blue of california

## Summary of Benefits

**Group Plan**
**PPO Plan**

# Bronze Tandem PPO 6500/70 OffEx

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.

**Medical Provider Network:** **Tandem PPO Network**

This Plan uses a specific network of Health Care Providers, called the Tandem 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.

**Pharmacy Network:** **Rx Spectrum**

**Drug Formulary:** **Standard Formulary**

## 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 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 any combination of Participating[3] and Non-Participating[4] Providers |
|---|---|---|---|
| **Calendar Year medical Deductible** | *Individual coverage* | $6,500 | $13,000 |
| | *Family coverage* | $6,500: individual | $13,000: individual |
| | | $13,000: Family | $26,000: Family |
| **Calendar Year pharmacy Deductible** | *Individual coverage* | $300 | Not covered |
| | *Family coverage* | $300: individual | Not covered |
| | | $600: Family | |

## Calendar Year Out-of-Pocket Maximum[5]

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 |
|---|---|---|
| *Individual coverage* | $8,350 | $16,700 |
| *Family coverage* | $8,350: individual | $16,700: individual |
| | $16,700: Family | $33,400: 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 Services.

## First Dollar Coverage:

10 office visits per Calendar Year

This Plan has first dollar coverage (FDC) for 10 office visits with Participating Providers. This means Blue Shield will pay for these Covered Services before you meet any Calendar Year Medical Deductible. These services are identified by a check mark (✔) in the Benefits chart below.

First dollar coverage is available for office visits to a participating Physician, participating Health Care Provider, or Mental Health Service Administrator (MHSA) Participating Provider, for any combination of these services:

- Primary care office visit (by a Primary Care Physician)
- Specialist care office visit
- Other practitioner office visit
- Outpatient mental health and substance use disorder office visit
- Podiatric service
- Urgent care

After you reach the maximum number of visits under the first dollar coverage benefit, additional office visits in the same Calendar Year are subject to any Calendar Year medical Deductible.

First dollar coverage is provided in addition to covered Preventive Health Services office visits. Covered Preventive Health Services are also paid by Blue Shield before you meet any Calendar Year medical Deductible.

## Benefits[6]

| | Your payment | | | | |
|---|---|---|---|---|---|
| | **When using a Participating Provider[3]** | **CYD[2] applies** | **FDC applies** | **When using a Non-Participating Provider[4]** | **CYD[2] applies** |
| **Preventive Health Services[7]** | | | | | |
| Preventive Health Services | $0 | | | Not covered | |
| California Prenatal Screening Program | $0 | | | $0 | |
| **Physician services** | | | | | |
| Primary care office visit | $70/visit | ✔ | ✔ | 50% | ✔ |
| Specialist care office visit | $80/visit | ✔ | ✔ | 50% | ✔ |
| Physician home visit | $70/visit | ✔ | ✔ | 50% | ✔ |
| Physician or surgeon services in an Outpatient Facility | 50% | ✔ | | 50% | ✔ |
| Physician or surgeon services in an inpatient facility | 50% | ✔ | | 50% | ✔ |
| **Other professional services** | | | | | |
| Other practitioner office visit<br>*Includes nurse practitioners, physician assistants, and therapists.* | $70/visit | ✔ | ✔ | 50% | ✔ |
| Acupuncture services | $25/visit | ✔ | | 50% | ✔ |
| Chiropractic services<br>*Up to 20 visits per Member, per Calendar Year.* | $15/visit | | | 50% | ✔ |
| Teladoc consultation | $0 | | | Not covered | |

| Benefits[6] | Your payment | | | | |
|---|---|---|---|---|---|
| | When using a Participating Provider[3] | CYD[2] applies | FDC applies | When using a Non-Participating Provider[4] | CYD[2] applies |
| 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 | 50% | ✔ | | Not covered | |
| Podiatric services | $80/visit | ✔ | ✔ | 50% | ✔ |
| **Pregnancy and maternity care** | | | | | |
| Physician office visits: prenatal and initial postnatal | $0 | | | 50% | ✔ |
| Physician services for pregnancy termination | 50% | ✔ | | 50% | ✔ |
| **Emergency Services** | | | | | |
| Emergency room services<br>*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.* | 50% | ✔ | | 50% | ✔ |
| Emergency room Physician services | 50% | ✔ | | 50% | ✔ |
| **Urgent care center services** | $70/visit | ✔ | ✔ | 50% | ✔ |
| **Ambulance services**<br>*This payment is for emergency or authorized transport.* | 50% | ✔ | | 50% | ✔ |
| **Outpatient Facility services** | | | | | |
| Ambulatory Surgery Center | 50% | ✔ | | 50%<br>Subject to a Benefit maximum of $350/day | ✔ |
| Outpatient Department of a Hospital: surgery | 50% | ✔ | | 50%<br>Subject to a Benefit maximum of $350/day | ✔ |

