

Summary of Benefits

Santa Ana Unified School District Custom PPO Certificated & Management

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

Provider Network:

Full PPO Network

This benefit Plan uses a specific network of Health Care Providers, called the Full PPO provider network. Providers in this network are called Participating Providers. You pay less for Covered Services when you use a Participating Provider than when you use a Non-Participating Provider. You can find Participating Providers in this network at blueshieldca.com.

Calendar Year Deductibles (CYD)²

A Calendar Year Deductible (CYD) is the amount a Member pays each Calendar Year before Blue Shield pays for Covered Services under the benefit 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 Participating Provider ³ | When using a Non-Participating Provider ⁴ |
|---|----------------------------|--|--|
| Calendar Year medical Deductible | <i>Individual coverage</i> | \$300 | \$600 |
| | <i>Family coverage</i> | \$300: individual | \$600: individual |
| | | \$600: Family | \$1,200: Family |

Calendar Year Out-of-Pocket Maximum⁵

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

| | When using a Participating Provider ³ | When using any combination of Participating ³ or Non-Participating ⁴ Providers |
|----------------------------|--|--|
| <i>Individual coverage</i> | \$2,800 | \$4,600 |
| <i>Family coverage</i> | \$2,800: individual | \$4,600: individual |
| | \$5,600: Family | \$9,200: Family |

No Lifetime Benefit Maximum

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

Benefits⁶

Your payment

| | When using a Participating Provider³ | CYD² applies | When using a Non-Participating Provider⁴ | CYD² applies |
|---|--|--------------------------------|--|--------------------------------|
| Preventive Health Services⁷ | \$0 | | Not covered | |
| California Prenatal Screening Program | \$0 | | \$0 | |
| Physician services | | | | |
| Primary care office visit | \$20/visit | | 40% | ✓ |
| Specialist care office visit | \$20/visit | | 40% | ✓ |
| Physician home visit | \$20/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, and therapists.</i> | \$20/visit | | 40% | ✓ |
| Acupuncture services | 20% | ✓ | 40% | ✓ |
| Chiropractic services <i>Up to 50 visits per Member, per Calendar Year.</i> | 20% | ✓ | 40% | ✓ |
| Teladoc consultation | \$5/consult | | Not covered | |
| Family planning | | | | |
| • Counseling, consulting, and education | \$0 | | Not covered | |
| • Injectable contraceptive | \$0 | | Not covered | |
| • Diaphragm fitting | \$0 | | Not covered | |
| • Intrauterine device (IUD) | \$0 | | 40% | ✓ |
| • Insertion and/or removal of Intrauterine device (IUD) | \$0 | | 40% | ✓ |
| • Implantable contraceptive | \$0 | | Not covered | |
| • Tubal ligation | \$0 | | Not covered | |
| • Vasectomy | 20% | ✓ | Not covered | |
| • Infertility services | Not covered | | Not covered | |
| Podiatric services | \$20/visit | | 40% | ✓ |
| Pregnancy and maternity care⁷ | | | | |
| Physician office visits: prenatal and postnatal | 20% | ✓ | 40% | ✓ |
| Physician services for pregnancy termination | 20% | ✓ | 40% | ✓ |

Benefits⁶

Your payment

| | When using a Participating Provider³ | CYD² applies | When using a Non-Participating Provider⁴ | CYD² applies |
|--|--|--------------------------------|--|--------------------------------|
| Emergency services | | | | |
| Emergency room services <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> | \$150/visit | | \$150/visit | |
| Emergency room Physician services | 20% | ✓ | 20% | ✓ |
| Urgent care center services | \$20/visit | | 40% | ✓ |
| Ambulance services <i>This payment is for emergency or authorized transport.</i> | 20% | ✓ | 20% | ✓ |
| Outpatient Facility services | | | | |
| Ambulatory Surgery Center | 20% | ✓ | 40% up to \$1,500/day plus 100% of additional charges | ✓ |
| Outpatient department of a Hospital: surgery | 20% | ✓ | 40% up to \$1,500/day plus 100% of additional charges | ✓ |
| Outpatient department of a Hospital: treatment of illness or injury, radiation therapy, chemotherapy, and necessary supplies | 20% | ✓ | 40% up to \$1,500/day plus 100% of additional charges | ✓ |
| Inpatient facility services | | | | |
| Hospital services and stay | 20% | ✓ | 40% up to \$1,500/day plus 100% of additional charges | ✓ |
| 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 | |

