Blue Shield of California

final sold rates and plans

City of Delano

Effective Date: July 1, 2020

Contract Period: July 1, 2020 – June 30, 2021

Final Sold Rates and Plans: Medical

Account: City of Delano
Effective Date: July 1, 2020

HMO1	Single	Two Party	Family
Custom Access+ HMO® Zero Admit 10	$536.24	$1,528.26	$1,528.26
Chiropractic 30 visits $10 copay	$2.08	$5.93	$5.93
Subtotal	**$538.32**	**$1,534.19**	**$1,534.19**
Enhanced Rx $10/20/35 with $0 Pharmacy Deductible	$92.50	$263.62	$263.62
TOTAL	**$630.82**	**$1,797.81**	**$1,797.81**
ESTIMATED ANNUAL PREMIUM			**$786,123.00**

HMO2	Single	Two Party	Family
Custom Trio ACO HMO Zero Admit 10	$410.89	$1,171.04	$1,171.04
Chiropractic 30 visits $10 copay	$1.54	$4.39	$4.39
Subtotal	**$412.43**	**$1,175.43**	**$1,175.43**
Enhanced Rx $10/20/35 with $0 Pharmacy Deductible	$72.98	$207.98	$207.98
TOTAL	**$485.41**	**$1,383.41**	**$1,383.41**
ESTIMATED ANNUAL PREMIUM			**$1,077,898.68**

PPO	Single	Two Party	Family
Full PPO Combined Deductible 20-200 90/70	$579.02	$1,650.18	$1,650.18
Subtotal	**$579.02**	**$1,650.18**	**$1,650.18**
Enhanced Rx $10/20/35 with $0 Pharmacy Deductible	$150.14	$427.91	$427.91
Chiro/Acu Included	Incl.	Incl.	Incl.
TOTAL	**$729.16**	**$2,078.09**	**$2,078.09**
ESTIMATED ANNUAL PREMIUM			**$332,058.00**

Additional Information

- **Wellvolution - available at no additional cost**
  Wellvolution is a lifestyle medicine platform that addresses whole health across the care continuum. It provides a personalized, structured lifestyle change experience utilizing highly rated apps, evidence-based therapies and member-centric design. Wellvolution allows members to create a personalized proven path to real health by answering a few questions about their health needs and goals, and then selecting the best tool from the options provided in their recommendation. The platform can help individuals with everything from improving nutrition, to getting better sleep, to preventing diabetes, to reversing a chronic condition. The Wellvolution hosts the largest premium lifestyle medicine network in the country, including almost 70 individual solutions using more than 35 provider partners. Eligible members will be directed to www.wellvolution.com to access the platform and enroll in a program.
- The total amount includes the total premium rate plus the Producer Service fee. The Producer Service Fee is not part of the premium.

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Medical Rate Assumptions

Account: City of Delano

1 Effective Date:

The renewal effective date is July 1, 2020. A change to the renewal effective date requires a rate re-evaluation.

2 Producer Service Fee:

Your group will work directly with the producer of record to determine the amount of the Producer Service Fee. Blue Shield will include the Producer Service Fee on the group's billing statement as part of the total amount due. After receiving payment, Blue Shield will pass the Producer Service Fee on to the producer, on behalf of your group. A group's payment of the amount due to Blue Shield upon renewal will acknowledge acceptance of this Producer Service Fee arrangement.
Rates in this package reflect premium plus the producer service fee percentages below. The Producer service fee percentages apply to premium.

- HMO1 5.26%
- HMO2 5.26%
- PPO 5.26%

Upon request, Blue Shield is prepared to issue a 1099 on a group's behalf. In order to accommodate this request, the Producer Service Fee Form 1099 Authorization will need to be completed and returned to Blue Shield no later than the first Friday in December of your plan year. Please contact your sales representative for more information about the authorization form.

3 Renewal Rate:

Renewal rates are based on 177 total contracts. If enrollment changes by +/- 10% from the assumed enrollment, BSC reserves the right to reevaluate the rates on the final enrollment.

4 Eligible Employees:

Eligible employees and dependents are as currently defined in our contract.

5 COBRA Participation:

Current COBRA enrollment is 2 contract(s). If COBRA participation increases to more than 10% of total Blue Shield enrollees, Blue Shield reserves the right to adjust rates.