| Benefits[6] | Your payment | | | | |
|---|---|---|---|---|---|
| | When using a Participating Provider[3] | CYD[2] applies | FDC applies | When using a Non-Participating Provider[4] | CYD[2] applies |
| Outpatient Department of a Hospital: treatment of illness or injury, radiation therapy, chemotherapy, and necessary supplies | 50% | ✔ | | 50% Subject to a Benefit maximum of $350/day | ✔ |
| **Inpatient facility services** | | | | | |
| Hospital services and stay | 50% | ✔ | | 50% Subject to a Benefit maximum of $2,000/day | ✔ |
| Transplant services | | | | | |
| *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.* | | | | | |
| • Special transplant facility inpatient services | 50% | ✔ | | Not covered | |
| • Physician inpatient services | 50% | ✔ | | Not covered | |
| **Bariatric surgery services, designated California counties** | | | | | |
| *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.* | | | | | |
| Inpatient facility services | 50% | ✔ | | Not covered | |
| Outpatient Facility services | 50% | ✔ | | Not covered | |
| Physician services | 50% | ✔ | | Not covered | |

| Benefits[6] | Your payment | | | | |
|---|---|---|---|---|---|
| | When using a Participating Provider[3] | CYD[2] applies | FDC applies | When using a Non-Participating Provider[4] | CYD[2] applies |
| **Diagnostic x-ray, imaging, pathology, and laboratory services** | | | | | |
| *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.* | | | | | |
| Laboratory services | | | | | |
| *Includes diagnostic Papanicolaou (Pap) test.* | | | | | |
| • Laboratory center | $75/visit | | | 50% | ✔ |
| • Outpatient Department of a Hospital | 50% | ✔ | | 50%<br>Subject to a Benefit maximum of $350/day | ✔ |
| X-ray and imaging services | | | | | |
| *Includes diagnostic mammography.* | | | | | |
| • Outpatient radiology center | $115/visit | ✔ | | 50% | ✔ |
| • Outpatient Department of a Hospital | $115/visit | ✔ | | 50%<br>Subject to a Benefit maximum of $350/day | ✔ |
| Other outpatient diagnostic testing | | | | | |
| *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.* | | | | | |
| • Office location | $115/visit | ✔ | | 50% | ✔ |
| • Outpatient Department of a Hospital | $115/visit | ✔ | | 50%<br>Subject to a Benefit maximum of $350/day | ✔ |
| Radiological and nuclear imaging services | | | | | |
| • Outpatient radiology center | 50% | ✔ | | 50% | ✔ |

| Benefits[6] | Your payment | | | | |
|---|---|---|---|---|---|
| | When using a Participating Provider[3] | CYD[2] applies | FDC applies | When using a Non-Participating Provider[4] | CYD[2] applies |
| • Outpatient Department of a Hospital | 50% | ✔ | | 50%<br>Subject to a Benefit maximum of $350/day | ✔ |
| **Rehabilitative and Habilitative Services**<br>*Includes Physical Therapy, Occupational Therapy, Respiratory Therapy, and Speech Therapy services. There is no visit limit for Rehabilitative or Habilitative Services.* | | | | | |
| Office location | $70/visit | ✔ | | 50% | ✔ |
| Outpatient Department of a Hospital | $70/visit | ✔ | | 50%<br>Subject to a Benefit maximum of $350/day | ✔ |
| **Durable medical equipment (DME)** | | | | | |
| DME | 50% | ✔ | | Not covered | |
| Breast pump | $0 | | | Not covered | |
| Orthotic equipment and devices | 50% | ✔ | | Not covered | |
| Prosthetic equipment and devices | 50% | ✔ | | Not covered | |
| **Home health care services**<br>*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.* | 50% | ✔ | | Not covered | |
| **Home infusion and home injectable therapy services** | | | | | |
| Home infusion agency services<br>*Includes home infusion drugs and medical supplies.* | 50% | ✔ | | Not covered | |
| Home visits by an infusion nurse | 50% | ✔ | | Not covered | |
| Hemophilia home infusion services<br>*Includes blood factor products.* | 50% | ✔ | | Not covered | |

