
Tier 2 Drugs	\$50/prescription	
Tier 3 Drugs	\$80/prescription	
Tier 4 Drugs	20% up to \$500/prescription	

Notes

1 Calendar Year Pharmacy Deductible (CYPD):

Calendar Year Pharmacy Deductible explained. A Calendar Year Pharmacy Deductible is the amount you pay each Calendar Year before Blue Shield pays for outpatient prescription Drugs under this Benefit.

If this Benefit has a Calendar Year Pharmacy Deductible, outpatient prescription Drugs subject to the Deductible are identified with a check mark (✓) in the Benefits chart above.

Any applicable Copayment, Coinsurance and CYPD you pay counts towards the Calendar Year Out-of-Pocket Maximum.

Outpatient prescription Drugs not subject to the Calendar Year Pharmacy Deductible. Some outpatient prescription Drugs received from Participating Pharmacies are paid by Blue Shield before you meet any Calendar Year Pharmacy Deductible. These outpatient prescription Drugs do not have a check mark (✓) next to them in the "CYPD applies" column in the Prescription Drug Benefits chart above.

2 Using Participating Pharmacies:

Participating Pharmacies have a contract to provide outpatient prescription Drugs to Members. When you obtain covered prescription Drugs from a Participating Pharmacy, you are only responsible for the Copayment or Coinsurance, once any Calendar Year Pharmacy Deductible has been met.

Participating Pharmacies and Drug Formulary. You can find a Participating Pharmacy and the Drug Formulary by visiting <https://www.blueshieldca.com/wellness/drugs/formulary#heading2>.

Non-Participating Pharmacies. Drugs from Non-Participating Pharmacies are not covered except in emergency situations.

3 Outpatient Prescription Drug Coverage:

Medicare Part D-creditable coverage-

This prescription Drug coverage is on average equivalent to or better than the standard benefit set by the federal government for Medicare Part D (also called creditable coverage). Because this prescription Drug coverage is creditable, you do not have to enroll in Medicare Part D while you maintain this coverage; however, you should be aware that if you do not enroll in Medicare Part D within 63 days following termination of this coverage, you could be subject to Medicare Part D premium penalties.

4 Outpatient Prescription Drug Coverage:

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

Notes

your Physician believes a Brand Drug is Medically Necessary, either person may request a Medical Necessity Review. If approved, the Brand Drug will be covered at the applicable Drug tier Copayment or Coinsurance.

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

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

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

Oral Anticancer Drugs. You pay up to \$250 for oral Anticancer Drugs from a Participating Pharmacy, up to a 30-day supply. Oral Anticancer Drugs from a Participating Pharmacy are not subject to any Deductible.

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

Mail service Drugs. You pay the applicable 30-day retail pharmacy Copayment or Coinsurance for a 30-day supply or less from the mail service pharmacy.

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

Summary of Benefits

This Summary of Benefits shows the amount you will pay for Covered Benefits under this acupuncture and chiropractic services Benefit.

Benefits	Your Payment	
<i>Covered Benefits must be determined as Medically Necessary by American Specialty Health Plans of California, Inc. (ASH Plans).</i>		
<i>Up to 30 visits per Member, per Calendar Year. The 30 visit maximum is for acupuncture and chiropractic services combined.</i>	When using an ASH Participating Provider	When using a Non-Participating Provider
<i>Services are not subject to the Calendar Year Deductible and do count towards the Calendar Year Out-of-Pocket Maximum.</i>		
Acupuncture Services		
Office visit	\$10/visit	Not covered
Chiropractic Services		
Office visit	\$10/visit	Not covered
Chiropractic Appliances	All charges above \$50	Not covered

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

Introduction

In addition to the Benefits listed in your Evidence of Coverage, your rider provides coverage for acupuncture and chiropractic services as described in this supplement. The Benefits covered under this rider must be received from an American Specialty Health Plans of California, Inc. (ASH Plans) Participating Provider. These acupuncture and chiropractic Benefits are separate from your health Plan, but the general provisions, limitations, and exclusions described in your Evidence of Coverage do apply. A referral from your Primary Care Physician is not required.

All Covered Benefits, except for (1) the initial examination and treatment by an ASH Participating Provider; and (2) Emergency Services, must be determined as Medically Necessary by ASH Plans.

Note: ASH Plans will respond to all requests for Medical Necessity review within five business days from receipt of the request.

Covered Benefits received from providers who are not ASH Participating Providers will not be covered except for Emergency Services and in certain circumstances, in counties in California in which there are no ASH Participating Providers. If ASH Plans determines Covered Benefits from a provider other than a Participating Provider are Medically Necessary, you will be responsible for the Participating Provider Copayment amount.

Benefits

Acupuncture Services

Benefits are available for Medically Necessary acupuncture services for the treatment of Musculoskeletal and Related Disorders.

Benefits include an initial examination, acupuncture and adjunctive therapy, and subsequent office visits for the treatment of:

- headaches (tension-type and migraines);
- hip or knee joint pain associated with osteoarthritis (OA);
- other extremity joint pain associated with OA or mechanical irritation;
- other pain syndromes involving the joints and associated soft tissues;
- back and neck pain; and
- nausea associated with pregnancy, surgery, or chemotherapy.

Chiropractic Services

Benefits are available for Medically Necessary chiropractic services for the treatment of Musculoskeletal and Related Disorders.

Benefits include an initial examination, subsequent office visits and the following services:

- spinal and extra-spinal joint manipulation (adjustments);
- adjunctive therapy such as electrical muscle stimulation or therapeutic exercises;
- plain film x-ray services; and
- chiropractic supports and appliances.

Visits for acupuncture and chiropractic services are limited to a per Member per Calendar Year maximum as

shown on the Summary of Benefits. Benefits must be provided in an office setting. You will be referred to your Primary Care Physician for evaluation of conditions not related to a Musculoskeletal and Related Disorder and for other services not covered under this rider such as diagnostic imaging (e.g. CAT scans or MRIs).

Note: You should exhaust the Benefits covered under this rider before accessing the same services through the "Alternative Care Discount Program," which is a wellness discount program. For more information about the Alternative Care Discount Program, visit www.blueshieldca.com.

See the Grievance Process portion of your EOC for information on filing a grievance, your right to seek assistance from the Department of Managed Health Care, and your rights to independent medical review.

Member Services

For all acupuncture and chiropractic services, Blue Shield of California has contracted with ASH Plans to act as the Plan's acupuncture and chiropractic services administrator. Contact ASH Plans with questions about acupuncture and chiropractic services, ASH Participating Providers, or acupuncture and chiropractic Benefits.

Contact ASH Plans at:

1-800-678-9133
American Specialty Health Plans of California, Inc.
P.O. Box 509002
San Diego, CA 92150-9002

ASH Plans can answer many questions over the telephone.

Exclusions

Acupuncture services do not include:

- treatment of asthma;
- treatment of addiction (including without limitation smoking cessation); or
- vitamins, minerals, nutritional supplements (including herbal supplements), or other similar products.

See the Grievance Process portion of your EOC for information on filing a grievance, your right to seek assistance from the Department of Managed Health Care, and your rights to independent medical review.

Definitions

American Specialty Health Plans of California, Inc. (ASH Plans)	ASH Plans is a licensed, specialized health care service plan that has entered into an agreement with Blue Shield of California to arrange for the delivery of acupuncture and chiropractic services.
ASH Participating Provider	An acupuncturist or a chiropractor under contract with ASH Plans to provide Covered Benefits to Members.

Musculoskeletal and Related Disorders

Musculoskeletal and Related Disorders are conditions with signs and symptoms related to the nervous, muscular, and/or skeletal systems. Musculoskeletal and Related Disorders are conditions typically categorized as: structural, degenerative, or inflammatory disorders; or biomechanical dysfunction of the joints of the body and/or related components of the muscle or skeletal systems (muscles, tendons, fascia, nerves, ligaments/capsules, discs and synovial structures) and related manifestations or conditions. Musculoskeletal and Related Disorders include Myofascial/Musculoskeletal Disorders, Musculoskeletal Functional Disorders and subluxation.

Please be sure to retain this document. It is not a contract but is a part of your EOC.

Summary of Benefits

**Group Plan
HMO Plan**

Local Access+ HMO® Zero Admit 20

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:

Local Access+ HMO Network

This Plan uses a specific network of Health Care Providers, called the Local Access+ HMO provider network. Medical Groups, Independent Practice Associations (IPAs), and Physicians in this network are called Participating Providers. You must select a Primary Care Physician from this network to provide your primary care and help you access services, but there are some exceptions. Please review your Evidence of Coverage for details about how to access care under this Plan. 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.

When using a Participating Provider³

Calendar Year medical Deductible	<i>Individual coverage</i>	\$0
	<i>Family coverage</i>	\$0: individual \$0: Family

Calendar Year Out-of-Pocket Maximum⁴

An Out-of-Pocket Maximum is the most a Member will pay for Covered Benefits each Calendar Year. Any exceptions are listed in the EOC.

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 Provider³

<i>Individual coverage</i>	\$1,500
<i>Family coverage</i>	\$1,500: individual \$3,000: Family

Benefits⁵

Your payment

	When using a Participating Provider³	CYD² applies
Preventive Health Services⁶		
Preventive Health Services	\$0	
California Prenatal Screening Program	\$0	
Physician services		
Primary care office visit	\$20/visit	
Access+ specialist care office visit (self-referral)	\$35/visit	
Other specialist care office visit (referred by PCP)	\$20/visit	
Physician home visit	\$20/visit	
Physician or surgeon services in an Outpatient Facility	\$0	
Physician or surgeon services in an inpatient facility	\$0	
Other professional services		
Other practitioner office visit <i>Includes nurse practitioners, physician assistants, therapists, and podiatrists.</i>	\$20/visit	
Teladoc Health consultation	\$0	
Family planning		
<ul style="list-style-type: none"> • Counseling, consulting, and education • Injectable contraceptive, diaphragm fitting, intrauterine device (IUD), implantable contraceptive, and related procedure. • Tubal ligation • Vasectomy 	\$0	
Medical nutrition therapy, not related to diabetes	\$0	
Infertility Services		
Physician or surgeon services in an Outpatient Facility	\$0	
Artificial Inseminations limited to 6 per lifetime	\$0	
Oocyte (egg) retrieval limited to 3 per lifetime		
<ul style="list-style-type: none"> • Ambulatory Surgery Center • Outpatient Department of a Hospital 	\$0	
In vitro fertilization (IVF)	\$0	
Embryo transfer		
<ul style="list-style-type: none"> • Ambulatory Surgery Center • Outpatient Department of a Hospital 	\$0	
Cryopreservation limited to 1 year of storage per lifetime for each of the following: sperm, reproductive tissue, oocytes (eggs), and embryos	\$0	

