Prescription Drug Benefits[7,8]	Your payment		
	When using a Participating Pharmacy[3]		CYD[2] applies
Tier 4 Drugs	20% up to $250/prescription	20% up to $250/prescription	
Retail pharmacy prescription Drugs			
Per prescription, for a 90-day supply.			
Contraceptive Drugs and devices	$0	$0	
Tier 1 Drugs	$30/prescription	$45/prescription	
Tier 2 Drugs	$75/prescription	$120/prescription	
Tier 3 Drugs	$90/prescription	$150/prescription	
Tier 4 Drugs	20% up to $750/prescription	20% up to $750/prescription	
Mail service pharmacy prescription Drugs			
Per prescription, for a 31-90-day supply.			
Contraceptive Drugs and devices	$0		
Tier 1 Drugs	$20/prescription		
Tier 2 Drugs	$50/prescription		
Tier 3 Drugs	$60/prescription		
Tier 4 Drugs	20% up to $500/prescription		

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
Pediatric dental[9]		
Diagnostic and preventive services		
• Oral exam	$0	
• Preventive – cleaning	$0	
• Preventive – x-ray	$0	
• Sealants per tooth	$0	
• Topical fluoride application	$0	
• Space maintainers - fixed	$0	
Basic services		
• Restorative procedures	20%	
• Periodontal maintenance	20%	
• Adjunctive general services	20%	
Major services		
• Oral surgery	50%	
• Endodontics	50%	
• Periodontics (other than maintenance)	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 Dentist[3]**	**CYD[2] applies**
• Crowns and casts	50%	
• Prosthodontics	50%	
Orthodontics (Medically Necessary)	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**
Pediatric vision[10]		
Comprehensive eye examination		
One exam per Calendar Year.		
• Ophthalmologic visit	$0	
• Optometric visit	$0	
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	
• Non-standard lenses	All charges above $60	
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	
Up to two pairs per eye per Calendar Year.		
Elective (cosmetic/convenience)		
Standard and non-standard, hard	$0	
Up to a 3 month supply for each eye per Calendar Year based on lenses selected.		
Standard and non-standard, soft	$0	
Up to a 6 month supply for each eye per Calendar Year based on lenses selected.		
• Eyeglass frames		
Collection frames	$0	
Non-collection frames	All charges above $150	

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**
• 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	
Lined bifocal	$0	
Lined trifocal	$0	
Lenticular	$0	
Optional eyeglass lenses and treatments		
• Ultraviolet protective coating (standard only)	$0	
• Polycarbonate lenses	$0	
• Standard progressive lenses	$55	
• Premium progressive lenses	$95	
• Anti-reflective lens coating (standard only)	$35	
• Photochromic - glass lenses	$25	
• Photochromic - plastic lenses	$25	
• High index lenses	$30	
• Polarized lenses	$45	
Low vision testing and equipment		
• Comprehensive low vision exam	35%	
Once every 5 Calendar Years.		
• Low vision devices	35%	
One aid per Calendar Year.		

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

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

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

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

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.

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

9 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.

10 Pediatric Vision Coverage:

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

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 $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.