| Benefits[6] | Your payment | | | | |
|---|---|---|---|---|---|
| | When using a Participating Provider[3] | CYD[2] applies | FDC applies | When using a Non-Participating Provider[4] | CYD[2] applies |
| **Skilled Nursing Facility (SNF) services**<br>*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.* | | | | | |
| Freestanding SNF | 50% | ✔ | | 50% | ✔ |
| Hospital-based SNF | 50% | ✔ | | 50%<br>Subject to a Benefit maximum of $2,000/day | ✔ |
| **Hospice program services**<br>*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.* | $0 | ✔ | | Not covered | |
| **Other services and supplies** | | | | | |
| Diabetes care services | | | | | |
| • Devices, equipment, and supplies | 50% | ✔ | | Not covered | |
| • Self-management training | $0 | | | 50% | ✔ |
| Dialysis services | 50% | ✔ | | 50%<br>Subject to a Benefit maximum of $350/day | ✔ |
| PKU product formulas and special food products | 50% | ✔ | | 50% | ✔ |
| Allergy serum billed separately from an office visit | 50% | ✔ | | 50% | ✔ |

| Mental Health and Substance Use Disorder Benefits | Your payment | | | | |
|---|---|---|---|---|---|
| *Mental health and substance use disorder Benefits are provided through Blue Shield's Mental Health Service Administrator (MHSA).* | When using a MHSA Participating Provider[3] | CYD[2] applies | FDC applies | When using a MHSA Non-Participating Provider[4] | CYD[2] applies |
| **Outpatient services** | | | | | |
| Office visit, including Physician office visit | $70/visit | ✔ | ✔ | 50% | ✔ |

| Mental Health and Substance Use Disorder Benefits | Your payment | | | | |
|---|---|---|---|---|---|
| *Mental health and substance use disorder Benefits are provided through Blue Shield's Mental Health Service Administrator (MHSA).* | **When using a MHSA Participating Provider[3]** | **CYD[2] applies** | **FDC applies** | **When using a MHSA Non-Participating Provider[4]** | **CYD[2] applies** |
| Teladoc behavioral 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 | 50% | ✔ | | 50% | ✔ |
| Partial Hospitalization Program | 50% | ✔ | | 50% Subject to a Benefit maximum of $350/day | ✔ |
| Psychological Testing | 50% | ✔ | | 50% | ✔ |
| **Inpatient services** | | | | | |
| Physician inpatient services | 50% | ✔ | | 50% | ✔ |
| Hospital services | 50% | ✔ | | 50% Subject to a Benefit maximum of $2,000/day | ✔ |
| Residential Care | 50% | ✔ | | 50% Subject to a Benefit maximum of $2,000/day | ✔ |

| Prescription Drug Benefits[8,9] | Your payment | | | | |
|---|---|---|---|---|---|
| *A separate Calendar Year pharmacy Deductible applies.* | **When using a Participating Pharmacy[3]** | | **CYD[2] applies** | **When using a Non-Participating Pharmacy[4]** | **CYD[2] applies** |
| | **Level A** | **Level B** | | | |
| **Retail pharmacy prescription Drugs** | | | | | |
| *Per prescription, up to a 30-day supply.* | | | | | |
| Contraceptive Drugs and devices | $0 | $0 | | Not covered | |
| Tier 1 Drugs | $20/prescription | $25/prescription | | Not covered | |
| Tier 2 Drugs | $130/prescription | $160/prescription | ✔ | Not covered | |

| Prescription Drug Benefits[8,9] | Your payment | | | | |
|---|---|---|---|---|---|
| *A separate Calendar Year pharmacy Deductible applies.* | **When using a Participating Pharmacy[3]** | | **CYD[2] applies** | **When using a Non-Participating Pharmacy[4]** | **CYD[2] applies** |
| Tier 3 Drugs | $160/prescription | $210/prescription | ✔ | Not covered | |
| Tier 4 Drugs | 50% up to $500/prescription | 50% up to $500/prescription | ✔ | Not covered | |
| **Retail pharmacy prescription Drugs** | | | | | |
| *Per prescription, up to a 90-day supply from a 90-day retail pharmacy.* | | | | | |
| Contraceptive Drugs and devices | $0 | $0 | | Not covered | |
| Tier 1 Drugs | $60/prescription | $75/prescription | | Not covered | |
| Tier 2 Drugs | $390/prescription | $480/prescription | ✔ | Not covered | |
| Tier 3 Drugs | $480/prescription | $630/prescription | ✔ | Not covered | |
| Tier 4 Drugs | 50% up to $1,500/prescription | 50% up to $1,500/prescription | ✔ | Not covered | |
| **Mail service pharmacy prescription Drugs** | | | | | |
| *Per prescription, up to a 90-day supply.* | | | | | |
| Contraceptive Drugs and devices | $0 | | | Not covered | |
| Tier 1 Drugs | $40/prescription | | | Not covered | |
| Tier 2 Drugs | $260/prescription | | ✔ | Not covered | |
| Tier 3 Drugs | $320/prescription | | ✔ | Not covered | |
| Tier 4 Drugs | 50% up to $1,000/prescription | | ✔ | Not covered | |