Benefits⁵

Your payment

	When using a Participating Provider³	CYD² applies
Pregnancy and maternity care		
Physician office visits: prenatal and postnatal	\$0	
Abortion and abortion-related services	\$0	
Emergency Services		
Emergency room services	\$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	\$0	
Urgent care center services		
	\$20/visit	
Ambulance services		
	\$100/transport	
<i>This payment is for emergency or authorized transport.</i>		
Outpatient Facility services		
Ambulatory Surgery Center	\$0	
Outpatient Department of a Hospital: surgery	\$0	
Outpatient Department of a Hospital: treatment of illness or injury, radiation therapy, chemotherapy, and necessary supplies	\$0	
Inpatient facility services		
Hospital services and stay	\$0	
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	\$0	
• Physician inpatient services	\$0	
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	\$0	
• Outpatient Department of a Hospital	\$0	

Benefits⁵

Your payment

	When using a Participating Provider³	CYD² applies
<p>Basic imaging services</p> <p><i>Includes plain film X-rays, ultrasounds, and diagnostic mammography.</i></p> <ul style="list-style-type: none"> • Outpatient radiology center \$0 • Outpatient Department of a Hospital \$0 <p>Other outpatient non-invasive diagnostic testing</p> <p><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></p> <ul style="list-style-type: none"> • Office location \$0 • Outpatient Department of a Hospital \$0 <p>Advanced imaging services</p> <p><i>Includes diagnostic radiological and nuclear imaging such as CT scans, MRIs, MRAs, and PET scans.</i></p> <ul style="list-style-type: none"> • Outpatient radiology center \$0 • Outpatient Department of a Hospital \$0 		
<p>Rehabilitative and Habilitative Services</p> <p><i>Includes physical therapy, occupational therapy, respiratory therapy, and speech therapy services.</i></p> <ul style="list-style-type: none"> Office location \$20/visit Outpatient Department of a Hospital \$20/visit 		
<p>Durable medical equipment (DME)</p> <ul style="list-style-type: none"> DME 20% Breast pump \$0 Orthotic equipment and devices \$0 Prosthetic equipment and devices \$0 		
<p>Home health care services</p> <p><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></p>	\$20/visit	
<p>Home infusion and home injectable therapy services</p> <ul style="list-style-type: none"> Home infusion agency services \$0 <p><i>Includes home infusion drugs, medical supplies, and visits by a nurse.</i></p> Hemophilia home infusion services \$0 <p><i>Includes blood factor products.</i></p> 		

Benefits⁵

Your payment

	When using a Participating Provider³	CYD² applies
Skilled Nursing Facility (SNF) services		
<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	\$0	
Hospital-based SNF	\$0	
Hospice program services		
<i>Includes pre-Hospice consultation, routine home care, 24-hour continuous home care, short-term inpatient care for pain and symptom management, and inpatient respite care.</i>		
Other services and supplies		
Diabetes care services		
<ul style="list-style-type: none"> • Devices, equipment, and supplies • Self-management training • Medical nutrition therapy 	<p>20%</p> <p>\$20/visit</p> <p>\$20/visit</p>	
Dialysis services	\$0	
PKU product formulas and special food products	\$0	
Allergy serum billed separately from an office visit	50%	

Mental Health or Substance Use Disorder Benefits

Your payment

	When using a Participating Provider³	CYD² applies
Outpatient services		
Office visit, including Physician office visit	\$20/visit	
Teladoc Health mental health	\$0	
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	\$0	
Partial Hospitalization Program	\$0	
Psychological Testing	\$0	
Inpatient services		
Physician inpatient services	\$0	
Hospital services	\$0	
Residential Care	\$0	

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.

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.

4 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 Allowed Charges 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, charges above the Allowed Charges, and charges for services above any Benefit maximum.

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.

5 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.

6 Preventive Health Services:

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

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

Enhanced Rx \$10/25/40 with \$0 Pharmacy Deductible
Summary of Benefits

This Summary of Benefits shows the amount you will pay for covered Drugs under this prescription Drug Benefit.

Pharmacy Network:

Rx Ultra

Drug Formulary:

Plus Formulary

Calendar Year Pharmacy Deductible(CYPD)¹

A Calendar Year Pharmacy Deductible (CYPD) is the amount a Member pays each Calendar Year before Blue Shield pays for covered Drugs under the outpatient prescription Drug Benefit. Blue Shield pays for some prescription Drugs before the Calendar Year Pharmacy Deductible is met, as noted in the Prescription Drug Benefits chart below.

When using a Participating² Pharmacy

Calendar Year Pharmacy Deductible *Per Member* \$0

Prescription Drug Benefits^{3,4}

Your payment

When using a Participating Pharmacy²

CYPD¹ applies

Retail pharmacy prescription Drugs

Per prescription, up to a 30-day supply.

Contraceptive Drugs and devices	\$0
Tier 1 Drugs	\$10/prescription
Tier 2 Drugs	\$25/prescription
Tier 3 Drugs	\$40/prescription
Tier 4 Drugs	20% up to \$250/prescription

Retail pharmacy prescription Drugs

Per prescription, for a 90-day supply.

Contraceptive Drugs and devices	\$0
Tier 1 Drugs	\$30/prescription
Tier 2 Drugs	\$75/prescription
Tier 3 Drugs	\$120/prescription
Tier 4 Drugs	20% up to \$750/prescription

Mail service pharmacy prescription Drugs

Per prescription, for a 31-90-day supply.

Contraceptive Drugs and devices	\$0
Tier 1 Drugs	\$20/prescription

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

Prescription Drug Benefits^{3,4}

Your payment

	When using a Participating Pharmacy ²	CYPD ¹ applies
Tier 2 Drugs	\$50/prescription	
Tier 3 Drugs	\$80/prescription	
Tier 4 Drugs	20% up to \$500/prescription	

Notes

1 Calendar Year Pharmacy Deductible (CYPD):

Calendar Year Pharmacy Deductible explained. A Calendar Year Pharmacy Deductible is the amount you pay each Calendar Year before Blue Shield pays for outpatient prescription Drugs under this Benefit.

If this Benefit has a Calendar Year Pharmacy Deductible, outpatient prescription Drugs subject to the Deductible are identified with a check mark (✓) in the Benefits chart above.

Any applicable Copayment, Coinsurance and CYPD you pay counts towards the Calendar Year Out-of-Pocket Maximum.

Outpatient prescription Drugs not subject to the Calendar Year Pharmacy Deductible. Some outpatient prescription Drugs received from Participating Pharmacies are paid by Blue Shield before you meet any Calendar Year Pharmacy Deductible. These outpatient prescription Drugs do not have a check mark (✓) next to them in the "CYPD applies" column in the Prescription Drug Benefits chart above.

2 Using Participating Pharmacies:

Participating Pharmacies have a contract to provide outpatient prescription Drugs to Members. When you obtain covered prescription Drugs from a Participating Pharmacy, you are only responsible for the Copayment or Coinsurance, once any Calendar Year Pharmacy Deductible has been met.

Participating Pharmacies and Drug Formulary. You can find a Participating Pharmacy and the Drug Formulary by visiting <https://www.blueshieldca.com/wellness/drugs/formulary#heading2>.

Non-Participating Pharmacies. Drugs from Non-Participating Pharmacies are not covered except in emergency situations.

3 Outpatient Prescription Drug Coverage:

Medicare Part D-creditable coverage-

This prescription Drug coverage is on average equivalent to or better than the standard benefit set by the federal government for Medicare Part D (also called creditable coverage). Because this prescription Drug coverage is creditable, you do not have to enroll in Medicare Part D while you maintain this coverage; however, you should be aware that if you do not enroll in Medicare Part D within 63 days following termination of this coverage, you could be subject to Medicare Part D premium penalties.

4 Outpatient Prescription Drug Coverage:

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

Notes

your Physician believes a Brand Drug is Medically Necessary, either person may request a Medical Necessity Review. If approved, the Brand Drug will be covered at the applicable Drug tier Copayment or Coinsurance.

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

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

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

Oral Anticancer Drugs. You pay up to \$250 for oral Anticancer Drugs from a Participating Pharmacy, up to a 30-day supply. Oral Anticancer Drugs from a Participating Pharmacy are not subject to any Deductible.

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

Mail service Drugs. You pay the applicable 30-day retail pharmacy Copayment or Coinsurance for a 30-day supply or less from the mail service pharmacy.

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

Summary of Benefits

This Summary of Benefits shows the amount you will pay for Covered Benefits under this acupuncture and chiropractic services Benefit.

Benefits	Your Payment	
<i>Covered Benefits must be determined as Medically Necessary by American Specialty Health Plans of California, Inc. (ASH Plans).</i>		
<i>Up to 30 visits per Member, per Calendar Year. The 30 visit maximum is for acupuncture and chiropractic services combined.</i>	When using an ASH Participating Provider	When using a Non-Participating Provider
<i>Services are not subject to the Calendar Year Deductible and do count towards the Calendar Year Out-of-Pocket Maximum.</i>		
Acupuncture Services		
Office visit	\$10/visit	Not covered
Chiropractic Services		
Office visit	\$10/visit	Not covered
Chiropractic Appliances	All charges above \$50	Not covered

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

Introduction

In addition to the Benefits listed in your Evidence of Coverage, your rider provides coverage for acupuncture and chiropractic services as described in this supplement. The Benefits covered under this rider must be received from an American Specialty Health Plans of California, Inc. (ASH Plans) Participating Provider. These acupuncture and chiropractic Benefits are separate from your health Plan, but the general provisions, limitations, and exclusions described in your Evidence of Coverage do apply. A referral from your Primary Care Physician is not required.

All Covered Benefits, except for (1) the initial examination and treatment by an ASH Participating Provider; and (2) Emergency Services, must be determined as Medically Necessary by ASH Plans.

Note: ASH Plans will respond to all requests for Medical Necessity review within five business days from receipt of the request.

Covered Benefits received from providers who are not ASH Participating Providers will not be covered except for Emergency Services and in certain circumstances, in counties in California in which there are no ASH Participating Providers. If ASH Plans determines Covered Benefits from a provider other than a Participating Provider are Medically Necessary, you will be responsible for the Participating Provider Copayment amount.

Benefits

Acupuncture Services

Benefits are available for Medically Necessary acupuncture services for the treatment of Musculoskeletal and Related Disorders.

Benefits include an initial examination, acupuncture and adjunctive therapy, and subsequent office visits for the treatment of:

- headaches (tension-type and migraines);
- hip or knee joint pain associated with osteoarthritis (OA);
- other extremity joint pain associated with OA or mechanical irritation;
- other pain syndromes involving the joints and associated soft tissues;
- back and neck pain; and
- nausea associated with pregnancy, surgery, or chemotherapy.

Chiropractic Services

Benefits are available for Medically Necessary chiropractic services for the treatment of Musculoskeletal and Related Disorders.

Benefits include an initial examination, subsequent office visits and the following services:

- spinal and extra-spinal joint manipulation (adjustments);
- adjunctive therapy such as electrical muscle stimulation or therapeutic exercises;
- plain film x-ray services; and
- chiropractic supports and appliances.

Visits for acupuncture and chiropractic services are limited to a per Member per Calendar Year maximum as

shown on the Summary of Benefits. Benefits must be provided in an office setting. You will be referred to your Primary Care Physician for evaluation of conditions not related to a Musculoskeletal and Related Disorder and for other services not covered under this rider such as diagnostic imaging (e.g. CAT scans or MRIs).

