

**Summary of Benefits**

**National University  
Effective July 1, 2026  
EPO Plan**

**ASO EPO Plan**

This Summary of Benefits shows the amount you will pay for Covered Services under this Claims Administrator benefit plan. It is only a summary and it is included as part of the Benefit Booklet.<sup>1</sup> Please read both documents carefully for details.

**Provider Network:**

**Full PPO Network**

This Plan uses a specific network of Health Care Providers, called the Full PPO provider network. Providers in this network are called Participating Providers. This is an Exclusive Provider Organization (EPO) plan. You must receive all Covered Services from a Participating Provider, but there are some exceptions. Please review your Benefit Booklet for details about how to access care under this Plan. You can find Participating Providers in this network at [blueshieldca.com](http://blueshieldca.com).

**Calendar Year Deductibles (CYD)<sup>2</sup>**

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

**When using a Participating Provider<sup>3</sup>**

<b>Calendar Year medical Deductible</b>	<i>Individual coverage</i>	\$500
	<i>Family coverage</i>	\$500: individual
		\$1,000: Family - 2 members
		\$1,500: Family - 3 or more members

**Calendar Year Out-of-Pocket Maximum<sup>4</sup>**

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

**When using a Participating Provider<sup>3</sup>**

<i>Individual coverage</i>	\$4,000
<i>Family coverage</i>	\$4,000: individual
	\$8,000: Family - 2 members
	\$12,000: Family - 3 or more members

**No Annual or Lifetime Dollar Limit**

Under this Plan there is no annual or lifetime dollar limit on the amount Claims Administrator will pay for Covered Services.

**Benefits<sup>5</sup>**

**Your payment**

	<b>When using a Participating Provider<sup>3</sup></b>	<b>CYD<sup>2</sup> applies</b>
<b>Preventive Health Services<sup>6</sup></b>		
Preventive Health Services	\$0	
<b>Physician services</b>		
Primary care office visit	\$25/visit	
Specialist care office visit	\$50/visit	
Office visit for allergy serum injection	\$0	✓
Physician home visit	10%	✓
Physician or surgeon services in an Outpatient Facility	10%	✓
Physician or surgeon services in an inpatient facility	10%	✓
<b>Other professional services</b>		
Other practitioner office visit <i>Includes nurse practitioners, physician assistants, and therapists.</i>	\$25/visit	
Acupuncture services	\$20/visit	
Chiropractic services <i>Up to 30 visits per Member, per Calendar Year.</i>	\$15/visit	✓
Teladoc Health consultation	\$20/consult	
Family planning		
<ul style="list-style-type: none"> <li>• Counseling, consulting, and education</li> <li>• Injectable contraceptive</li> <li>• Diaphragm fitting</li> <li>• Intrauterine device (IUD)</li> <li>• Insertion and/or removal of intrauterine device (IUD)</li> <li>• Implantable contraceptive</li> <li>• Tubal ligation</li> <li>• Vasectomy</li> </ul>	<ul style="list-style-type: none"> <li>\$0</li> <li>\$0</li> <li>\$0</li> <li>\$0</li> <li>\$0</li> <li>\$0</li> <li>\$0</li> <li>\$20/surgery</li> </ul>	<ul style="list-style-type: none"> <li></li> <li></li> <li></li> <li></li> <li></li> <li></li> <li></li> <li>✓</li> </ul>
Podiatric services	\$50/visit	
Medical nutrition therapy, not related to diabetes	10%	✓
Diagnosis and Testing Only of the Cause of Infertility	50%	✓
<b>Pregnancy and maternity care</b>		
Physician office visits: prenatal and postnatal	\$0	
Physician services for pregnancy termination	\$20/visit	✓