| Pediatric Benefits | Your payment | | | |
|---|---|---|---|---|
| *Pediatric Benefits are available through the end of the month in which the Member turns 19.* | **When using a Participating Dentist[3]** | **CYD[2] applies** | **When using a Non-Participating Dentist[4]** | **CYD[2] applies** |
| **Pediatric dental[10]** | | | | |
| Diagnostic and preventive services | | | | |
| • Oral exam | $0 | | 20% | |
| • Preventive – cleaning | $0 | | 20% | |

| Pediatric Benefits | Your payment | | | |
|---|---|---|---|---|
| *Pediatric Benefits are available through the end of the month in which the Member turns 19.* | **When using a Participating Dentist[3]** | **CYD[2] applies** | **When using a Non-Participating Dentist[4]** | **CYD[2] applies** |
| • Preventive – x-ray | $0 | | 20% | |
| • Sealants per tooth | $0 | | 20% | |
| • Topical fluoride application | $0 | | 20% | |
| • Space maintainers - fixed | $0 | | 20% | |
| Basic services | | | | |
| • Restorative procedures | 20% | | 30% | |
| • Periodontal maintenance | 20% | | 30% | |
| • Adjunctive general services | 20% | | 30% | |
| Major services | | | | |
| • Oral surgery | 50% | | 50% | |
| • Endodontics | 50% | | 50% | |
| • Periodontics (other than maintenance) | 50% | | 50% | |
| • Crowns and casts | 50% | | 50% | |
| • Prosthodontics | 50% | | 50% | |
| Orthodontics (Medically Necessary) | 50% | | 50% | |

| Pediatric Benefits | Your payment | | | |
|---|---|---|---|---|
| *Pediatric Benefits are available through the end of the month in which the Member turns 19.* | **When using a Participating Provider[3]** | **CYD[2] applies** | **When using a Non-Participating Provider[4]** | **CYD[2] applies** |
| **Pediatric vision[11]** | | | | |
| Comprehensive eye examination | | | | |
| *One exam per Calendar Year.* | | | | |
| • Ophthalmologic visit | $0 | | All charges above $30 | |
| • Optometric visit | $0 | | All charges above $30 | |
| Contact lens fitting and evaluation | | | | |
| *When you choose contact lenses instead of eyeglasses, one per Member every 12 months by a Participating Provider if administered at the same time as the comprehensive exam. There is a maximum of two follow up visits.* | | | | |
| • Standard lenses | $0 | | Not covered | |
| • Non-standard lenses | All charges above $60 | | Not covered | |

| Pediatric Benefits | Your payment | | | |
|---|---|---|---|---|
| *Pediatric Benefits are available through the end of the month in which the Member turns 19.* | **When using a Participating Provider[3]** | **CYD[2] applies** | **When using a Non-Participating Provider[4]** | **CYD[2] applies** |
| Eyewear/materials | | | | |
| *One eyeglass frame and eyeglass lenses, or contact lenses instead of eyeglasses, up to the Benefit per Calendar Year. Any exceptions are noted below.* | | | | |
| • Contact lenses | | | | |
| Non-elective (Medically Necessary) - hard or soft | $0 | | All charges above $225 | |
| *Up to two pairs per eye per Calendar Year.* | | | | |
| Elective (cosmetic/convenience) | | | | |
| Standard and non-standard, hard | $0 | | All charges above $75 | |
| *Up to a 3 month supply for each eye per Calendar Year based on lenses selected.* | | | | |
| Standard and non-standard, soft | $0 | | All charges above $75 | |
| *Up to a 6 month supply for each eye per Calendar Year based on lenses selected.* | | | | |
| • Eyeglass frames | | | | |
| Collection frames | $0 | | All charges above $40 | |
| Non-collection frames | All charges above $150 | | All charges above $40 | |
| • Eyeglass lenses | | | | |
| *Lenses include choice of glass or plastic lenses, all lens powers (single vision, bifocal, trifocal, lenticular), fashion or gradient tint, scratch coating, oversized, and glass-grey #3 prescription sunglasses.* | | | | |
| Single vision | $0 | | All charges above $25 | |
| Lined bifocal | $0 | | All charges above $35 | |
| Lined trifocal | $0 | | All charges above $45 | |
| Lenticular | $0 | | All charges above $45 | |
| Optional eyeglass lenses and treatments | | | | |
| • Ultraviolet protective coating (standard only) | $0 | | Not covered | |
| • Polycarbonate lenses | $0 | | Not covered | |