Note: You should exhaust the Benefits covered under this rider before accessing the same services through the "Alternative Care Discount Program," which is a wellness discount program. For more information about the Alternative Care Discount Program, visit www.blueshieldca.com.

See the Grievance Process portion of your EOC for information on filing a grievance, your right to seek assistance from the Department of Managed Health Care, and your rights to independent medical review.

Member Services

For all acupuncture and chiropractic services, Blue Shield of California has contracted with ASH Plans to act as the Plan's acupuncture and chiropractic services administrator. Contact ASH Plans with questions about acupuncture and chiropractic services, ASH Participating Providers, or acupuncture and chiropractic Benefits.

Contact ASH Plans at:

1-800-678-9133
American Specialty Health Plans of California, Inc.
P.O. Box 509002
San Diego, CA 92150-9002

ASH Plans can answer many questions over the telephone.

Exclusions

Acupuncture services do not include:

- treatment of asthma;
- treatment of addiction (including without limitation smoking cessation); or
- vitamins, minerals, nutritional supplements (including herbal supplements), or other similar products.

See the Grievance Process portion of your EOC for information on filing a grievance, your right to seek assistance from the Department of Managed Health Care, and your rights to independent medical review.

Definitions	
American Specialty Health Plans of California, Inc. (ASH Plans)	ASH Plans is a licensed, specialized health care service plan that has entered into an agreement with Blue Shield of California to arrange for the delivery of acupuncture and chiropractic services.
ASH Participating Provider	An acupuncturist or a chiropractor under contract with ASH Plans to provide Covered Benefits to Members.

Musculoskeletal and Related Disorders

Musculoskeletal and Related Disorders are conditions with signs and symptoms related to the nervous, muscular, and/or skeletal systems. Musculoskeletal and Related Disorders are conditions typically categorized as: structural, degenerative, or inflammatory disorders; or biomechanical dysfunction of the joints of the body and/or related components of the muscle or skeletal systems (muscles, tendons, fascia, nerves, ligaments/capsules, discs and synovial structures) and related manifestations or conditions. Musculoskeletal and Related Disorders include Myofascial/Musculoskeletal Disorders, Musculoskeletal Functional Disorders and subluxation.

Please be sure to retain this document. It is not a contract but is a part of your EOC.

Summary of Benefits

**Group Plan
PPO Plan**

Full PPO Combined Deductible 25-250 90/60

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 Participating³ or Non-Participating⁴ Provider

Calendar Year medical Deductible	<i>Individual coverage</i>	\$250
	<i>Family coverage</i>	\$250: individual \$750: 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 Provider³	When using any combination of Participating³ or Non-Participating⁴ Providers
<i>Individual coverage</i>	\$3,750	\$7,750
<i>Family coverage</i>	\$3,750: individual \$7,500: Family	\$7,750: individual \$15,500: Family

Benefits⁶

Your payment

	When using a Participating Provider³	CYD² applies	When using a Non-Participating Provider⁴	CYD² applies
Preventive Health Services⁷				
Preventive Health Services	\$0		Not covered	
California Prenatal Screening Program	\$0		\$0	
Physician services				
Primary care office visit	\$25/visit		40%	✓
Specialist care office visit	\$30/visit		40%	✓
Physician home visit	\$25/visit		40%	✓
Physician or surgeon services in an Outpatient Facility	10%	✓	40%	✓
Physician or surgeon services in an inpatient facility	10%	✓	40%	✓
Other professional services				
Other practitioner office visit <i>Includes nurse practitioners, physician assistants, therapists, and podiatrists.</i>	\$25/visit		40%	✓
Acupuncture services <i>Up to 20 visits per Member, per Calendar Year.</i>	\$25/visit		40%	✓
Chiropractic services <i>Up to 20 visits per Member, per Calendar Year.</i>	\$25/visit		40%	✓
Teladoc Health consultation	\$0		Not covered	
Family planning				
• Counseling, consulting, and education	\$0		Not covered	
• Injectable contraceptive, diaphragm fitting, intrauterine device (IUD), implantable contraceptive, and related procedure.	\$0		Not covered	
• Tubal ligation	\$0		Not covered	
• Vasectomy	\$0		Not covered	
Medical nutrition therapy, not related to diabetes	10%	✓	40%	✓
Infertility Services				
Physician or surgeon services in an Outpatient Facility	10%	✓	40%	✓
Artificial Inseminations limited to 6 per lifetime	10%	✓	40%	✓
Oocyte (egg) retrieval limited to 3 per lifetime			40%	
• Ambulatory Surgery Center	5%	✓	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
<ul style="list-style-type: none"> Outpatient Department of a Hospital 	15%	✓	40% Subject to a Benefit maximum of \$350/day	✓
In vitro fertilization (IVF) Embryo transfer	10%	✓	40%	✓
<ul style="list-style-type: none"> Ambulatory Surgery Center 	5%	✓	40% Subject to a Benefit maximum of \$350/day	✓
<ul style="list-style-type: none"> Outpatient Department of a Hospital 	15%	✓	40% Subject to a Benefit maximum of \$350/day	✓
Cryopreservation limited to 1 year of storage per lifetime for each of the following: sperm, reproductive tissue, oocytes (eggs), and embryos	10%	✓	40%	✓
Pregnancy and maternity care				
Physician office visits: prenatal and postnatal	10%	✓	40%	✓
Abortion and abortion-related services	\$0		\$0	
Emergency Services				
Emergency room services	\$150/visit plus 10%		\$150/visit plus 10%	
<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%	
Urgent care center services				
	\$25/visit		40%	✓
Ambulance services				
	10%	✓	10%	✓
<i>This payment is for emergency or authorized transport.</i>				
Outpatient Facility services				
Ambulatory Surgery Center	5%	✓	40% Subject to a Benefit maximum of \$350/day	✓
Outpatient Department of a Hospital: surgery	15%	✓	40% Subject to a Benefit maximum of \$350/day	✓

Benefits⁶

Your payment

	When using a Participating Provider³	CYD² applies	When using a Non-Participating Provider⁴	CYD² applies
Outpatient Department of a Hospital: treatment of illness or injury, radiation therapy, chemotherapy, and necessary supplies	10%	✓	40% Subject to a Benefit maximum of \$350/day	✓
Inpatient facility services				
Hospital services and stay	10%	✓	40% 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	
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	10%	✓	Not covered	
Outpatient Facility services	15%	✓	Not covered	
Physician services	10%	✓	Not covered	
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	\$25/visit	✓	40%	✓

Benefits⁶

Your payment

	When using a Participating Provider ³	CYD ² applies	When using a Non-Participating Provider ⁴	CYD ² applies
<ul style="list-style-type: none"> Outpatient Department of a Hospital 	\$50/visit	✓	40% Subject to a Benefit maximum of \$350/day	✓
<p>Basic imaging services</p> <p><i>Includes plain film X-rays, ultrasounds, and diagnostic mammography.</i></p>				
<ul style="list-style-type: none"> Outpatient radiology center 	\$25/visit	✓	40%	✓
<ul style="list-style-type: none"> Outpatient Department of a Hospital 	\$50/visit	✓	40% Subject to a Benefit maximum of \$350/day	✓
<p>Other outpatient non-invasive diagnostic testing</p> <p><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></p>				
<ul style="list-style-type: none"> Office location 	\$25/visit	✓	40%	✓
<ul style="list-style-type: none"> Outpatient Department of a Hospital 	\$50/visit	✓	40% Subject to a Benefit maximum of \$350/day	✓
<p>Advanced imaging services</p> <p><i>Includes diagnostic radiological and nuclear imaging such as CT scans, MRIs, MRAs, and PET scans.</i></p>				
<ul style="list-style-type: none"> Outpatient radiology center 	10%	✓	40%	✓
<ul style="list-style-type: none"> Outpatient Department of a Hospital 	20%	✓	40% Subject to a Benefit maximum of \$350/day	✓
Rehabilitative and Habilitative Services				
<i>Includes physical therapy, occupational therapy, respiratory therapy, and speech therapy services.</i>				
Office location	\$25/visit	✓	40%	✓
Outpatient Department of a Hospital	\$25/visit	✓	40% Subject to a Benefit maximum of \$350/day	✓
Durable medical equipment (DME)				
DME	10%	✓	40%	✓

Benefits⁶

Your payment

	When using a Participating Provider³	CYD² applies	When using a Non-Participating Provider⁴	CYD² applies
Breast pump	\$0		Not covered	
Orthotic equipment and devices	10%	✓	40%	✓
Prosthetic equipment and devices	10%	✓	40%	✓
Home health care services <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>	10%	✓	Not covered	
Home infusion and home injectable therapy services				
Home infusion agency services <i>Includes home infusion drugs, medical supplies, and visits by a nurse.</i>	\$45/visit	✓	Not covered	
Hemophilia home infusion services <i>Includes blood factor products.</i>	\$45/visit	✓	Not covered	
Skilled Nursing Facility (SNF) services <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%	✓	40%	✓
Hospital-based SNF	10%	✓	40% Subject to a Benefit maximum of \$600/day	✓
Hospice program services <i>Includes pre-Hospice consultation, routine home care, 24-hour continuous home care, short-term inpatient care for pain and symptom management, and inpatient respite care.</i>	\$0		Not covered	
Other services and supplies				
Diabetes care services				
• Devices, equipment, and supplies	10%	✓	40%	✓
• Self-management training	\$25/visit		40%	✓
• Medical nutrition therapy	\$25/visit		40%	✓

Benefits⁶

Your payment

	When using a Participating Provider³	CYD² applies	When using a Non-Participating Provider⁴	CYD² applies
Dialysis services	10%	✓	40% 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%	✓	40%	✓

Mental Health or Substance Use Disorder Benefits

Your payment

	When using a Participating Provider³	CYD² applies	When using a Non-Participating Provider⁴	CYD² applies
Outpatient services				
Office visit, including Physician office visit	\$25/visit		40%	✓
Teladoc Health mental health	\$0		Not covered	
Other outpatient services, including intensive outpatient care, electroconvulsive therapy, transcranial magnetic stimulation, Behavioral Health Treatment for pervasive developmental disorder or autism in an office setting, home, or other non-institutional facility setting, and office-based opioid treatment	10%	✓	40%	✓
Partial Hospitalization Program	10%	✓	40% Subject to a Benefit maximum of \$350/day	✓
Psychological Testing	10%	✓	40%	✓
Inpatient services				
Physician inpatient services	\$0	✓	40%	✓
Hospital services	10%	✓	40% Subject to a Benefit maximum of \$600/day	✓
Residential Care	10%	✓	40% 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 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.

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:

Notes

- 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. 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.



Outpatient Prescription Drug Rider

Group Rider
PPO

Enhanced Rx \$10/25/40 with \$0 Pharmacy Deductible Summary of Benefits

This Summary of Benefits shows the amount you will pay for covered Drugs under this prescription Drug Benefit.

Pharmacy Network:

Rx Ultra

Drug Formulary:

Plus Formulary

Calendar Year Pharmacy Deductible(CYPD)¹

A Calendar Year Pharmacy Deductible (CYPD) is the amount a Member pays each Calendar Year before Blue Shield pays for covered Drugs under the outpatient prescription Drug Benefit. Blue Shield pays for some prescription Drugs before the Calendar Year Pharmacy Deductible is met, as noted in the Prescription Drug Benefits chart below.