6 Participation Requirements:

75% of eligible employees must enroll in employer-sponsored medical coverage. When offering BSC coverage with another carrier, 75% of eligible employees must enroll in employer-sponsored medical coverage and, in locations where another carrier is offered, of those enrolling, a minimum of 50% must select BSC.

7 Employer Contribution:

Minimum employer contribution is 75% of employee dues, or 50% of employee and dependent dues. If the employer contributes 100% of employee dues, all eligible employees must enroll; except those who signed a valid waiver that confirms other group insurance or have TRICARE, formerly known as CHAMPUS, or decline for religious reasons. Super-composite rates assume employer contributes 100% for employee and dependent costs. The contribution formula cannot select against the Blue Shield benefit plans. Our proposed rates assume that there are no changes in the contribution approach from the prior year. If BSC Trio HMO plans are offered, the Trio HMO plans must be the lowest cost employee contribution plans or equal to Kaiser's contributions for employees.

- 0% EE / 0% Dependents for HMO1

- 0% EE / 0% Dependents for HMO2
- 0% EE / 0% Dependents for PPO

8 Rates:
Rates are guaranteed for a period of 12 months, unless otherwise noted.

9 Wellvolution:
This proposal includes Wellvolution at no additional cost. For further details on the included programs and features, please reference the Wellvolution flier included.

10 HSA Funding:
Quoted HSA compatible plan rates assume the employer will contribute up to 50% of the deductible per Member into the HSA account (per Member contribution is subject to family maximum). If the actual funding is different, Blue Shield of California reserves the right to modify or rescind quoted rates.

11 PPACA:
Blue Shield has undertaken its best efforts to analyze and implement the requirements of the federal Patient Protection and Affordable Care Act ("PPACA" or "ACA"). The information included in this quote includes those benefit changes and fees/taxes that we understand at this time are required by the Act.

Blue Shield has attempted to include all applicable Federal, State, and ACA fees/taxes in the rates. For calendar year 2019, the ACA Insurer Fee is 0% for DMHC and 0% for DOI. For calendar year 2020, the ACA Insurer Fee is 2.1% for DMHC and 0% for DOI. The ACA Insurer Fee is prorated based on the number of contract months in 2019 and 2020. The Patient Centered Outcomes Research Institute ("PCORI") and the state law managed care organization ("MCO") tax have expired.

Should Blue Shield be assessed any Federal, State, or ACA fees/taxes on account of any of the health benefit plans included in this quote, but not presently included in the rates, Blue Shield reserves the right to amend the rates to include such fees/taxes. In the case of federal excise taxes, Blue Shield also reserves the right to amend the rates to include any increased federal income taxes to Blue Shield associated with such federal excise taxes.

12 Benefit Solutions Program:
The Benefit Solutions program is available to all new and existing groups with 101 to 1,000 eligible employees that purchase new, Blue Shield dental, vision, and life products. Rate savings apply only to fully insured medical rates and are passed on due to increased Blue Shield efficiencies by administering medical and specialty products together on a group's behalf. Rate savings are subject to change at Blue Shield's discretion.

Rate savings do not apply to clients with existing dental, vision, and/or life products that do not purchase new dental, vision, or life products. Discount is applied as a one-time savings when a dental, vision, and/or life product is added. These discounts only apply as long as dental, vision, and/or life coverage remain in force. As part of the Benefit Solutions program, prescription and rider premiums including substance use disorder, infertility, hearing aids, chiropractic, and chiropractic acupuncture premiums are also eligible for savings as part of the total medical premium.

For life insurance coverage to be eligible for Benefit Solutions, a group must purchase a minimum of $25,000 in coverage for the .5% discount. Adding supplemental life insurance to an existing life insurance policy does not qualify for Benefit Solutions. If a group purchases both life and supplemental life insurance coverage, the two products count as one product for the purposes of Benefit Solutions.

Benefit Solutions discount applies to fully insured, non-voluntary dental, vision, and life plans. The benefit

solutions discount does not apply to the Duo Dental & Vision plan, Vision Eye Exam Only Plan and the Smile In-Network Only D&P plan.

Blue Shield retains sole and complete discretion to revise or terminate the Benefit Solutions program at any time.