## Pediatric Benefits

| *Pediatric Benefits are available through the end of the month in which the Member turns 19.* | Your payment: When using a Participating Provider[3] | CYD[2] applies | When using a Non-Participating Provider[4] | CYD[2] applies |
|---|---|---|---|---|
| • Standard progressive lenses | $55 | | Not covered | |
| • Premium progressive lenses | $95 | | Not covered | |
| • Anti-reflective lens coating (standard only) | $35 | | Not covered | |
| • Photochromic - glass lenses | $25 | | Not covered | |
| • Photochromic - plastic lenses | $25 | | Not covered | |
| • High index lenses | $30 | | Not covered | |
| • Polarized lenses | $45 | | Not covered | |
| Low vision testing and equipment | | | | |
| • Comprehensive low vision exam<br>*Once every 5 Calendar Years.* | 35% | | Not covered | |
| • Low vision devices<br>*One aid per Calendar Year.* | 35% | | Not covered | |
| Diabetes management referral | $0 | | Not covered | |

## Prior Authorization

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

- Radiological and nuclear imaging services
- Outpatient mental health services, except office visits
- Inpatient facility services
- Pediatric vision non-elective contact lenses and low vision testing and equipment
- Hospice program services
- Some prescription Drugs (see blueshieldca.com/pharmacy)

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 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.

## Notes

*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.

- *First Dollar Coverage (FDC).* This Plan also has first dollar coverage. See the section on first dollar coverage for office visits that are also paid by Blue Shield before you meet any Calendar Year medical Deductible. Covered Services with first dollar coverage are identified with a check mark (✔) in the "FDC applies" column in the Benefits chart above.

*This Plan has a separate medical Deductible and pharmacy Deductible*.

*This Plan has a Participating Provider Calendar Year Deductible as well as a combined Participating Provider and Non-Participating Provider Calendar Year Deductible.* This means that any amounts you pay towards your Participating Provider Calendar Year Deductible also count towards your combined Participating and Non-Participating Provider Calendar Year Deductible.

*Family coverage has an individual Deductible within the Family Deductible.* This means that the Deductible will be met for an individual with Family coverage who meets the individual Deductible prior to the Family meeting the Family Deductible within a Calendar Year. Any amount you have paid toward the individual Deductible will be applied to both the individual Deductible and the Family Deductible. Once the individual Deductible or Family Deductible is reached, cost sharing applies until the Out-of-Pocket Maximum is reached.

**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.

*Participating Pharmacies.* Blue Shield has two participation levels for retail pharmacies; Level A and Level B. You can go to any Level A or Level B pharmacy to obtain covered Drugs.

*Teladoc.* Teladoc mental health and substance use disorder (behavioral health) consultations are provided through Teladoc. These services are not administered by Blue Shield's Mental Health Service Administrator (MHSA).

*"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 Services 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 Out-of-Pocket Maximum, and are your responsibility for payment to the provider. This out-of-pocket expense can be significant.

## Notes

**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 Services in a Calendar Year. Once you reach your Out-of-Pocket Maximum, Blue Shield 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 the following Covered Services after the Calendar Year Out-of-Pocket Maximum is met:

- dialysis center Benefits: dialysis services from a Non-Participating Provider.
- 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 medical or pharmacy Calendar Year 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. Any amount you have paid toward the individual OOPM will be applied to both the individual OOPM and the Family OOPM, except for Out-of-Network pediatric dental services. Cost sharing payments for pediatric dental services made by each individual child for Out-of-Network Covered Services do not accumulate to the Family Out-of-Pocket 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. 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 Services during the Physician office visit, you may have a Copayment or Coinsurance for the visit.