| | When using a Participating Provider ³ | CYD ² applies | When using a Non-Participating Provider ⁴ | CYD ² applies |
|--|--|--------------------------|---|--------------------------|
| Bariatric surgery services, designated California counties | | | | |
| <p><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></p> | | | | |
| Inpatient facility services | 20% | ✓ | Not covered | |
| Outpatient Facility services | 20% | ✓ | Not covered | |
| Physician services | 20% | ✓ | Not covered | |
| Diagnostic x-ray, imaging, pathology, and laboratory services | | | | |
| <p><i>This payment is for Covered Services that are diagnostic, non-Preventive Health Services, and diagnostic radiological procedures, such as CT scans, MRIs, MRAs, and PET scans. For the payments for Covered Services that are considered Preventive Health Services, see Preventive Health Services.</i></p> | | | | |
| <p>Laboratory services</p> <p><i>Includes diagnostic Papanicolaou (Pap) test.</i></p> | | | | |
| <ul style="list-style-type: none"> Laboratory center | 20% | ✓ | 40% | ✓ |
| <ul style="list-style-type: none"> Outpatient department of a Hospital | 20% | ✓ | 40% up to \$1,500/day plus 100% of additional charges | ✓ |
| <p>X-ray and imaging services</p> <p><i>Includes diagnostic mammography.</i></p> | | | | |
| <ul style="list-style-type: none"> Outpatient radiology center | 20% | ✓ | 40% | ✓ |
| <ul style="list-style-type: none"> Outpatient department of a Hospital | 20% | ✓ | 40% up to \$1,500/day plus 100% of additional charges | ✓ |

Benefits⁶

Your payment

| | When using a Participating Provider³ | CYD² applies | When using a Non-Participating Provider⁴ | CYD² applies |
|--|--|--------------------------------|--|--------------------------------|
| Other outpatient diagnostic testing | | | | |
| <i>Testing to diagnose illness or injury such as vestibular function tests, EKG, ECG, cardiac monitoring, non-invasive vascular studies, sleep medicine testing, muscle and range of motion tests, EEG, and EMG.</i> | | | | |
| • Office location | 20% | ✓ | 40% | ✓ |
| • Outpatient department of a Hospital | 20% | ✓ | 40% up to \$1,500/day plus 100% of additional charges | ✓ |
| Radiological and nuclear imaging services | | | | |
| • Outpatient radiology center | 20% | ✓ | 40% | ✓ |
| • Outpatient department of a Hospital | 20% | ✓ | 40% up to \$1,500/day plus 100% of additional charges | ✓ |
| Rehabilitative and Habilitative Services | | | | |
| <i>Includes Physical Therapy, Occupational Therapy, Respiratory Therapy, and Speech Therapy services.</i> | | | | |
| Office location | 20% | ✓ | 40% | ✓ |
| Outpatient department of a Hospital | 20% | ✓ | 40% up to \$1,500/day plus 100% of additional charges | ✓ |
| Durable medical equipment (DME) | | | | |
| DME | 20% | ✓ | 40% | ✓ |
| Breast pump | \$0 | | 40% | ✓ |
| Orthotic equipment and devices | 20% | ✓ | 40% | ✓ |
| Prosthetic equipment and devices | 20% | ✓ | 40% | ✓ |