13 Mental Health and Substance Use Disorder Benefits:

Blue Shield has undertaken its best efforts to ensure that health benefit plans comply with the requirements of the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA), as applicable. MHPAEA generally prohibits group health plans and health insurance issuers that provide mental health or substance use disorder benefits from imposing less favorable benefit limitations on those benefits than on medical/surgical benefits. The information included in this quote reflects benefits that we understand at this time are compliant with MHPAEA.

blue of california

Group Plan
HMO Plan

Summary of Benefits

Access+ HMO® Zero Admit 10

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: **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 Services under the Plan.

		When using a Participating Provider[3]
Calendar Year medical Deductible	*Individual coverage*	$0
	Family coverage	$0: individual $0: Family

Calendar Year Out-of-Pocket Maximum[4]

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

	When using a Participating Provider[3]
Individual coverage	$1,500
Family coverage	$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 Services.

Benefits[5]	Your payment	
	When using a Participating Provider[3]	CYD[2] applies
Preventive Health Services[6]		
Preventive Health Services	$0	
California Prenatal Screening Program	$0	
Physician services		
Primary care office visit	$10/visit	
Access+ specialist care office visit (self-referral)	$20/visit	
Other specialist care office visit (referred by PCP)	$10/visit	
Physician home visit	$10/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 *Includes nurse practitioners, physician assistants, and therapists.*	$10/visit	
Teladoc consultation	$5/consult	
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	
Podiatric services	$10/visit	
Pregnancy and maternity care[6]		
Physician office visits: prenatal and postnatal	$0	
Physician services for pregnancy termination	$0	
Emergency services		
Emergency room services *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.*	$100/visit	
Emergency room Physician services	$0	

Benefits[5]	Your payment	
	When using a Participating Provider[3]	CYD[2] applies
Urgent care center services	$10/visit	
Ambulance services *This payment is for emergency or authorized transport.*	$100/transport	
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 *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	$0	
• Physician inpatient services	$0	
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	$0	
• Outpatient Department of a Hospital	$0	
X-ray and imaging services *Includes diagnostic mammography.*		
• Outpatient radiology center	$0	
• Outpatient Department of a Hospital	$0	
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	$0	
• Outpatient Department of a Hospital	$0	

Benefits[5]	Your payment	
	When using a Participating Provider[3]	CYD[2] applies
Radiological and nuclear imaging services		
• Outpatient radiology center	$0	
• Outpatient Department of a Hospital	$0	
Rehabilitative and Habilitative Services		
Includes Physical Therapy, Occupational Therapy, Respiratory Therapy, and Speech Therapy services.		
Office location	$10/visit	
Outpatient Department of a Hospital	$10/visit	
Durable medical equipment (DME)		
DME	20%	
Breast pump	$0	
Orthotic equipment and devices	$0	
Prosthetic equipment and devices	$0	
Home health care services	$10/visit	
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.		
Home infusion and home injectable therapy services		
Home infusion agency services	$0	
Includes home infusion drugs and medical supplies.		
Home visits by an infusion nurse	$10/visit	
Hemophilia home infusion services	$0	
Includes blood factor products.		
Skilled Nursing Facility (SNF) services		
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	$0	
Hospital-based SNF	$0	
Hospice program services	$0	
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.		

Benefits[5]	Your payment	
	When using a Participating Provider[3]	**CYD[2] applies**
Other services and supplies		
Diabetes care services		
• Devices, equipment, and supplies	20%	
• Self-management training	$10/visit	
Dialysis services	$0	
PKU product formulas and Special Food Products	$0	
Allergy serum billed separately from an office 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**
Outpatient services		
Office visit, including Physician office visit	$10/visit	
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 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

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.

4 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.

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 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.

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.

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

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Outpatient Prescription Drug Rider

Group Rider
HMO/POS

Enhanced Rx $10/20/35 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 Participating[2] 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		
Per prescription, up to a 30-day supply.		
Contraceptive Drugs and devices	$0	
Tier 1 Drugs	$10/prescription	
Tier 2 Drugs	$20/prescription	
Tier 3 Drugs	$35/prescription	
Tier 4 Drugs (excluding Specialty Drugs)	20% up to $200/prescription	
Mail service pharmacy prescription Drugs		
Per prescription, up to a 90-day supply.		
Contraceptive Drugs and devices	$0	
Tier 1 Drugs	$20/prescription	
Tier 2 Drugs	$40/prescription	
Tier 3 Drugs	$70/prescription	
Tier 4 Drugs (excluding Specialty Drugs)	20% up to $400/prescription	
Network Specialty Pharmacy Drugs		
Per prescription, up to a 30-day supply.		
Tier 4 Specialty Drugs	20% up to $200/prescription	
Oral anticancer Drugs		
Per prescription, up to a 30-day supply.	20% up to $200/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.