**8 Outpatient Prescription Drug Coverage:**

**Medicare Part D-non-creditable coverage-**

This Plan's prescription drug coverage provides less coverage on average than the standard benefit set by the federal government for Medicare Part D (also called non-creditable coverage). It is important to know that generally you may only enroll in a Part D plan when you are initially eligible for Medicare, and from October 15th through December 7th of each subsequent year. You may also be eligible for a special enrollment period with Medicare when you lose creditable coverage. If you do not enroll in Medicare Part D when first eligible, you may be subject to payment of higher Part D premiums when you do enroll at a later date. For more information about this drug coverage, call the Customer Services telephone number on your Member identification card, Monday through Thursday, 8 a.m. to 5 p.m., or Friday 9 a.m. to 5 p.m.

**9 Outpatient Prescription Drug Coverage:**

*Brand Drug coverage when a Generic Drug is available.* If you, the Physician, or Health Care Provider, select a Brand Drug when a Generic Drug equivalent is available, you are responsible for the difference between the cost to Blue Shield for the Brand Drug and its Generic Drug equivalent plus the tier 1 Copayment or Coinsurance. This difference in

cost will not count towards any Calendar Year pharmacy Deductible, medical Deductible, or the Calendar Year Out-of-Pocket Maximum.

*Request for Medical Necessity Review.* 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.

*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.

*High Deductible Health Plan (HDHP) preventive Drugs.* HDHP preventive Drugs obtained from a Participating Pharmacy are covered at the applicable Drug tier Copayment but are not subject to the Deductible. HDHP preventive Drugs do not include those preventive Drugs that are required by Health Care Reform to be covered at no charge. Visit blueshieldca.com/pharmacy for lists of these Drugs.

**10 Pediatric Dental Coverage:**

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

*Orthodontic Covered Services.* The Copayment or Coinsurance for Medically Necessary orthodontic Covered Services applies to a course of treatment even if it extends beyond a Calendar Year. This applies as long as the Member remains enrolled in the Plan.

*This plan is compliant with requirements of the pediatric dental EHB benchmark plan, including coverage of services in circumstances of Medical Necessity as defined in the Early Periodic Screening, Diagnosis and Treatment (EPSDT) benefit.*

**11 Pediatric Vision Coverage:**

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

*Covered Services from Non-Participating Providers.* There is no Copayment or Coinsurance up to the listed Allowable Amount. You pay all charges above the Allowable Amount.

*Coverage for frames.* If frames are selected that are more expensive than the Allowable Amount established for frames under this Benefit, you pay the difference between the Allowable Amount and the provider's charge.

"Collection frames" are covered with no Member payment from Participating Providers. Retail chain Participating Providers do not usually display the frames as "collection," but a comparable selection of frames is maintained.

"Non-collection frames" are covered up to an Allowable Amount of $150; however, if the Participating Provider uses:

- wholesale pricing, then the Allowable Amount will be up to $99.06.
- warehouse pricing, then the Allowable Amount will be up to $103.64.

Participating Providers using wholesale pricing are identified in the provider directory.

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

# Blue Shield of California

## Notice Informing Individuals about Nondiscrimination and Accessibility Requirements

### Discrimination is against the law

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 does not exclude people or treat them differently because of race, color, national origin, ancestry, religion, sex, marital status, gender, gender identity, sexual orientation, age, or disability.

Blue Shield of California:

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

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

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

Blue Shield of California
Civil Rights Coordinator
P.O. Box 629007
El Dorado Hills, CA 95762-9007

**Phone: (844) 831-4133 (TTY: 711)**
**Fax: (844) 696-6070**
**Email: BlueShieldCivilRightsCoordinator@blueshieldca.com**

You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, our Civil Rights Coordinator is available to help you. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at **https://ocrportal.hhs.gov/ocr/portal/lobby.jsf**, or by mail or phone at:

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

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

# Notice of the Availability of Language Assistance Services
## Blue Shield of California

**IMPORTANT:** Can you read this letter? If not, we can have somebody help you read it. You may also be able to get this letter written in your language. For help at no cost, please call right away at the Member/Customer Service telephone number on the back of your Blue Shield ID card, or (866) 346-7198.