**Benefits<sup>5</sup>**

**Your payment**

	<b>When using a Participating Provider<sup>3</sup></b>	<b>CYD<sup>2</sup> applies</b>
<b>Emergency Services</b>		
Emergency room services	\$250/visit	
<i>If admitted to the Hospital, this payment for emergency room services does not apply. Instead, you pay the Participating Provider payment under Inpatient facility services/ Hospital services and stay.</i>		
Emergency room Physician services	10%	✓
<b>Urgent care center services</b>		
	\$50/visit	
<b>Ambulance services</b>		
	10%	✓
<i>This payment is for emergency or authorized transport.</i>		
<b>Outpatient Facility services</b>		
Ambulatory Surgery Center	\$200/surgery	✓
Outpatient Department of a Hospital: surgery	\$300/surgery	✓
Outpatient Department of a Hospital: treatment of illness or injury, radiation therapy, chemotherapy, and necessary supplies	\$35/visit	✓
<b>Inpatient facility services</b>		
Hospital services and stay	\$300/day up to 3 days/admission	✓
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	\$300/day up to 3 days/admission	✓
• Physician inpatient services	10%	✓
<b>Bariatric surgery services, designated California counties</b>		
<i>This payment is for bariatric surgery services for residents of designated California counties. For bariatric surgery services for residents of non-designated California counties, the payments for Inpatient facility services/ Hospital services and stay and Physician inpatient and surgery services apply for inpatient services; or, if provided on an outpatient basis, the Outpatient Facility services and outpatient Physician services payments apply.</i>		
Inpatient facility services	\$300/day up to 3 days/admission	✓
Outpatient Facility services	\$500/surgery	✓
Physician services	10%	✓

	When using a Participating Provider <sup>3</sup>	CYD <sup>2</sup> applies
<b>Diagnostic x-ray, imaging, pathology, and laboratory services</b>		
<i>This payment is for Covered Services that are diagnostic, non-Preventive Health Services, and diagnostic radiological procedures. For the payments for Covered Services that are considered Preventive Health Services, see Preventive Health Services.</i>		
Laboratory and pathology services		
<i>Includes diagnostic Papanicolaou (Pap) test.</i>		
• Laboratory center	10%	✓
• Outpatient Department of a Hospital	10%	✓
Basic imaging services		
<i>Includes plain film X-rays, ultrasounds, and diagnostic mammography.</i>		
• Outpatient radiology center	10%	✓
• Outpatient Department of a Hospital	10%	✓
Other outpatient non-invasive diagnostic testing		
<i>Testing to diagnose illness or injury such as vestibular function tests, EKG, cardiac monitoring, non-invasive vascular studies, sleep medicine testing, muscle and range of motion tests, EEG, and EMG.</i>		
• Office location	10%	✓
• Outpatient Department of a Hospital	10%	✓
Advanced imaging services		
<i>Includes diagnostic radiological and nuclear imaging such as CT scans, MRIs, MRAs, and PET scans.</i>		
• Outpatient radiology center	\$100/visit	✓
• Outpatient Department of a Hospital	\$100/visit	✓
<b>Rehabilitative and Habilitative Services</b>		
<i>Includes physical therapy, occupational therapy, and respiratory therapy.</i>		
<i>Up to 20 visits for respiratory therapy, per Member per Calendar Year.</i>		
Office location	\$20/visit	✓
Outpatient Department of a Hospital	\$20/visit	✓
<b>Speech Therapy services</b>		
Office location	\$20/visit	✓
Outpatient Department of a Hospital	\$20/visit	✓
<b>Durable medical equipment (DME)</b>		
DME	10%	✓