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 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 Drug is available. If you 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. If your Physician or Health Care Provider prescribes a Brand Drug and indicates that a Generic Drug equivalent should not be substituted, you pay your applicable tier Copayment or Coinsurance. If your Physician or Health Care Provider does not indicate that a Generic Drug equivalent should not be substituted, you 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.

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

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Chiropractic Services Rider

Group Rider
HMO/POS

Summary of Benefits

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

Benefits	Your Payment	
Covered Services must be determined as Medically Necessary by American Specialty Health Plans of California, Inc. (ASH Plans). *Up to 30 visits per Member, per Calendar Year.* *Services are not subject to the Calendar Year Deductible and do count towards the Calendar Year Out-of-Pocket Maximum.*	**When using an ASH Participating Provider**	**When using a Non-Participating Provider**
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 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 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 Services, 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 Services 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 Services from a provider other than a Participating Provider are Medically Necessary, you will be responsible for the Participating Provider Copayment amount.

Benefits

Chiropractic Services

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

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

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 chiropractic services.
ASH Participating Provider	A chiropractor under contract with ASH Plans to provide Covered Services 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.

blue of california

Group Plan
HMO Plan

Summary of Benefits

Trio HMO Zero Admit 10

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: 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 Services under the Plan.

		When using a Participating Provider[3]
Calendar Year medical Deductible	*Individual coverage*	$0
	Family coverage	$0: individual
		$0: Family

Calendar Year Out-of-Pocket Maximum[4]

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

	When using a Participating Provider[3]
Individual coverage	$1,500
Family coverage	$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 Services.

Benefits[5]	Your payment	
	When using a Participating Provider[3]	CYD[2] applies
Preventive Health Services[6]		
Preventive Health Services	$0	
California Prenatal Screening Program	$0	
Physician services		
Primary care office visit	$10/visit	
Trio+ specialist care office visit (self-referral)	$10/visit	
Other specialist care office visit (referred by PCP)	$10/visit	
Physician home visit	$10/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	$10/visit	
Includes nurse practitioners, physician assistants, and therapists.		
Teladoc 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	
Podiatric services	$10/visit	
Pregnancy and maternity care[6]		
Physician office visits: prenatal and postnatal	$0	
Physician services for pregnancy termination	$0	
Emergency services		
Emergency room services	$100/visit	
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.		
Emergency room Physician services	$0	

Benefits[5]	Your payment	
	When using a Participating Provider[3]	CYD[2] applies
Urgent care center services	$10/visit	
Ambulance services *This payment is for emergency or authorized transport.*	$100/transport	
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 *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	$0	
• Physician inpatient services	$0	
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	$0	
• Outpatient Department of a Hospital	$0	
X-ray and imaging services *Includes diagnostic mammography.*		
• Outpatient radiology center	$0	
• Outpatient Department of a Hospital	$0	
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	$0	
• Outpatient Department of a Hospital	$0	

Benefits[5]	Your payment	
	When using a Participating Provider[3]	CYD[2] applies
Radiological and nuclear imaging services		
• Outpatient radiology center	$0	
• Outpatient Department of a Hospital	$0	
Rehabilitative and Habilitative Services		
Includes Physical Therapy, Occupational Therapy, Respiratory Therapy, and Speech Therapy services.		
Office location	$10/visit	
Outpatient Department of a Hospital	$10/visit	
Durable medical equipment (DME)		
DME	20%	
Breast pump	$0	
Orthotic equipment and devices	$0	
Prosthetic equipment and devices	$0	
Home health care services	$10/visit	
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.		
Home infusion and home injectable therapy services		
Home infusion agency services	$0	
Includes home infusion drugs and medical supplies.		
Home visits by an infusion nurse	$10/visit	
Hemophilia home infusion services	$0	
Includes blood factor products.		
Skilled Nursing Facility (SNF) services		
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	$0	
Hospital-based SNF	$0	
Hospice program services	$0	
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.		