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

**重要通知：**您能讀懂這封信嗎？如果不能，我們可以請人幫您閱讀。這封信也可以 用您所講的語言書寫。如需免费幫助，請立即撥打登列在您的Blue Shield ID卡背面上的 會員/客戶服務部的電話，或者撥打電話 (866) 346-7198。(Chinese)

**QUAN TRỌNG:** Quý vị có thể đọc lá thư này không? Nếu không, chúng tôi có thể nhờ người giúp quý vị đọc thư. Quý vị cũng có thể nhận lá thư này được viết bằng ngôn ngữ của quý vị. Để được hỗ trợ miễn phí, vui lòng gọi ngay đến Ban Dịch vụ Hội viên/Khách hàng theo số ở mặt sau thẻ ID Blue Shield của quý vị hoặc theo số (866) 346-7198. (Vietnamese)

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

**Baa' ákohwiindzindooígí:** Díí naaltsoosísh yíiníłta'go bíiníghah? Doo bíiníghahgóó éí, naaltsoos nich'į' yiidóołtahígíí ła' nihee hóló. Díí naaltsoos ałdó' t'áá Diné k'ehjí ádoolníił nínízingo bíighah. Doo bąąh ílínígó shíká' adoowoł nínízingó nihich'į' béésh bee hodíilnih dóó námboo éí díí Blue Shield bee néího'dílzinígí bine'déé' bikáá' éí doodagó éí (866) 346-7198 jį' hodíilnih. (Navajo)

**중요:** 이 서신을 읽을 수 있으세요? 읽으실 수 경우, 도움을 드릴 수 있는 사람이 있습니다. 또한 다른 언어로 작성된 이 서신을 받으실 수도 있습니다. 무료로 도움을 받으시려면 Blue Shield ID 카드 뒷면의 회원/고객 서비스 전화번호 또는 (866) 346-7198로 지금 전환하세요. (Korean)

**ԿԱՐԵՎՈՐ Է.** Կարողանում ե՞ք կարդալ այս նամակը: Եթե ոչ, ապա մենք կօգնենք ձեզ: Դուք պետք է նաև կարողանաք ստանալ այս նամակը ձեր լեզվով: Ծառայությունն անվճար է: Խնդրում ենք անմիջապես զանգահարել Հաճախորդների սպասարկման բաժնի հեռախոսահամարով, որը նշված է ձեր Blue Shield ID քարտի ետևի մասում, կամ (866) 346-7198 համարով: (Armenian)

**ВАЖНО:** Не можете прочесть данное письмо? Мы поможем вам, если необходимо. Вы также можете получить это письмо написанное на вашем родном языке. Позвоните в Службу клиентской/членской поддержки прямо сейчас по телефону, указанному сзади идентификационной карты Blue Shield, или по телефону (866) 346-7198, и вам помогут совершенно бесплатно. (Russian)

**重要：**お客様は、この手紙を読むことができますか？ もし読むことができない場合、弊社が、お客様をサポートする人物を手配いたします。 また、お客様の母国語で書かれた手紙をお送りすることも可能です。 無料のサポートを希望される場合は、Blue Shield IDカードの裏面に記載されている会員/お客様サービスの電話番号、または、(866) 346-7198にお電話をおかけください。 (Japanese)

**مهم:** آیا می‌توانید این نامه را بخوانید؟ اگر پاسختان منفی است، می‌توانیم کسی را برای کمک به شما در اختیارتان قرار دهیم. حتی می‌توانید نسخه مکتوب این نامه را به زبان خودتان دریافت کنید. برای دریافت کمک رایگان، لطفاً بدون فوت وقت از طریق شماره تلفنی که در پشت کارت شناسی Blue Shield تان درج شده است و یا از طریق شماره تلفن 346-7198 (866) با خدمات اعضا/مشتری تماس بگیرید. (Persian)

**ਮਹੱਤਵਪੂਰਨ:** ਕੀ ਤੁਸੀਂ ਇਸ ਪੱਤਰ ਨੂੰ ਪੜ੍ਹ ਸਕਦੇ ਹੋ? ਜੇ ਨਹੀਂ ਤਾਂ ਇਸ ਨੂੰ ਪੜ੍ਹਨ ਵਿਚ ਮਦਦ ਲਈ ਅਸੀਂ ਕਿਸੇ ਵਿਅਕਤੀ ਦਾ ਪ੍ਰਬੰਧ ਕਰ ਸਕਦੇ ਹਾਂ। ਤੁਸੀਂ ਇਹ ਪੱਤਰ ਆਪਣੀ ਭਾਸ਼ਾ ਵਿਚ ਲਿਖਿਆ ਹੋਇਆ ਵੀ ਪ੍ਰਾਪਤ ਕਰ ਸਕਦੇ ਹੋ। ਮੁਫ਼ਤ ਵਿਚ ਮਦਦ ਪ੍ਰਾਪਤ ਕਰਨ ਲਈ ਤੁਹਾਡੇ Blue Shield ID ਕਾਰਡ ਦੇ ਪਿੱਛੇ ਦਿੱਤੇ ਮੈਂਬਰ/ਕਸਟਮਰ ਸਰਵਿਸ ਟੈਲੀਫ਼ੋਨ ਨੰਬਰ ਤੇ, ਜਾਂ (866) 346-7198 ਤੇ ਕਾੱਲ ਕਰੋ। (Punjabi)