When using a Participating² or Non-Participating³ Pharmacy

Calendar Year Pharmacy Deductible *Per Member* \$0

Prescription Drug Benefits^{4,5}

Your payment

	When using a Participating Pharmacy ²	CYPD ¹ applies	When using a Non-Participating Pharmacy ³	CYPD ¹ applies
Retail pharmacy prescription Drugs				
<i>Per prescription, up to a 30-day supply.</i>				
Contraceptive Drugs and devices	\$0		Applicable Tier 1, Tier 2, or Tier 3 Copayment	
Tier 1 Drugs	\$10/prescription		25% plus \$10/prescription	
Tier 2 Drugs	\$25/prescription		25% plus \$25/prescription	
Tier 3 Drugs	\$40/prescription		25% plus \$40/prescription	
Tier 4 Drugs	30% up to \$250/prescription		30% up to \$250/prescription plus 25% of purchase price	
Retail pharmacy prescription Drugs				
<i>Per prescription, for a 90-day supply.</i>				
Contraceptive Drugs and devices	\$0		Not covered	
Tier 1 Drugs	\$30/prescription		Not covered	

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

Prescription Drug Benefits^{4,5}

Your payment

	When using a Participating Pharmacy²	CYPD¹ applies	When using a Non-Participating Pharmacy³	CYPD¹ applies
Tier 2 Drugs	\$75/prescription		Not covered	
Tier 3 Drugs	\$120/prescription		Not covered	
Tier 4 Drugs	30% up to \$750/prescription		Not covered	
Mail service pharmacy prescription Drugs				
<i>Per prescription, for a 31-90-day supply.</i>				
Contraceptive Drugs and devices	\$0		Not covered	
Tier 1 Drugs	\$20/prescription		Not covered	
Tier 2 Drugs	\$50/prescription		Not covered	
Tier 3 Drugs	\$80/prescription		Not covered	
Tier 4 Drugs	30% up to \$500/prescription		Not covered	

Notes

1 Calendar Year Pharmacy Deductible (CYPD):

Calendar Year Pharmacy Deductible explained. A Calendar Year Pharmacy Deductible is the amount you pay each Calendar Year before Blue Shield pays for outpatient prescription Drugs under this Benefit.

If this Benefit has a Calendar Year Pharmacy Deductible, outpatient prescription Drugs subject to the Deductible are identified with a check mark (✓) in the Benefits chart above.

Any applicable Copayment, Coinsurance and CYPD you pay counts towards the Calendar Year Out-of-Pocket Maximum.

Outpatient prescription Drugs not subject to the Calendar Year Pharmacy Deductible. Some outpatient prescription Drugs received from Participating Pharmacies are paid by Blue Shield before you meet any Calendar Year Pharmacy Deductible. These outpatient prescription Drugs do not have a check mark (✓) next to them in the "CYPD applies" column in the Prescription Drug Benefits chart above.

2 Using Participating Pharmacies:

Participating Pharmacies have a contract to provide outpatient prescription Drugs to Members. When you obtain covered prescription Drugs from a Participating Pharmacy, you are only responsible for the Copayment or Coinsurance, once any Calendar Year Pharmacy Deductible has been met.

Participating Pharmacies and Drug Formulary. You can find a Participating Pharmacy and the Drug Formulary by visiting <https://www.blueshieldca.com/wellness/drugs/formulary#heading2>.

3 Using Non-Participating Pharmacies:

Non-Participating Pharmacies do not have a contract to provide outpatient prescription Drugs to Members. When you obtain prescription Drugs from a Non-Participating Pharmacy, you must pay all charges for the prescription, then submit a completed claim form for reimbursement. You will be reimbursed based on the price you paid for the Drug.

4 Outpatient Prescription Drug Coverage:

Medicare Part D-creditable coverage-

This prescription Drug coverage is on average equivalent to or better than the standard benefit set by the federal government for Medicare Part D (also called creditable coverage). Because this prescription Drug coverage is creditable, you do not have to enroll in Medicare Part D while you maintain this coverage; however, you should be aware that if you do not enroll in Medicare Part D within 63 days following termination of this coverage, you could be subject to Medicare Part D premium penalties.

5 Outpatient Prescription Drug Coverage:

Brand Drug coverage when a Generic or Biosimilar Drug is available. If you, the Physician, or Health Care Provider select a Brand Drug when a Generic Drug equivalent or Biosimilar Drug is available, you are responsible for the difference between the cost to Blue Shield for the Brand Drug and its Generic Drug equivalent or Biosimilar Drug plus the applicable tier Copayment or Coinsurance of the Brand Drug. This difference in cost will not count towards any Calendar Year Pharmacy Deductible, medical Deductible, or the Calendar Year Out-of-Pocket Maximum. If you or your Physician believes a Brand Drug is Medically Necessary, either person may request a Medical Necessity Review. If approved, the Brand Drug will be covered at the applicable Drug tier Copayment or Coinsurance.

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

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

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

Oral Anticancer Drugs. You pay up to \$250 for oral Anticancer Drugs from a Participating Pharmacy, up to a 30-day supply. Oral Anticancer Drugs from a Participating Pharmacy are not subject to any Deductible.

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

Mail service Drugs. You pay the applicable 30-day retail pharmacy Copayment or Coinsurance for a 30-day supply or less from the mail service pharmacy.

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

Summary of Benefits

**Group Plan
PPO Plan**

Full PPO Split Deductible 35-1000 80/60

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 Provider³	When using a Non-Participating Provider⁴
Calendar Year medical Deductible	<i>Individual coverage</i>	\$1,000	\$3,000
	<i>Family coverage</i>	\$1,000: individual \$3,000: Family	\$3,000: individual \$9,000: 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 Provider³	When using any combination of Participating³ or Non-Participating⁴ Providers
<i>Individual coverage</i>	\$5,500	\$10,000
<i>Family coverage</i>	\$5,500: individual \$11,000: Family	\$10,000: individual \$20,000: Family

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		Not covered	
California Prenatal Screening Program	\$0		\$0	
Physician services				
Primary care office visit	\$35/visit		40%	✓
Specialist care office visit	\$40/visit		40%	✓
Physician home visit	\$35/visit		40%	✓
Physician or surgeon services in an Outpatient Facility	20%	✓	40%	✓
Physician or surgeon services in an inpatient facility	20%	✓	40%	✓
Other professional services				
Other practitioner office visit <i>Includes nurse practitioners, physician assistants, therapists, and podiatrists.</i>	\$35/visit		40%	✓
Acupuncture services <i>Up to 20 visits per Member, per Calendar Year.</i>	\$25/visit		40%	✓
Chiropractic services <i>Up to 20 visits per Member, per Calendar Year.</i>	\$25/visit		40%	✓
Teladoc Health consultation	\$0		Not covered	
Family planning				
• Counseling, consulting, and education	\$0		Not covered	
• Injectable contraceptive, diaphragm fitting, intrauterine device (IUD), implantable contraceptive, and related procedure.	\$0		Not covered	
• Tubal ligation	\$0		Not covered	
• Vasectomy	\$0		Not covered	
Medical nutrition therapy, not related to diabetes	20%	✓	40%	✓
Infertility Services				
Physician or surgeon services in an Outpatient Facility	20%	✓	40%	✓
Artificial Inseminations limited to 6 per lifetime	20%	✓	40%	✓
Oocyte (egg) retrieval limited to 3 per lifetime				
• Ambulatory Surgery Center	10%	✓	40% Subject to a Benefit maximum of \$350/day	✓

Benefits⁶

Your payment

	When using a Participating Provider³	CYD² applies	When using a Non-Participating Provider⁴	CYD² applies
<ul style="list-style-type: none"> Outpatient Department of a Hospital 	25%	✓	40% Subject to a Benefit maximum of \$350/day	✓
In vitro fertilization (IVF) Embryo transfer	20%	✓	40%	✓
<ul style="list-style-type: none"> Ambulatory Surgery Center 	10%	✓	40% Subject to a Benefit maximum of \$350/day	✓
<ul style="list-style-type: none"> Outpatient Department of a Hospital 	25%	✓	40% Subject to a Benefit maximum of \$350/day	✓
Cryopreservation limited to 1 year of storage per lifetime for each of the following: sperm, reproductive tissue, oocytes (eggs), and embryos	20%	✓	40%	✓
Pregnancy and maternity care				
Physician office visits: prenatal and postnatal	20%	✓	40%	✓
Abortion and abortion-related services	\$0		\$0	
Emergency Services				
Emergency room services	\$150/visit plus 20%		\$150/visit plus 20%	
<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	20%		20%	
Urgent care center services				
	\$35/visit		40%	✓
Ambulance services				
	20%	✓	20%	✓
<i>This payment is for emergency or authorized transport.</i>				
Outpatient Facility services				
Ambulatory Surgery Center	10%	✓	40% Subject to a Benefit maximum of \$350/day	✓
Outpatient Department of a Hospital: surgery	25%	✓	40% Subject to a Benefit maximum of \$350/day	✓

Benefits⁶

Your payment

	When using a Participating Provider³	CYD² applies	When using a Non-Participating Provider⁴	CYD² applies
Outpatient Department of a Hospital: treatment of illness or injury, radiation therapy, chemotherapy, and necessary supplies	20%	✓	40% Subject to a Benefit maximum of \$350/day	✓
Inpatient facility services				
Hospital services and stay	20%	✓	40% Subject to a Benefit maximum of \$600/day	✓
Transplant services				
<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	20%	✓	Not covered	
• Physician inpatient services	20%	✓	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	20%	✓	Not covered	
Outpatient Facility services	25%	✓	Not covered	
Physician services	20%	✓	Not covered	
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	\$35/visit	✓	40%	✓

Benefits⁶

Your payment

	When using a Participating Provider ³	CYD ² applies	When using a Non-Participating Provider ⁴	CYD ² applies
<ul style="list-style-type: none"> Outpatient Department of a Hospital 	\$60/visit	✓	40% Subject to a Benefit maximum of \$350/day	✓
<p>Basic imaging services</p> <p><i>Includes plain film X-rays, ultrasounds, and diagnostic mammography.</i></p>				
<ul style="list-style-type: none"> Outpatient radiology center 	\$35/visit	✓	40%	✓
<ul style="list-style-type: none"> Outpatient Department of a Hospital 	\$60/visit	✓	40% Subject to a Benefit maximum of \$350/day	✓
<p>Other outpatient non-invasive diagnostic testing</p> <p><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></p>				
<ul style="list-style-type: none"> Office location 	\$35/visit	✓	40%	✓
<ul style="list-style-type: none"> Outpatient Department of a Hospital 	\$60/visit	✓	40% Subject to a Benefit maximum of \$350/day	✓
<p>Advanced imaging services</p> <p><i>Includes diagnostic radiological and nuclear imaging such as CT scans, MRIs, MRAs, and PET scans.</i></p>				
<ul style="list-style-type: none"> Outpatient radiology center 	20%	✓	40%	✓
<ul style="list-style-type: none"> Outpatient Department of a Hospital 	30%	✓	40% Subject to a Benefit maximum of \$350/day	✓
Rehabilitative and Habilitative Services				
<i>Includes physical therapy, occupational therapy, respiratory therapy, and speech therapy services.</i>				
Office location	\$35/visit	✓	40%	✓
Outpatient Department of a Hospital	\$35/visit	✓	40% Subject to a Benefit maximum of \$350/day	✓
Durable medical equipment (DME)				
DME	20%	✓	40%	✓

