blue california

# Summary of Benefits

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

## Bronze Full PPO 7500/65 OffEx

This Summary of Benefits shows the amount you will pay for Covered Benefits 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 Benefits 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 Benefits under the Plan. Blue Shield pays for some Covered Benefits 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 and pharmacy Deductible** | *Individual coverage* | $7,500 | $15,000 |
| *This Plan combines medical and pharmacy Deductibles into one Calendar Year Deductible* | *Family coverage* | $7,500: individual<br>$15,000: Family | $15,000: individual<br>$30,000: Family |

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

An Out-of-Pocket Maximum is the most a Member will pay for Covered Benefits 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* | $11,000 | $22,000 |
| *Family coverage* | $11,000: individual<br>$22,000: Family | $22,000: individual<br>$44,000: 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 Benefits.

**First Dollar Coverage:** 10 office visits per Calendar Year

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This Plan has first dollar coverage (FDC) for 10 office visits with Participating Providers. This means Blue Shield will pay for these Covered Benefits 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 or participating Health Care Provider for any combination of these services:

- Primary care office visit (by a Primary Care Physician)
- Other practitioner office visit
- Mental health or substance use disorder office visit
- Urgent care
- Physician home visit

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** | | | | | |
| Virtual Blue program primary or Specialist care visit | $0 | | | Not covered | |
| Primary care office visit | $65/visit | ✔ | ✔ | 50% | ✔ |
| Specialist care office visit | 50% | ✔ | | 50% | ✔ |
| Physician home visit | $65/visit | ✔ | ✔ | 50% | ✔ |
| Physician or surgeon services in an Outpatient Facility | 50% | ✔ | | 50% | ✔ |
| Physician or surgeon services in an inpatient facility | 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 |
| **Other professional services** | | | | | |
| Other practitioner office visit<br>*Includes nurse practitioners, physician assistants, therapists, and podiatrists.* | $65/visit | ✔ | ✔ | 50% | ✔ |
| Acupuncture services | 50% | ✔ | | 50% | ✔ |
| Chiropractic services<br>*Up to 20 visits per Member, per Calendar Year.* | 50% | ✔ | | 50% | ✔ |
| 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 | $0 | | | Not covered | |
| Medical nutrition therapy, not related to diabetes | 50% | ✔ | | 50% | ✔ |
| **Pregnancy and maternity care** | | | | | |
| Physician office visits: prenatal and initial postnatal | $0 | | | 50% | ✔ |
| Abortion and abortion-related services | $0 | | | $0 | |
| **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% | ✔ |

| 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 |
| **Urgent care center services** | $65/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 | ✔ |
| Outpatient Department of a Hospital: treatment of illness or injury, radiation therapy, chemotherapy, and necessary supplies | 50% | ✔ | | 50%<br>Subject to a Benefit maximum of $350/day | ✔ |
| **Inpatient facility services** | | | | | |
| Hospital services and stay | 50% | ✔ | | 50%<br>Subject to a Benefit maximum of $2,000/day | ✔ |
| Transplant services<br>*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 | |

| 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 |
| **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 | |
| **Diagnostic x-ray, imaging, pathology, and laboratory services** | | | | | |
| *This payment is for Covered Benefits that are diagnostic, non-Preventive Health Services, and diagnostic radiological procedures. For the payments for Covered Benefits that are considered Preventive Health Services, see Preventive Health Services.* | | | | | |
| Laboratory and pathology services | | | | | |
| *Includes diagnostic Papanicolaou (Pap) test.* | | | | | |
| • Laboratory center | 50% | ✔ | | 50% | ✔ |
| • Outpatient Department of a Hospital | 50% | ✔ | | 50% Subject to a Benefit maximum of $350/day | ✔ |
| Basic imaging services | | | | | |
| *Includes plain film X-rays, ultrasounds, and diagnostic mammography.* | | | | | |
| • Outpatient radiology center | 50% | ✔ | | 50% | ✔ |
| • Outpatient Department of a Hospital | 50% | ✔ | | 50% 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 |
| Other outpatient non-invasive diagnostic testing<br>*Testing to diagnose illness or injury such as vestibular function tests, EKG, cardiac monitoring, non-invasive vascular studies, sleep medicine testing, muscle and range of motion tests, EEG, and EMG.* | | | | | |
| • Office location | 50% | ✔ | | 50% | ✔ |
| • Outpatient Department of a Hospital | 50% | ✔ | | 50%<br>Subject to a Benefit maximum of $350/day | ✔ |
| Advanced imaging services<br>*Includes diagnostic radiological and nuclear imaging such as CT scans, MRIs, MRAs, and PET scans.* | | | | | |
| • Outpatient radiology center | 50% | ✔ | | 50% | ✔ |
| • 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 | 50% | ✔ | | 50% | ✔ |
| Outpatient Department of a Hospital | 50% | ✔ | | 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 | |