**Benefits<sup>5</sup>**

**Your payment**

	<b>When using a Participating Provider<sup>3</sup></b>	<b>CYD<sup>2</sup> applies</b>
Breast pump	\$0	
Orthotic equipment and devices	10%	✓
Prosthetic equipment and devices	10%	✓
<b>Home health care services</b>	\$0	
<i>Up to 100 visits per Member, per Calendar Year, by a home health care agency. All visits count towards the limit, including visits during any applicable Deductible period. Includes home visits by a nurse, Home Health Aide, medical social worker, physical therapist, speech therapist, or occupational therapist, and medical supplies.</i>		
<b>Home infusion and home injectable therapy services</b>		
Home infusion agency services	\$0	
<i>Includes home infusion drugs, medical supplies, and visits by a nurse.</i>		
Hemophilia home infusion services	\$0	
<i>Includes blood factor products.</i>		
<b>Skilled Nursing Facility (SNF) services</b>		
<i>Up to 100 days per Member, per benefit period, except when provided as part of a Hospice program. All days count towards the limit, including days during any applicable Deductible period and days in different SNFs during the Calendar Year.</i>		
Freestanding SNF	\$0	
Hospital-based SNF	\$0	
<b>Hospice program services</b>		
<i>Up to a maximum of 360 days during the period of time a covered person is covered under the plan.</i>		
Pre-Hospice consultation	\$0	
Routine home care	\$0	
24-hour continuous home care	\$0	
Short-term inpatient care for pain and symptom management	\$0	
Inpatient respite care	\$0	
<b>Other services and supplies</b>		
Diabetes care services		
• Devices, equipment, and supplies	10%	✓
• Self-management training	\$25/visit	
• Medical nutrition therapy	\$25/visit	
Dialysis services	\$35/visit	✓
PKU product formulas and special food products	\$0	

## Benefits<sup>5</sup>

### Your payment

	When using a Participating Provider <sup>3</sup>	CYD <sup>2</sup> applies
Allergy serum billed separately from an office visit	\$0	✓
Hearing aid services		
<ul style="list-style-type: none"> <li>Hearing aids and equipment</li> </ul> <p><i>1 pair of hearing aids per member per 24 months</i></p> <p><i>Up to \$2,500 combined maximum per Member, per 24-month period.</i></p>	10%	✓
Eye Examination	\$0	
<ul style="list-style-type: none"> <li>One Comprehensive eye examination in a consecutive 24-month period.</li> </ul>		
<p><i>Note: See Eye Examination Benefit in the Plan Benefits section for more information on this benefit provided through the contracted VPA.</i></p>		

## Mental Health and Substance Use Disorder Benefits

### Your payment

	When using a Participating Provider <sup>3</sup>	CYD <sup>2</sup> applies
<b>Outpatient services</b>		
Office visit, including Physician office visit	\$25/visit	
Teladoc Health mental health	\$20/consult	
Intensive outpatient care	10%	✓
Behavioral Health Treatment in an office setting	10%	✓
Behavioral Health Treatment in home or other non-institutional setting	10%	✓
Office-based opioid treatment	10%	✓
Partial Hospitalization Program	10%	✓
Psychological Testing	10%	✓
<b>Inpatient services</b>		
Physician inpatient services	10%	✓
Hospital services	\$300/day up to 3 days/admission	✓
Residential Care	\$300/day up to 3 days/admission	✓

## Prior Authorization

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

- Advanced imaging services
- Outpatient mental health services, except office visits and office-based opioid treatment
- Inpatient facility services
- Hospice program services

Please review the Benefit Booklet for more about Benefits that require prior authorization.

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## Notes

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### 1 Benefit Booklet:

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

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

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### 2 Calendar Year Deductible (CYD):

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

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

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

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.

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### 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.

"Allowable Amount" is defined in the Benefit Booklet. In addition:

- Coinsurance is calculated from the Allowable Amount or Benefit maximum, whichever is less.
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### 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 Services in a Calendar Year. Once you reach your Out-of-Pocket Maximum, the Claims Administrator will pay 100% of the Allowable Amount for Covered Services for the rest of the Calendar Year.

Your payment after you reach the Calendar Year OOPM. You will continue to pay all charges for services that are not covered, charges above the Allowable Amount, and charges for services above any Benefit maximum.

## Notes

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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.

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.

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### **5 Separate Member Payments When Multiple Covered Services are Received:**

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

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### **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 Services during the Physician office visit, you may have a Copayment or Coinsurance for the visit.

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Plans may be modified to ensure compliance with Federal requirements.

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