Benefits⁶

Your payment

	When using a Participating Provider³	CYD² applies	When using a Non-Participating Provider⁴	CYD² applies
Breast pump	\$0		Not covered	
Orthotic equipment and devices	20%	✓	40%	✓
Prosthetic equipment and devices	20%	✓	40%	✓
Home health care services <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>	20%	✓	Not covered	
Home infusion and home injectable therapy services				
Home infusion agency services <i>Includes home infusion drugs, medical supplies, and visits by a nurse.</i>	\$45/visit	✓	Not covered	
Hemophilia home infusion services <i>Includes blood factor products.</i>	\$45/visit	✓	Not covered	
Skilled Nursing Facility (SNF) services <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	20%	✓	40%	✓
Hospital-based SNF	20%	✓	40% Subject to a Benefit maximum of \$600/day	✓
Hospice program services <i>Includes pre-Hospice consultation, routine home care, 24-hour continuous home care, short-term inpatient care for pain and symptom management, and inpatient respite care.</i>	\$0		Not covered	
Other services and supplies				
Diabetes care services				
• Devices, equipment, and supplies	20%	✓	40%	✓
• Self-management training	\$35/visit		40%	✓
• Medical nutrition therapy	\$35/visit		40%	✓

Benefits⁶

Your payment

	When using a Participating Provider³	CYD² applies	When using a Non-Participating Provider⁴	CYD² applies
Dialysis services	20%	✓	40% Subject to a Benefit maximum of \$350/day	✓
PKU product formulas and special food products	20%	✓	20%	✓
Allergy serum billed separately from an office visit	20%	✓	40%	✓

Mental Health or Substance Use Disorder Benefits

Your payment

	When using a Participating Provider³	CYD² applies	When using a Non-Participating Provider⁴	CYD² applies
Outpatient services				
Office visit, including Physician office visit	\$35/visit		40%	✓
Teladoc Health mental health	\$0		Not covered	
Other outpatient services, including intensive outpatient care, electroconvulsive therapy, transcranial magnetic stimulation, Behavioral Health Treatment for pervasive developmental disorder or autism in an office setting, home, or other non-institutional facility setting, and office-based opioid treatment	20%	✓	40%	✓
Partial Hospitalization Program	20%	✓	40% Subject to a Benefit maximum of \$350/day	✓
Psychological Testing	20%	✓	40%	✓
Inpatient services				
Physician inpatient services	\$0	✓	40%	✓
Hospital services	20%	✓	40% Subject to a Benefit maximum of \$600/day	✓
Residential Care	20%	✓	40% Subject to a Benefit maximum of \$600/day	✓

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 separate Participating Provider Deductible and Non-Participating Provider Deductible.

Family coverage has an individual Deductible within the Family Deductible. This means that the Deductible will be met for an individual with Family coverage who meets the individual Deductible prior to the Family meeting the Family Deductible within a Calendar Year.

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. 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.



Outpatient Prescription Drug Rider

Group Rider
PPO

Enhanced Rx \$10/25/40 with \$0 Pharmacy Deductible Summary of Benefits

This Summary of Benefits shows the amount you will pay for covered Drugs under this prescription Drug Benefit.

Pharmacy Network:

Rx Ultra

Drug Formulary:

Plus Formulary

Calendar Year Pharmacy Deductible(CYPD)¹

A Calendar Year Pharmacy Deductible (CYPD) is the amount a Member pays each Calendar Year before Blue Shield pays for covered Drugs under the outpatient prescription Drug Benefit. Blue Shield pays for some prescription Drugs before the Calendar Year Pharmacy Deductible is met, as noted in the Prescription Drug Benefits chart below.

When using a Participating² or Non-Participating³ Pharmacy

Calendar Year Pharmacy Deductible *Per Member* \$0

Prescription Drug Benefits^{4,5}

Your payment

	When using a Participating Pharmacy ²	CYPD ¹ applies	When using a Non-Participating Pharmacy ³	CYPD ¹ applies
Retail pharmacy prescription Drugs				
<i>Per prescription, up to a 30-day supply.</i>				
Contraceptive Drugs and devices	\$0		Applicable Tier 1, Tier 2, or Tier 3 Copayment	
Tier 1 Drugs	\$10/prescription		25% plus \$10/prescription	
Tier 2 Drugs	\$25/prescription		25% plus \$25/prescription	
Tier 3 Drugs	\$40/prescription		25% plus \$40/prescription	
Tier 4 Drugs	30% up to \$250/prescription		30% up to \$250/prescription plus 25% of purchase price	
Retail pharmacy prescription Drugs				
<i>Per prescription, for a 90-day supply.</i>				
Contraceptive Drugs and devices	\$0		Not covered	
Tier 1 Drugs	\$30/prescription		Not covered	

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

Prescription Drug Benefits^{4,5}

Your payment

	When using a Participating Pharmacy²	CYPD¹ applies	When using a Non-Participating Pharmacy³	CYPD¹ applies
Tier 2 Drugs	\$75/prescription		Not covered	
Tier 3 Drugs	\$120/prescription		Not covered	
Tier 4 Drugs	30% up to \$750/prescription		Not covered	
Mail service pharmacy prescription Drugs				
<i>Per prescription, for a 31-90-day supply.</i>				
Contraceptive Drugs and devices	\$0		Not covered	
Tier 1 Drugs	\$20/prescription		Not covered	
Tier 2 Drugs	\$50/prescription		Not covered	
Tier 3 Drugs	\$80/prescription		Not covered	
Tier 4 Drugs	30% up to \$500/prescription		Not covered	

Notes

1 Calendar Year Pharmacy Deductible (CYPD):

Calendar Year Pharmacy Deductible explained. A Calendar Year Pharmacy Deductible is the amount you pay each Calendar Year before Blue Shield pays for outpatient prescription Drugs under this Benefit.

If this Benefit has a Calendar Year Pharmacy Deductible, outpatient prescription Drugs subject to the Deductible are identified with a check mark (✓) in the Benefits chart above.

Any applicable Copayment, Coinsurance and CYPD you pay counts towards the Calendar Year Out-of-Pocket Maximum.

Outpatient prescription Drugs not subject to the Calendar Year Pharmacy Deductible. Some outpatient prescription Drugs received from Participating Pharmacies are paid by Blue Shield before you meet any Calendar Year Pharmacy Deductible. These outpatient prescription Drugs do not have a check mark (✓) next to them in the "CYPD applies" column in the Prescription Drug Benefits chart above.

2 Using Participating Pharmacies:

Participating Pharmacies have a contract to provide outpatient prescription Drugs to Members. When you obtain covered prescription Drugs from a Participating Pharmacy, you are only responsible for the Copayment or Coinsurance, once any Calendar Year Pharmacy Deductible has been met.

Participating Pharmacies and Drug Formulary. You can find a Participating Pharmacy and the Drug Formulary by visiting <https://www.blueshieldca.com/wellness/drugs/formulary#heading2>.

3 Using Non-Participating Pharmacies:

Non-Participating Pharmacies do not have a contract to provide outpatient prescription Drugs to Members. When you obtain prescription Drugs from a Non-Participating Pharmacy, you must pay all charges for the prescription, then submit a completed claim form for reimbursement. You will be reimbursed based on the price you paid for the Drug.

4 Outpatient Prescription Drug Coverage:

Medicare Part D-creditable coverage-

This prescription Drug coverage is on average equivalent to or better than the standard benefit set by the federal government for Medicare Part D (also called creditable coverage). Because this prescription Drug coverage is creditable, you do not have to enroll in Medicare Part D while you maintain this coverage; however, you should be aware that if you do not enroll in Medicare Part D within 63 days following termination of this coverage, you could be subject to Medicare Part D premium penalties.

5 Outpatient Prescription Drug Coverage:

Brand Drug coverage when a Generic or Biosimilar Drug is available. If you, the Physician, or Health Care Provider select a Brand Drug when a Generic Drug equivalent or Biosimilar Drug is available, you are responsible for the difference between the cost to Blue Shield for the Brand Drug and its Generic Drug equivalent or Biosimilar Drug plus the applicable tier Copayment or Coinsurance of the Brand Drug. This difference in cost will not count towards any Calendar Year Pharmacy Deductible, medical Deductible, or the Calendar Year Out-of-Pocket Maximum. If you or your Physician believes a Brand Drug is Medically Necessary, either person may request a Medical Necessity Review. If approved, the Brand Drug will be covered at the applicable Drug tier Copayment or Coinsurance.

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

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

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

Oral Anticancer Drugs. You pay up to \$250 for oral Anticancer Drugs from a Participating Pharmacy, up to a 30-day supply. Oral Anticancer Drugs from a Participating Pharmacy are not subject to any Deductible.

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

Mail service Drugs. You pay the applicable 30-day retail pharmacy Copayment or Coinsurance for a 30-day supply or less from the mail service pharmacy.

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

SmileSM Spectrum Premier Plus 50/1500/Ortho/U90

This Summary of Benefits shows the amount you will pay for Covered Services under this Blue Shield of California Plan. It is only a summary and it is included as part of the Evidence of Coverage (EOC)¹. Please read both documents carefully for details.

Dental Provider Network:

DPPO Network

This Plan uses a specific network of dental care providers, called the DPPO provider network. Dentists in this network are called Participating Dentists. You pay less for Covered Services when you use a Participating Dentist than when you use a Non-Participating Dentist. You can find Participating Dentists in this network at blueshieldca.com.

Calendar Year Deductible (CYD)²

A Calendar Year Deductible (CYD) is the amount a Member pays each Calendar Year before Blue Shield pays for Covered Services under the Plan. Blue Shield pays for some Covered Services before the Calendar Year Deductible is met, as noted in the Benefits chart below.

		When using a Participating³ or Non-Participating⁴ Dentist
Calendar Year Deductible	<i>Individual coverage</i>	\$50 per individual
	<i>Family coverage</i>	\$50: individual
		\$150: Family

Calendar Year Benefit Maximum⁵

This Plan pays up to the maximum payment amount as listed for Covered Services and supplies per year.

	When using a Participating³ or Non-Participating⁴ Dentist
Calendar Year Benefit Maximum	\$1,500: individual

Calendar Year Benefit Maximum (Orthodontic Services)⁵

This maximum for covered Orthodontic Services is separate and in addition to the Calendar Year Benefit maximum listed above. Orthodontic Benefits are covered for adults and children.

	When using a Participating³ or Non-Participating⁴ Dentist
Calendar Year Benefit Maximum	\$1,000: individual

Waiting Period

A waiting period is the length of time you must be covered under the Plan before Blue Shield will pay for Covered Services.

Waiting period	No waiting period
-----------------------	-------------------

No Lifetime Dollar Limit

Under this Plan there is no dollar limit on the total amount Blue Shield will pay for Covered Services in a Member's lifetime.