| | When using a Participating Provider ³ | CYD ² applies | When using a Non-Participating Provider ⁴ | CYD ² applies |
|--|--|--------------------------|---|--------------------------|
| Home health 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, except hemophilia and home infusion nursing visits.</i> | | | | |
| Home health agency services <i>Includes home visits by a nurse, Home Health Aide, medical social worker, physical therapist, speech therapist, or occupational therapist.</i> | 20% | ✓ | Not covered | |
| Home visits by an infusion nurse | 20% | ✓ | Not covered | |
| Home health medical supplies | 20% | ✓ | Not covered | |
| Home infusion agency services | 20% | ✓ | Not covered | |
| Hemophilia home infusion services <i>Includes blood factor products.</i> | 20% | ✓ | 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% | ✓ | 20% | ✓ |
| Hospital-based SNF | 20% | ✓ | 40% up to \$1,500/day plus 100% of additional charges | ✓ |
| Hospice program services | | | | |
| | \$0 | | Not covered | |
| <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 | | | | |
| • Devices, equipment, and supplies | 20% | ✓ | 40% | ✓ |
| • Self-management training | \$20/visit | | 40% | ✓ |
| Dialysis services | 20% | ✓ | 40% up to \$1,500/day plus 100% of additional charges | ✓ |

Benefits⁶

Your payment

| | When using a Participating Provider³ | CYD² applies | When using a Non-Participating Provider⁴ | CYD² applies |
|---|--|--------------------------------|--|--------------------------------|
| PKU product formulas and Special Food Products | 20% | ✓ | 20% | ✓ |
| Allergy serum | 20% | ✓ | 40% | ✓ |
| Hearing services <ul style="list-style-type: none"> Hearing aids and equipment | \$0 | | \$0 | |
| <i>Up to \$2,000 combined maximum per member, per 24 months.</i> | | | | |

Mental Health and Substance Use Disorder Benefits

Your payment

| <i>Mental health and substance use disorder Benefits are provided through Blue Shield's Mental Health Services Administrator (MHSA).</i> | When using a MHSA Participating Provider³ | CYD² applies | When using a MHSA Non-Participating Provider⁴ | CYD² applies |
|---|---|--------------------------------|---|--------------------------------|
| Outpatient services | | | | |
| Office visit, including Physician office visit | \$5/visit | | 40% | ✓ |
| Other outpatient services, including intensive outpatient care, 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% up to \$1,500/day plus 100% of additional charges | ✓ |
| Psychological Testing | 20% | ✓ | 40% | ✓ |
| Inpatient services | | | | |
| Physician inpatient services | 20% | ✓ | 40% | ✓ |
| Hospital services | 20% | ✓ | 40% up to \$1,500/day plus 100% of additional charges | ✓ |
| Residential Care | 20% | ✓ | 40% up to \$1,500/day plus 100% of additional charges | ✓ |

Prior Authorization

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

- Radiological and nuclear imaging services
- Inpatient facility services
- Home health services from Non-Participating Providers
- Mental health services, except outpatient office visits
- 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 benefit 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.

Defined terms are 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 benefit Plan.

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

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

This benefit plan has separate Deductibles for:

- 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 Services from a Participating Provider, you are only responsible for the Copayment or Coinsurance, once any Calendar Year Deductible has been met.

Your payment for services from "Other Providers." You will pay the Copayment or Coinsurance applicable to Participating Providers for Covered Services received from Other Providers. However, Other Providers do not have a contract to provide health care services to Members and so are not Participating Providers. Therefore, you will also pay all charges above the Allowable Amount. This out-of-pocket expense can be significant.

4 Using Non-Participating Providers:

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

- Any Coinsurance is determined from the Allowable Amount.
- Any charges above the Allowable Amount are not covered, do not count towards the Out-of-Pocket Maximum, and are your responsibility for payment to the provider. This out-of-pocket expense can be significant.
- Some Benefits from Non-Participating Providers have the Allowable Amount listed in the Benefits chart as a specific dollar (\$) amount. You are responsible for any charges above the Allowable Amount, whether or not an amount is listed in the Benefits chart.

5 Calendar Year Out-of-Pocket Maximum (OOPM):

Your payment after you reach the Calendar Year OOPM. You will continue to pay all charges above a Benefit maximum.

Essential health benefits count towards the OOPM.

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

This benefit Plan has a Participating Provider OOPM as well as a combined Participating Provider and Non-Participating Provider OOPM. This means that any amounts you pay towards your Participating Provider OOPM also count towards your combined Participating and Non-Participating Provider OOPM.

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

6 Separate Member Payments When Multiple Covered Services are Received:

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

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

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