Benefits[5]	Your payment	
	When using a Participating Provider[3]	**CYD[2] applies**
Other services and supplies		
Diabetes care services		
• Devices, equipment, and supplies	20%	
• Self-management training	$10/visit	
Dialysis services	$0	
PKU product formulas and Special Food Products	$0	
Allergy serum billed separately from an office 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**
Outpatient services		
Office visit, including Physician office visit	$10/visit	
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 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

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.

4 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.

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 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.

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.

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

blue of california

Group Plan
PPO Plan

Summary of Benefits

Full PPO Combined Deductible 20-200 90/70

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: **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 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 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[3] or Non-Participating[4] Provider
Calendar Year medical Deductible	*Individual coverage*	$200
	Family coverage	$200: individual $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	$2,700	$5,200
Family coverage	$2,700: individual $5,400: Family	$5,200: individual $10,400: 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.

Benefits[6]	Your payment			
	When using a Participating Provider[3]	CYD[2] 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	$20/visit		30%	✔
Specialist care office visit	$20/visit		30%	✔
Physician home visit	$20/visit		30%	✔
Physician or surgeon services in an outpatient facility	10%	✔	30%	✔
Physician or surgeon services in an inpatient facility	10%	✔	30%	✔
Other professional services				
Other practitioner office visit	$20/visit		30%	✔
Includes nurse practitioners, physician assistants, and therapists.				
Acupuncture services	$25/visit		30%	✔
Up to 20 visits per Member, per Calendar Year.				
Chiropractic services	$25/visit		30%	✔
Up to 20 visits per Member, per Calendar Year.				
Teladoc consultation	$5/consult		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	10%	✔	Not covered	
Podiatric services	$20/visit		30%	✔
Pregnancy and maternity care[7]				
Physician office visits: prenatal and postnatal	10%	✔	30%	✔
Physician services for pregnancy termination	10%	✔	30%	✔

Benefits[6]	Your payment			
	When using a Participating Provider[3]	CYD[2] applies	When using a Non-Participating Provider[4]	CYD[2] applies
Emergency services				
Emergency room services *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.*	$150/visit plus 10%		$150/visit plus 10%	
Emergency room Physician services	10%		10%	
Urgent care center services	$20/visit		30%	✔
Ambulance services *This payment is for emergency or authorized transport.*	10%	✔	10%	✔
Outpatient facility services				
Ambulatory Surgery Center	5%	✔	30% of up to $350/day plus 100% of additional charges	✔
Outpatient Department of a Hospital: surgery	15%	✔	30% of up to $350/day plus 100% of additional charges	✔
Outpatient Department of a Hospital: treatment of illness or injury, radiation therapy, chemotherapy, and necessary supplies	10%	✔	30% of up to $350/day plus 100% of additional charges	✔
Inpatient facility services				
Hospital services and stay	10%	✔	30% of up to $600/day plus 100% of additional charges	✔
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	10%	✔	Not covered	
• Physician inpatient services	10%	✔	Not covered	

Benefits[6]	Your payment			
	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				
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	10%	✔	Not covered	
Outpatient facility services	15%	✔	Not covered	
Physician services	10%	✔	Not covered	
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	$20/visit	✔	30%	✔
• Outpatient Department of a Hospital	$45/visit	✔	30% of up to $350/day plus 100% of additional charges	✔
X-ray and imaging services				
Includes diagnostic mammography.				
• Outpatient radiology center	$20/visit	✔	30%	✔
• Outpatient Department of a Hospital	$45/visit	✔	30% of up to $350/day plus 100% of additional charges	✔