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

Benefits^{6,7,8}

Your payment

	When using a Participating Dentist ³	CYD ² applies	When using a Non-Participating Dentist ⁴	CYD ² applies
Diagnostic and preventive services				
Oral exam	\$0		\$0	
Preventive – cleaning	\$0		\$0	
Preventive – x-ray	\$0		\$0	
Topical fluoride application	\$0		\$0	
Periodontal maintenance	\$0		\$0	
Enhanced dental benefits for pregnant women	\$0		\$0	
Basic services				
Sealants per tooth	10%	✓	20%	✓
Space maintainers – fixed	10%	✓	20%	✓
Restorative procedures	10%	✓	20%	✓
Oral Surgery	10%	✓	20%	✓
Endodontics	10%	✓	20%	✓
Periodontics (other than maintenance)	10%	✓	20%	✓
Major services				
Crowns and casts	40%	✓	50%	✓
Prosthodontics	40%	✓	50%	✓
Implants	40%	✓	50%	✓
Orthodontics	50%		50%	
<i>Orthodontic Benefits are covered for adults and children.</i>				

Notes

1 Evidence of Coverage (EOC):

The Evidence of Coverage (EOC) describes the Benefits, limitations, and exclusions that apply to coverage under this Plan. Please review the EOC for more details of coverage outlined in this Summary of Benefits. You can request a copy of the EOC at any time.

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

2 Calendar Year Deductible (CYD):

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

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

Covered Services not subject to the Calendar Year Deductible. Some Covered Services are paid by Blue Shield before you meet any Calendar Year Deductible. These Covered Services do not have a check mark (✓) next to them in the "CYD applies" column in the Benefits chart above.

Notes

Family coverage has an individual Deductible within the Family Deductible. This means that the Deductible will be met for an individual with Family coverage who meets the individual Deductible prior to the Family meeting the Family Deductible within a Calendar Year. Any amount you have paid toward the Deductible for your individual plan will be applied to both the individual Deductible and the Family Deductible for your new plan.

3 Using Participating Dentists:

Participating Dentists have a contract to provide Dental Care Services to Members. When you receive Covered Services from a Participating Dentist, 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 Dentists:

Non-Participating Dentists do not have a contract to provide Dental Care Services to Members. When you receive Covered Services from a Non-Participating Dentist, you are responsible for both:

- the Copayment or Coinsurance (once any Calendar Year Deductible has been met), and
- any charges above the Allowable Amount (which can be significant).

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

- Coinsurance is calculated from the Allowable Amount.
- Any charges above the Allowable Amount are not covered, do not count towards any Benefit maximums, and are your responsibility for payment to the provider. This out-of-pocket expense can be significant.

The Non-Participating Dentist reimbursement amount is the usual, customary, and reasonable rate or UCR rate. The UCR rate is the cost for a typical service within a specified region and it may differ depending on where you receive services. When you receive services from a Non-Participating Dentist, you pay any amount above the UCR rate. The Allowable Amount is based off the 90th percentile of UCR.

5 Benefit Maximum(s):

Your payment after you reach any Benefit maximum. You will pay 100% of all charges after you reach a Benefit maximum.

All Covered Services count towards the Calendar Year Benefit maximum except for Orthodontic services. The Plan pays up to the maximum payment amount as listed for Covered Services and supplies.

All Orthodontic Covered Services count towards the Calendar Year Orthodontic Benefit maximum. The Plan pays up to the maximum payment amount as listed for Covered Services and supplies.

Enhanced dental benefits for pregnant women do not apply towards the Calendar Year Benefit Maximum.

6 Separate Member Payments When Multiple Covered Services are Received:

Each time you receive multiple Covered Services, you might have separate payments (Copayment or Coinsurance) for each service. When this happens, you may be responsible for multiple Copayments or Coinsurance.

7 Dental Care Services:

All dental Benefits are provided through Blue Shield's Dental Plan Administrator (DPA).

Orthodontic Covered Services. The Copayment or Coinsurance for Orthodontic Covered Services applies to one course of treatment per lifetime. The course of treatment must be received in a 24 consecutive month period. This applies only if the Member remains enrolled in the Plan. All procedures performed in connection with Orthodontic treatment are payable as Orthodontic Covered Services.

8 Prior Authorization:

Prior Authorization or precertification for Covered Services. Before any course of treatment expected to cost more than \$250 is started, you should obtain prior authorization of Benefits, except in an emergency.

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



Blue Shield of California Life & Health Insurance Company
Summary of Benefits

Group Vision Plan

Vision Deluxe 15/25/130

This Summary of Benefits shows the amount you will pay for Covered Services under this Blue Shield of California Life & Health Insurance Company (Blue Shield Life) Plan. It is only a summary and it is included as part of the Certificate of Insurance (COI).¹ Please read both documents carefully for details.

Provider Network:

This Plan uses a contracted network of vision care providers. 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.

Benefit Frequency Limits

This Plan pays up to the Allowance and frequency limits as listed for Covered Services.

Comprehensive exam	One every 12 consecutive months
Eyeglass lenses or contact lenses	Once every 12 consecutive months
Eyeglass frame	One every 12 consecutive months
Low vision testing	One every 12 consecutive months

Waiting Period

A waiting period is the length of time you must be covered under the Plan before Blue Shield Life will pay for Covered Services.

Waiting period	No waiting period
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No Deductible

Under this Plan there is no dollar amount an Insured must pay before Blue Shield Life will pay for Covered Services.

No Lifetime Dollar Limit

Under this Plan there is no dollar limit on the total amount Blue Shield Life will pay for Covered Services in an Insured's lifetime.

	When using a Participating Provider ³	When using a Non-Participating Provider ⁴
Eye examinations		
Comprehensive exam <i>One per Insured every 12 months.</i>		
Ophthalmologic visit	\$15	All charges above \$60
Optometric visit	\$15	All charges above \$60
Retinal Imaging <i>One per Insured every 12 months by a Participating Provider.</i>	\$39	Not covered
Standard contact lens fitting and evaluation <i>One per Insured every 12 months by a Participating Provider.</i>	\$15	Not covered
Eyewear/Materials		
Eyeglass frame <i>One per Insured every 12 months.</i>	\$25 plus all charges above \$130	All charges above \$85
Plano (non-prescription) sunglasses <i>One per Insured every 12 months instead of an eyeglass frame when prescribed by a Participating Provider or surgeon after vision correction surgery.</i>	\$25 plus all charges above \$130	All charges above \$85
Eyeglass lenses and lens treatments <i>One pair of lenses per Insured every 12 months.</i>		
• Single vision	\$25	All charges above \$43
• Lined bifocal	\$25	All charges above \$60
• Lined trifocal	\$25	All charges above \$75
• Lenticular	\$25	All charges above \$200
• Polycarbonate lenses (for Dependent children only)	\$25 plus all charges above \$100	All charges above \$75
• Polycarbonate photochromic single vision lenses (for Dependent children only)	\$25 plus all charges above \$160	All charges above \$115
• Standard progressive lenses (no-line bifocals)	\$25	All charges above \$75
• Premium progressive lenses (no-line bifocals)	\$25 plus all charges above \$140	All charges above \$100
• Anti-reflective lens coating	\$25 plus all charges above \$50	All charges above \$35
• Photochromic lenses	\$25 plus all charges above \$200	All charges above \$150

Benefits²

Your payment

	When using a Participating Provider ³	When using a Non-Participating Provider ⁴
<p>Contact lenses</p> <p><i>Elective or Non-Elective Contact Lenses are provided per Insured every 12 months. Benefits are provided instead of eyeglass frames and lenses up to the Allowance.</i></p> <ul style="list-style-type: none"> Elective (cosmetic/convenience) <p style="text-align: center;">\$25 plus all charges above \$130</p> Non-Elective (Medically Necessary) <p style="text-align: center;">\$25</p> <p><i>Requires a report from the provider and prior authorization from the VPA.</i></p> Scleral and hybrid lenses <p style="text-align: center;">All charges above \$350</p> <p><i>Requires a report from the provider and prior authorization from the VPA.</i></p> 		<p>All charges above \$85</p> <p>All charges above \$250</p> <p>All charges above \$350</p>
<p>Other services</p> <p>Low-vision testing and equipment</p> <p style="text-align: center;">25% plus all charges above \$1,000</p> <p><i>One per Insured every 12 months by a Participating Provider. Exam must be Medically Necessary.</i></p>		Not covered

Notes

1 Certificate of Insurance (COI):

The Certificate of Insurance (COI) describes the Benefits, limitations, and exclusions that apply to coverage under this Plan. Please review the COI for more details of coverage outlined in this Summary of Benefits. You can request a copy of the COI at any time.

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

2 Vision Care Services:

All vision Benefits are provided through Blue Shield Life's Vision Plan Administrator (VPA).

Contact lenses. The Allowance for contact lenses may be used towards the fitting fees. If you receive Elective or Non-Elective Contact Lenses, no Benefits will be available for eyeglass frames and lenses until you satisfy the Benefit frequency.

3 Using Participating Providers:

Participating Providers have a contract to provide vision care services to Insureds. When you receive Covered Services from a Participating Provider, you are responsible for:

- the Copayment, and
- any charges above the stated Allowance, which is the Benefit maximum.

When the Participating Provider uses wholesale pricing, the maximum frame Allowances are:

- wholesale Allowance: \$88.83.

Note: This pricing replaces the frame Allowance shown in the Summary of Benefits. If a more expensive frame is selected at a provider location that uses wholesale pricing, the Insured Person is responsible for the additional cost

Notes

above the wholesale Allowance. Participating Providers using wholesale pricing are identified in the directory of Participating Providers at [blueshieldca.com](https://www.blueshieldca.com).

4 Using Non-Participating Providers:

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

- any charges above the stated Allowance, which is the Benefit maximum.
-

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

James Perse Enterprises, LLC Basic Group Term Life and Accidental Death & Dismemberment (AD&D) Insurance

James Perse Enterprises Inc. – All Eligible Employees

Benefit Summary Effective August 1, 2026

Basic Group Term Life Insurance is an important part of a complete benefits package. It provides protection to you and your beneficiaries. Below is information about how our coverage can meet your needs.

Employee Basic Group Term Life Benefit		1 x salary to \$200,000 max
Age Reduction Schedule	Your Benefit will reduce to 65% of the original amount when you turn 65 and to 50% of the original amount when you reach 70.	
Waiver of Premium Provision	If you become totally disabled, as defined in the certificate, you can continue your Life Insurance coverage without any premium payments. The amount of coverage will be the coverage in effect at the time you become disabled. This waiver is subject to age limitations, reductions and terminations.	
Accelerated Death Benefit	If you become terminally ill, you may elect an advanced payment of up to 50% of the death benefit to a maximum of \$250,000.	
Conversion	You may convert your Basic Group Term Life Insurance coverage to a Whole Life policy if your employment ends. You must apply for conversion within 31 days after your termination of employment. Rates are based on your age at the time of conversion.	