**ប្រការសំខាន់ៈ** តើអ្នកអាចលិខិតនេះ បានដែរឬទេ? បើមិនអាចទេ យើងអាចឲ្យគេជួយអ្នកក្នុងការអានលិខិតនេះ។ អ្នកក៏អាចទទួលបានលិខិតនេះជាភាសារបស់អ្នកផងដែរ។ សម្រាប់ជំនួយដោយឥតគិតថ្លៃ សូមហៅទូរស័ព្ទភ្លាមៗទៅកាន់លេខទូរស័ព្ទសេវាសមាជិក/អតិថិជនដែលមាននៅលើខ្នងប័ណ្ណសម្គាល់ Blue Shield របស់អ្នក ឬតាមរយៈលេខ (866) 346-7198។ (Khmer)

**المهم :**هل تستطيع قراءة هذا الخطاب؟ أن لم تستطع قراءته، يمكننا إحضار شخص ما ليساعدك في قراءته. قد تحتاج أيضاً إلى الحصول على هذا الخطاب مكتوباً بلغتك. للحصول على المساعدة بدون تكلفة، يرجى الاتصال الآن على رقم هاتف خدمة العملاء/أحد الأعضاء المدون على الجانب الخلفي من بطاقة الهوية Blue Shield أو على الرقم 346-7198 (866).(Arabic)

**TSEEM CEEB:** Koj pos tuaj yeem nyeem tau tsab ntawv no? Yog hais tias nyeem tsis tau, peb tuaj yeem nrhiav ib tug neeg los pab nyeem nws rau koj. Tej zaum koj kuj yuav tau txais muab tsab ntawv no sau ua koj hom lus. Rau kev pab txhais dawb, thov hu kiag rau tus xov tooj Kev Pab Cuam Tub Koom Xeeb/Tub Lag Luam uas nyob rau sab nraum nrob qaum ntawm koj daim npav Blue Shield ID, los yog hu rau tus xov tooj (866) 346-7198. (Hmong)

**สำคัญ:** คุณอ่านจดหมายฉบับนี้ได้หรือไม่ หากไม่ได้ โปรดขอความช่วยจากผู้อ่านได้ คุณอาจได้รับจดหมายฉบับนี้เป็นภาษาของคุณ หากต้องการความช่วยเหลือโดยไม่มีค่าใช้จ่าย โปรดติดต่อฝ่ายบริการลูกค้า/สมาชิกทางเบอร์โทรศัพท์ในบัตรประจำตัว Blue Shield ของคุณ หรือโทร (866) 346-7198 (Thai)

**महत्वपूर्ण:** क्या आप इस पत्र को पढ़ सकते हैं? यदि नहीं, तो हम इसे पढ़ने में आपकी मदद के लिए किसी व्यक्ति का प्रबंध कर सकते हैं। आप इस पत्र को अपनी भाषा में भी प्राप्त कर सकते हैं। नि:शुल्क मदद प्राप्त करने के लिए अपने Blue Shield ID कार्ड के पीछे दिए गये मेंबर/कस्टमर सर्विस टेलीफोन नंबर, या (866) 346-7198 पर कॉल करें। (Hindi)

**ສິ່ງສຳຄັນ:** ທ່ານສາມາດອ່ານຈົດໝາຍນີ້ໄດ້ບໍ? ຖ້າອ່ານບໍ່ໄດ້, ພວກເຮົາສາມາດໃຫ້ບາງຄົນຊ່ວຍອ່ານໃຫ້ທ່ານຟັງໄດ້. ທ່ານຍັງສາມາດຂໍໃຫ້ແປຈົດໝາຍນີ້ເປັນພາສາຂອງທ່ານໄດ້.ສຳລັບຄວາມຊ່ວຍເຫຼືອແບບບໍ່ເສຍຄ່າ, ກະລຸນາ ໂທຫາເບີໂທຂອງຝ່າຍບໍລິການສະມາຊິກ/ລູກຄ້າໃນທັນທີເບີໂທລະສັບຢູ່ດ້ານຫຼັງບັດສະມາຊິກ Blue Shield ຂອງທ່ານ, ຫຼືໂທໄປຫາເບີ(866) 346-7198. (Laotian)