Benefits[6]	Your payment			
	When using a Participating Provider[3]	CYD[2] applies	When using a Non-Participating Provider[4]	CYD[2] applies
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	$20/visit	✔	30%	✔
• Outpatient Department of a Hospital	$45/visit	✔	30% of up to $350/day plus 100% of additional charges	✔
Radiological and nuclear imaging services				
• Outpatient radiology center	10%	✔	30%	✔
• Outpatient Department of a Hospital	20%	✔	30% of up to $350/day plus 100% of additional charges	✔
Rehabilitative and Habilitative Services *Includes Physical Therapy, Occupational Therapy, Respiratory Therapy, and Speech Therapy services.*				
Office location	$20/visit	✔	30%	✔
Outpatient Department of a Hospital	$20/visit	✔	30% of up to $350/day plus 100% of additional charges	✔
Durable medical equipment (DME)				
DME	10%	✔	30%	✔
Breast pump	$0		Not covered	
Orthotic equipment and devices	10%	✔	30%	✔
Prosthetic equipment and devices	10%	✔	30%	✔

Benefits[6]	Your payment			
	When using a Participating Provider[3]	CYD[2] applies	When using a Non-Participating Provider[4]	CYD[2] applies
Home health care services *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.*	10%	✔	Not covered	
Home infusion and home injectable therapy services				
Home infusion agency services *Includes home infusion drugs and medical supplies.*	10%	✔	Not covered	
Home visits by an infusion nurse	10%	✔	Not covered	
Hemophilia home infusion services *Includes blood factor products.*	10%	✔	Not covered	
Skilled Nursing Facility (SNF) services *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	10%	✔	10%	✔
Hospital-based SNF	10%	✔	30% of up to $600/day plus 100% of additional charges	✔
Hospice program services *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	10%	✔	30%	✔
• Self-management training	$20/visit		30%	✔

Benefits[6]	Your payment			
	When using a Participating Provider[3]	CYD[2] applies	When using a Non-Participating Provider[4]	CYD[2] applies
Dialysis services	10%	✔	30% of up to $350/day plus 100% of additional charges	✔
PKU product formulas and Special Food Products	10%	✔	10%	✔
Allergy serum billed separately from an office visit	10%	✔	30%	✔

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	When using a MHSA Non-Participating Provider[4]	CYD[2] applies
Outpatient services				
Office visit, including Physician office visit	$20/visit		30%	✔
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	✔	30%	✔
Partial Hospitalization Program	$0	✔	30% of up to $350/day plus 100% of additional charges	✔
Psychological Testing	$0	✔	30%	✔
Inpatient services				
Physician inpatient services	$0	✔	30%	✔
Hospital services	10%	✔	30% of up to $600/day plus 100% of additional charges	✔
Residential Care	10%	✔	30% of up to $600/day plus 100% of additional charges	✔

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
- 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 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 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.

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.

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

- Coinsurance is calculated from the Allowable Amount or Benefit maximum, whichever is less.

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, or
- any charges above the stated dollar amount, which is the Benefit maximum.

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

- Coinsurance is calculated from the Allowable Amount or Benefit maximum, whichever is less.

Notes

- Charges above the Allowable Amount or Benefit maximum 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.

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 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.

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

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Outpatient Prescription Drug Rider

Group Rider
PPO

Enhanced Rx $10/20/35 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 Participating[2] or Non-Participating[3] 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				
Per prescription, up to a 30-day supply.				
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	$20/prescription		25% plus $20/prescription	
Tier 3 Drugs	$35/prescription		25% plus $35/prescription	
Tier 4 Drugs (excluding Specialty Drugs)	30% up to $200/prescription		30% up to $200/prescription plus 25% of purchase price	
Mail service pharmacy prescription Drugs				
Per prescription, up to a 90-day supply.				
Contraceptive Drugs and devices	$0		Not covered	
Tier 1 Drugs	$20/prescription		Not covered	
Tier 2 Drugs	$40/prescription		Not covered	
Tier 3 Drugs	$70/prescription		Not covered	
Tier 4 Drugs (excluding Specialty Drugs)	30% up to $400/prescription		Not covered	

Network Specialty Pharmacy Drugs *Per prescription, up to a 30-day supply.* Tier 4 Specialty Drugs	30% up to $200/prescription		Not covered	
Oral anticancer Drugs *Per prescription, up to a 30-day supply.*	30% up to $200/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.

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 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 Drug is available. If you 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. If your Physician or Health Care Provider prescribes a Brand Drug and indicates that a Generic Drug equivalent should not be substituted,

Notes

you pay your applicable tier Copayment or Coinsurance. If your Physician or Health Care Provider does not indicate that a Generic Drug equivalent should not be substituted, you 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.

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