Employee Basic Group Term AD&D Benefit	
Type of Loss	Portion of Principal Sum
Loss of Life	100%
Loss of a hand, foot, complete loss of sight in one eye or hearing in one ear	50%
Loss of an arm or leg	75%
Complete loss of sight in both eyes or hearing in both ears	100%
Loss of the thumb and index finger or all 4 fingers on the same hand	25%
Loss of all toes on one foot	25%
Loss of speech	50%
Loss of speech and hearing	100%
Paralysis of both upper and lower limbs (Quadriplegia)	100%
Paralysis of both lower limbs or both upper limbs (Paraplegia)	75%
Paralysis of upper and lower limb one side (Hemiplegia)	50%
Paralysis of one arm or leg	25%

Employee Basic Group Term AD&D Benefit	Additional Provisions when an AD&D Benefit is Payable
Seat Belt and Air Bag Benefit	An additional benefit of 10% up to a maximum of \$25,000 will be paid if you lose your life in an automobile accident (either driving or riding in a car) while properly wearing a seat belt and the airbag is deployed at the time of the accident.
Special Education Benefit Spouse/Domestic Partner and Children	Your Spouse/Domestic Partner is eligible for a one-time benefit up to a maximum of \$5,000 when enrolled as a full-time student. Each of your children is eligible for a benefit of \$2,500/year (4 consecutive years) when enrolled, before the age of 26 and within 1 year after your date of death, as a full time in an accredited college, university, or vocational school. Maximum benefit payable per child is \$10,000.
Repatriation Benefit	An additional benefit up to a maximum of \$2,000, for the purposes defined in the certificate, if you lose your life at least 100 miles away from your permanent place of residence.
Comatose Benefit	An additional benefit of 50% if you become comatose as a direct result of an accident and remain continuously so for 60 days.
Felonious Assault Benefit	An additional benefit of 10% if you incur a loss as the result of a Violent Criminal Act or Felonious Assault. The Felonious Assault must be inflicted by someone other than a fellow employee or a member of your family or household and must occur while you are working for or on your Employer's premises.
Common Carrier Benefit	An additional benefit is payable if you die as a result of an Accident which occurs while you are a fare-paying passenger of a Public Conveyance.
Surgical Reattachment Benefit	An additional benefit for a loss incurred if a part is dismembered as a result of an injury and the surgical reattachment is not successful within a period of 365 days.

This Benefit Summary is an overview of Blue Shield of California Life & Health Insurance Company (Blue Shield Life) Basic Group Term Life Insurance available for eligible employees. Please refer to your Certificate for a complete description of benefits, limitations, exclusions and other terms and conditions of coverage.

In the event of a discrepancy between the English and Spanish versions of this Benefit Summary, the English version prevails.

Basic Group Term Life and AD&D insurance is underwritten by Blue Shield of California Life & Health Insurance Company.

2.



Find a provider/Rx

Use the information in this section to help you find a doctor and learn about your prescription drug options.

Find the doctor of your choice

Blue Shield believes that finding a doctor shouldn't give you a headache. That's why blueshieldca.com features our most up-to-date listings of doctors, specialists, pharmacies, and hospitals.

We're making it easier!

Finding the latest listing of doctors, specialists, mental health providers, hospitals, dentists, vision care providers, or pharmacies is easy. Go to blueshieldca.com and select *Find a Doctor* from the menu. Here are some helpful shortcuts:

1. How you start depends on the type of plan:

- For Access+ HMO®: Go to blueshieldca.com/networkhmo.
- For Local Access+ HMO®: Go to blueshieldca.com/networklocalaccess.
- For Access+ HMO SaveNetSM: Go to blueshieldca.com/networksavenet.
- For Trio HMO: Go to blueshieldca.com/networktriohmo.

- For PPO: Go to blueshieldca.com/pponetwork.

- For Tandem PPO: Go to blueshieldca.com/networktandemppo.

2. Select the type of provider you need (e.g., doctor, facility, mental health).
3. Enter your preferred location.
4. Select whether you want to search by provider specialty or provider name.
5. Relevant results will be displayed.

Special considerations for each plan type

If you are enrolling in an HMO plan

When you enroll in an HMO plan, you and your dependents must choose a primary care physician (PCP) within 15 miles or a 30-minute drive* from where you live or work. You can either search for your PCP using Blue Shield of California's *Find a Doctor* tool found at blueshieldca.com, or call Member Services for assistance. If you do not select a PCP when you enroll, we will assign you one. You can then change your PCP at any time. PCPs provide routine checkups, immunizations, and urgent care and refer you to specialists.

If you are enrolling in a PPO plan

As a PPO plan member, you can choose your own doctor and do not need a referral to see a specialist. Choosing a provider in the PPO networks can save you money and ensure that you receive the highest level of benefits available to you.

When you visit doctors outside the PPO network, you may be responsible for higher copayments plus any charges in excess of Blue Shield's allowed amount for the services.

If you access care outside California

PPO members who access care outside California may do so through the BlueCard® Program Network, which includes access to more than 95% of doctors and 96% of hospitals nationwide. Whenever possible, you should choose a doctor or hospital from the BlueCard network to save you money and ensure you receive the highest level of benefits available to you. When you visit doctors who are not in the BlueCard network, you may be responsible for higher copayments plus any charges in excess of Blue Shield's allowed amount for the services.

To find a BlueCard physician or hospital in the United States, go to provider.bcbs.com or call BlueCard Access toll-free at **(800) 810-BLUE (2583)**.

To find an international Blue Shield Global Core Network physician or hospital, go to bcbsglobalcore.com. You can also call the Blue Shield Global Core Service Center at **(800) 810-BLUE (2583)** from within the United States, or call collect at **(804) 673-1177** from outside the country.

* Primary care physician service areas vary by contract.

Prescription drug program

Our prescription drug program provides access to a network of chain and independent pharmacies, as well as a mail service pharmacy and specialty pharmacies. For more information, visit blueshieldca.com/pharmacy.

Chain and independent pharmacies

The Blue Shield pharmacy network includes all major pharmacy chains and most independent pharmacies in California. It's easy to find a local network pharmacy. Search our online listing of pharmacies, where you'll find the most up-to-date information:

- Visit blueshieldca.com/pharmacy and go to the *Pharmacy networks* section.
- If you want to locate a pharmacy where your prescription is covered, go to blueshieldca.com and select *Find a Doctor* from the menu, then choose *Pharmacies*.

Mail service pharmacy

We offer a mail service pharmacy benefit that gives you up to a 90-day supply of covered maintenance drugs through the mail. This service is available if you are taking stabilized dosages of covered maintenance drugs on an ongoing basis for treatment of chronic health conditions, such as high blood pressure. For more information, go to blueshieldca.com/90dayRX.

Specialty pharmacy

Network specialty pharmacies are available to Blue Shield members. These pharmacies provide convenient delivery of specialty medications, including self-administered injectables. All supplies required for administration of specialty medications that are injectable (such as needles/syringes, alcohol swabs, sharps containers) are included at no additional charge.

Prior authorization is required for specialty medications. Members prescribed self-administered injectables with a specialty drug benefit are required to get these drugs from a network specialty pharmacy.

Learn if your prescription is covered

The Blue Shield drug formulary is a list of preferred generic and brand-name drugs.

It's easy to learn if your medication is covered in our formulary. Go to blueshieldca.com/pharmacy, and choose *Drug formularies* to find a drug formulary that applies to you.

How to contact us

If you have questions about the information included in this booklet, please contact a Blue Shield representative at one of the numbers below. Service is available in multiple languages.

Member Services	(888) 256-1915	8 a.m. to 5 p.m PST, Monday through Friday
Trio HMO Member Services	(855) 829-3566	7 a.m. to 7 p.m PST, Monday through Friday
Dental Member Services	(888) 702-4171	8 a.m. to 5 p.m PST, Monday through Friday
Vision Member Services	(877) 601-9083	8 a.m. to 5 p.m PST, Monday through Friday

Or, you can always visit us online at blueshieldca.com, anytime, day or night.

Si desea recibir este Aviso Sobre Practicas de Privacidad en español, por favor llame a Servicios a Clientes en el numero que se encuentra en su tarjeta de identificación de Blue Shield.

Notice of privacy practices

Blue Shield of California and Blue Shield of California Life & Health Insurance Company

This Notice describes how medical information about you, as a Blue Shield member, may be used and disclosed, and how you can get access to your information.

Our privacy commitment

At Blue Shield, we understand the importance of keeping your personal information private, and we take our obligation to do so very seriously.

In the normal course of doing business, we create records about you, your medical treatment, and the services we provide to you. The information in those records is called protected health information (PHI) and includes your individually identifiable personal information such as your name, address, telephone number, and Social Security number, as well as your health information, such as healthcare diagnosis or claim information.

We are required by federal and state law to provide you with this Notice of our legal duties and privacy practices as they relate to your PHI. We are required to maintain the privacy of your PHI and to notify you in the event that you are affected by a breach of unsecured PHI. When we use or give out ("disclose") your PHI, we are bound by the terms of this Notice, which applies to all records that we create, obtain, and/or maintain that contain your PHI.

How we protect your privacy

We maintain physical, technical, and administrative safeguards to ensure the privacy of your PHI. To protect your privacy, only Blue Shield workforce members who are authorized and trained are given access to our paper and electronic records and to non-public areas where this information is stored.

Workforce members are trained on topics including:

- Privacy and data protection policies and procedures, including how paper and electronic records are labeled, stored, filed, and accessed.
- Physical, technical, and administrative safeguards in place to maintain the privacy and security of your PHI.

Our corporate Privacy Office monitors how we follow our privacy policies and procedures, and educates our organization on this important topic.

How we use and disclose your PHI

Uses of PHI without your authorization.

We may disclose your PHI without your written authorization if necessary while providing health benefits and services

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to you. We may disclose your PHI for the following purposes:

- **Treatment:**

- To share with nurses, doctors, pharmacists, optometrists, health educators, and other healthcare professionals so they can determine your plan of care.
- To help you obtain services and treatment you may need – for example, ordering lab tests and using the results.
- To coordinate your health care and related services with a healthcare facility or professional.

- **Payment:**

- To obtain payment of premiums for your coverage.
- To make coverage determinations – for example, to speak to a healthcare professional about payment for services provided to you.
- To coordinate benefits with other coverage you may have – for example, to speak to another health plan or insurer to determine your eligibility or coverage.
- To obtain payment from a third party that may be responsible for payment, such as a family member.
- To otherwise determine and fulfill our responsibility to provide your health benefits – for example, to administer claims.

- **Healthcare operations:**

- To provide customer service.
- To support and/or improve the programs or services we offer you.
- To assist you in managing your health – for example, to provide you

with information about treatment alternatives you may be entitled to, or to provide you with healthcare service or treatment reminders.

- To support another health plan, insurer, or healthcare professional who has a relationship with you, to improve the programs it offers you – for example, for case management or in support of an accountable care organization (ACO) or patient-centered medical home arrangement.
- For underwriting, dues, or premium rating, or other activities relating to the creation, renewal, or replacement of a contract for health coverage or insurance. Please note, however, that we will not use or disclose your PHI that is genetic information for underwriting purposes – doing so is prohibited by federal law.

We may also disclose your PHI without your written authorization for other purposes, as permitted or required by law. This includes:

- **Disclosures to others involved in your health care.**

- If you are present or otherwise available to direct us to do so, we may disclose your PHI to others, for example, a family member, a close friend, or your caregiver.
- If you are in an emergency situation, are not present, are incapacitated, or if you are deceased, we will use our professional judgment to decide whether disclosing your PHI to others is in your best interest. If we do disclose your PHI in a situation where you are unavailable, we will disclose only information that is directly relevant to the person's involvement

with your treatment or for payment related to your treatment. We may also disclose your PHI in order to notify (or assist in notifying) such persons of your location, your general medical condition, or your death.

- We may disclose your minor child's PHI to the child's other parent.

- **Disclosures to your plan sponsor.** We may disclose PHI to the sponsor of your group health plan, which may be your employer, or to a company acting on behalf of the plan sponsor, so that they can monitor, audit, and otherwise administer the health plan you participate in. Your employer is not permitted to use the PHI we disclose for any purpose other than administration of your benefits. See your plan sponsor's plan documents for information about whether your employer/plan sponsor receives PHI, and for a full explanation of the limited uses and disclosures that the plan sponsor may make of your PHI.

- **Disclosures to vendors and accreditation organizations.** We may disclose your PHI to:

- Companies that perform certain services on behalf of Blue Shield. For example, we may engage vendors to help us provide information and guidance to members with chronic conditions like diabetes and asthma.
- Accreditation organizations such as the National Committee for Quality Assurance (NCQA) for quality measurement purposes.

Please note that before we share your PHI, we obtain the vendor's or accreditation organization's written agreement to protect the privacy of your PHI.

- **Communications.** We may use your PHI to contact you with information about your Blue Shield health plan coverage, benefits, health-related programs and services, treatment reminders, or treatment alternatives available to you. We do not use your PHI for fundraising purposes.

- **Health or safety.** We may disclose your PHI to prevent or lessen a serious and imminent threat to your health or safety, or the health or safety of the general public.

- **Public health activities.** We may disclose your PHI to:

- Report health information to public health authorities authorized by law to receive such information for the purpose of preventing or controlling disease, injury or disability, or monitoring immunizations.
- Report child abuse or neglect, or adult abuse, including domestic violence, to a government authority authorized by law to receive such reports.
- Report information about a product or activity that is regulated by the U.S. Food and Drug Administration (FDA) to a person responsible for the quality, safety, or effectiveness of the product or activity.
- Alert a person who may have been exposed to a communicable disease, if we are authorized by law to give such a notice.

- **Health oversight activities.** We may disclose your PHI to:

- A government agency that is legally responsible for oversight of the healthcare system or for ensuring compliance with the rules of government benefit programs such as Medicare or Medicaid.

- Other regulatory programs that need health information to determine compliance.
- **Research.** We may disclose your PHI for research purposes, but only according to, and as allowed by, law.
- **Compliance with the law.** We may use and disclose your PHI to comply with the law.
- **Judicial and administrative proceedings.** We may disclose your PHI in a judicial or administrative proceeding or in response to a valid legal order.
- **Law enforcement officials.** We may disclose your PHI to the police or other law enforcement officials, as required by law or in compliance with a court order or other process authorized by law.
- **Government functions.** We may disclose your PHI to various departments of the government, such as the U.S. military or the U.S. Department of State, as required by law.
- **Workers' compensation.** We may disclose your PHI when necessary to comply with workers' compensation laws.

Uses of PHI that require your authorization.

Other than for the purposes described above, we must obtain your written authorization to use or disclose your PHI. For example, we will not use your PHI for marketing purposes without your prior written authorization, nor will we give your PHI to a prospective employer without your written authorization.

Uses and disclosure of certain PHI deemed "highly confidential." For certain kinds of PHI, federal and state law may require enhanced privacy protection. This includes PHI that is:

- Maintained in psychotherapy notes.
- About alcohol and drug abuse prevention, treatment, and referral.
- About HIV/AIDS testing, diagnosis, or treatment.
- About venereal and/or communicable disease(s).
- About genetic testing.

We can only disclose this type of specially protected PHI with your prior written authorization except when specifically permitted or required by law.

Authorization cancellation. At any time, you may cancel a written authorization that you previously gave us. When submitted to us in writing, the cancellation will apply to future uses and disclosures of your PHI. It will not affect uses or disclosures made previously, while your authorization was in effect.

Your individual rights

You have the following rights regarding the PHI that Blue Shield creates, obtains, and/or maintains about you:

- **Right to request restrictions.** You may ask us to restrict the way we use and disclose your PHI for treatment, payment, and healthcare operations, as explained in this Notice. We are not required to agree to your restriction requests, but we will consider them carefully.

If we agree to a restriction request, we will abide by it until you request or agree to terminate the restriction. We may also inform you that we are terminating our agreement to a restriction. In that case, the termination will apply only to PHI created or received after we have informed you of the termination.

- **Right to receive confidential communications.** You may ask to receive Blue Shield communications containing PHI by alternative means or at alternative locations. As required by law, and whenever feasible, we will accommodate reasonable requests. We may require that you make your request in writing. If your request involves a minor child, we may ask you to provide legal documentation to support your request.
- **Right to access your PHI.** You may ask to inspect or to receive a copy of certain PHI that we maintain about you in a “designated record set.” This includes, for example, records of enrollment, payment, claims adjudication, and case or medical management record systems, and any information we used to make decisions about you. Your request must be in writing. Whenever possible, and as required by law, we will provide you with a copy of your PHI in the form (paper or electronic) and format you request. If you request a copy of your PHI, we may charge you a reasonable, cost-based fee for preparing, copying, and/or mailing it to you. In certain limited circumstances permitted by law, we may deny you access to a portion of your records.
- **Right to amend your records.** You have the right to ask us to correct or amend the PHI that we maintain about you in a designated record set. Your request must be made in writing and explain why you want your PHI amended. If we determine that the PHI is inaccurate or incomplete, we will correct it if permitted by law. If a doctor or healthcare facility created the PHI that you want to change, you should ask them to amend the information.
- **Right to receive an accounting of disclosures.** Upon your written request, we will provide you with a list of the disclosures we have made of your PHI for a specified time period, up to six years prior to the date of your request. However, the list will exclude:
 - Disclosures you have authorized.
 - Disclosures made earlier than six years before the date of your request.
 - Disclosures made for treatment, payment, and healthcare operations purposes, except when required by law.
 - Certain other disclosures that we are allowed by law to exclude from the accounting.

If you request an accounting more than once during any 12-month period, we will charge you a reasonable, cost-based fee for each accounting report after the first one.
- **Right to name a personal representative.** You may name another person to act as your personal representative. Your representative will be allowed access to your PHI, to communicate with the healthcare professionals and facilities providing your care, and to exercise all other HIPAA rights on your behalf. Depending on the authority you grant your representative, he or she may also have authority to make healthcare decisions for you.
- **Right to receive a paper copy of this Notice.** Upon your request, we will provide a paper copy of this Notice, even if you have agreed to receive the Notice electronically. See the “Notice Availability and Duration” section of this Notice.

Actions you may take

Contact Blue Shield. If you have questions about your privacy rights, believe that we may have violated your privacy rights, or disagree with a decision that we made about access to your PHI, you may contact us:

Blue Shield of California Privacy Office
P.O. Box 272540
Chico, CA 95927-2540

Phone: (888) 266-8080 (toll-free)

Fax: (800) 201-9020 (toll-free)

Email: privacy@blueshieldca.com

For certain types of requests, you must complete and mail us a form that is available either by calling the customer service number on your Blue Shield member ID card or by visiting our website at blueshieldca.com/privacyforms.

Contact a government agency. You may also file a written complaint with the Secretary of the U.S. Department of Health & Human Services (HHS) if you believe we may have violated your privacy rights. Your complaint may be sent by email, fax, or mail to the HHS Office for Civil Rights (OCR).

For more information, or to file a complaint with the Secretary of HHS, visit the OCR website at www.hhs.gov/ocr/privacy/hipaa/complaints.

If you are a California resident, you may contact the OCR Regional Manager for California as follows:

Region IX Regional Manager
Office for Civil Rights
U.S. Department of Health & Human Services

90 7th St., Suite 4-100
San Francisco, CA 94103

Phone: (800) 368-1019

Fax: (202) 619-3818

TTY: (800) 537-7697

We will not take any action against you if you exercise your right to file a complaint, either with us or with HHS.

Notice availability and duration

Notice availability. A copy of this Notice is available by calling the customer service number on your Blue Shield member ID card or by visiting our website at blueshieldca.com/privacynotice.

Right to change terms of this Notice. We are required to abide by the terms of this Notice as long as it remains in effect. We may change the terms of this Notice at any time, and, at our discretion, we may make the new terms effective for all of your PHI in our possession, including any PHI we created or received before we issued the new Notice.

If we change this Notice, we will update the Notice on our website, and if you are enrolled in a Blue Shield benefit plan at that time, we will send you the new Notice when and as required by law.

Effective date. This Notice is effective as of August 16, 2013.

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

Blue Shield of California cumple con las leyes estatales y las leyes federales de derechos civiles vigentes, y no discrimina por motivos de raza, color, país de origen, ascendencia, religión, sexo, estado civil, género, identidad de género, orientación sexual, edad ni discapacidad.

Blue Shield of California 遵循適用的州法律和聯邦公民權利法律，並且不以種族、膚色、原國籍、血統、宗教、性別、婚姻狀況、性別認同、性取向、年齡或殘障為由而進行歧視。



NOTICES AVAILABLE ONLINE

Nondiscrimination and Language Assistance Services

Blue Shield complies with applicable state and federal civil rights laws. We also offer language assistance services at no additional cost.

View our nondiscrimination notice and language assistance notice: blueshieldca.com/notices. You can also call for language assistance services: **(866) 346-7198 (TTY: 711)**.

If you are unable to access the website above and would like to receive a copy of the nondiscrimination notice and language assistance notice, please call Customer Care at **(888) 256-3650 (TTY: 711)**.

Servicios de asistencia en idiomas y avisos de no discriminación

Blue Shield cumple con las leyes de derechos civiles federales y estatales aplicables. También, ofrecemos servicios de asistencia en idiomas sin costo adicional.

Vea nuestro aviso de no discriminación y nuestro aviso de asistencia en idiomas en blueshieldca.com/notices. Para obtener servicios de asistencia en idiomas, también puede llamar al **(866) 346-7198 (TTY: 711)**.

Si no puede acceder al sitio web que aparece arriba y desea recibir una copia del aviso de no discriminación y del aviso de asistencia en idiomas, llame a Atención al Cliente al **(888) 256-3650 (TTY: 711)**.

非歧視通知和語言協助服務

Blue Shield 遵守適用的州及聯邦政府的民權法。同時，我們免費提供語言協助服務。

如需檢視我司的非歧視通知和語言幫助通知，請造訪 blueshieldca.com/notices。您還可致電尋求語言協助服務：**(866) 346-7198 (TTY: 711)**。

如果您無法造訪上述網站，且希望收到一份非歧視通知和語言幫助通知的副本，請致電客戶服務部，電話：**(888) 256-3650 (TTY: 711)**。