| 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 |
| **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, medical supplies, and visits by a nurse.* | $45/visit | ✔ | | Not covered | |
| Hemophilia home infusion services<br>*Includes blood factor products.* | $45/visit | ✔ | | Not covered | |
| **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% | ✔ |
| • Medical nutrition therapy | $0 | | | 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 |
| 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 or Substance Use Disorder Benefits | Your payment | | | | |
|---|---|---|---|---|---|
| | When using a Participating Provider[3] | CYD[2] applies | FDC applies | When using a Non-Participating Provider[4] | CYD[2] applies |
| **Outpatient services** | | | | | |
| Virtual Blue program mental health visit | $0 | | | Not covered | |
| Office visit, including Physician office visit | $65/visit | ✔ | ✔ | 50% | ✔ |
| Other outpatient services, including intensive outpatient care, electroconvulsive therapy, transcranial magnetic stimulation, Behavioral Health Treatment for pervasive developmental disorder or autism | | | | | |
| • Office location, clinic, home, or other non-institutional facility setting | 50% | ✔ | | 50% | ✔ |
| • Outpatient Department of a Hospital | 50% | ✔ | | 50%<br>Subject to a Benefit maximum of $350/day | ✔ |
| Office-based opioid treatment | 50% | ✔ | | 50% | ✔ |
| Partial Hospitalization Program | 50% | ✔ | | 50%<br>Subject to a Benefit maximum of $350/day | ✔ |
| Neuropsychological and Psychological Testing | 50% | ✔ | | 50% | ✔ |
| **Inpatient services** | | | | | |
| Physician inpatient services | 50% | ✔ | | 50% | ✔ |

| Mental Health or Substance Use Disorder Benefits | Your payment | | | | |
|---|---|---|---|---|---|
| | When using a Participating Provider[3] | CYD[2] applies | FDC applies | When using a Non-Participating Provider[4] | CYD[2] applies |
| Hospital services | 50% | ✔ | | 50%<br>Subject to a Benefit maximum of $2,000/day | ✔ |
| Residential Care | 50% | ✔ | | 50%<br>Subject to a Benefit maximum of $2,000/day | ✔ |

| Prescription Drug Benefits[8,9] | Your payment | | | | |
|---|---|---|---|---|---|
| | 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**<br>*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 | 50% up to $250/prescription | 50% up to $500/prescription | ✔ | Not covered | |
| Tier 3 Drugs | 50% up to $250/prescription | 50% up to $500/prescription | ✔ | Not covered | |
| Tier 4 Drugs | 50% up to $500/prescription | 50% up to $500/prescription | ✔ | Not covered | |
| **Retail pharmacy prescription Drugs**<br>*Per prescription, for a 90-day supply.* | | | | | |
| Contraceptive Drugs and devices | $0 | $0 | | Not covered | |
| Tier 1 Drugs | $60/prescription | $75/prescription | | Not covered | |
| Tier 2 Drugs | 50% up to $750/prescription | 50% up to $1,500/prescription | ✔ | Not covered | |
| Tier 3 Drugs | 50% up to $750/prescription | 50% up to $1,500/prescription | ✔ | Not covered | |
| Tier 4 Drugs | 50% up to $1,500/prescription | 50% up to $1,500/prescription | ✔ | Not covered | |

| Prescription Drug Benefits[8,9] | Your payment | | | |
|---|---|---|---|---|
| | When using a Participating Pharmacy[3] | CYD[2] applies | When using a Non-Participating Pharmacy[4] | CYD[2] applies |
| **Home delivery pharmacy prescription Drugs** | | | | |
| *Per prescription, for a 31-90-day supply.* | | | | |
| Contraceptive Drugs and devices | $0 | | Not covered | |
| Tier 1 Drugs | $40/prescription | | Not covered | |
| Tier 2 Drugs | 50% up to $500/prescription | ✔ | Not covered | |
| Tier 3 Drugs | 50% up to $500/prescription | ✔ | Not covered | |
| Tier 4 Drugs | 50% up to $500/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% | |
| • 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 | |
| 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 | |

| 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** |
| • Eyeglass lenses<br>*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 | |
| • 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 | |

## Prior Authorization

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

- Advanced imaging services
- Outpatient mental health services, except office visits and office-based opioid treatment
- Inpatient facility services
- 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 Benefits under the Plan.

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

*Covered Benefits not subject to the Calendar Year combined medical and pharmacy Deductible.* Some Covered Benefits received from Participating Providers are paid by Blue Shield before you meet any Calendar Year combined medical and pharmacy Deductible. These Covered Benefits 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 combined medical and pharmacy Deductible. Covered Benefits with first dollar coverage are identified with a check mark (✔) in the "FDC applies" column in the Benefits chart above.

*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.

## Notes

**3 Using Participating Providers:**

*Participating Providers have a contract to provide health care services to Members.* When you receive Covered Benefits 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.

**4 Using Non-Participating Providers:**

*Non-Participating Providers do not have a contract to provide health care services to Members.* When you receive Covered Benefits 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 Deductible or 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):**

*Calendar Year Out-of-Pocket Maximum explained.* The Out-of-Pocket Maximum is the most you are required to pay for Covered Benefits in a Calendar Year. Once you reach your Out-of-Pocket Maximum, Blue Shield will pay 100% of the Allowable Amount for Covered Benefits 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 Benefits 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 Calendar Year combined medical and pharmacy 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 Benefits do not accumulate to the Family Out-of-Pocket Maximum.

**6 Separate Member Payments When Multiple Covered Benefits are Received:**

Each time you receive multiple Covered Benefits, 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.

## Notes

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

**8 Outpatient Prescription Drug Coverage:**

**Medicare Part D-creditable coverage-**

This Plan's 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 plan's 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.

**9 Outpatient Prescription Drug Coverage:**

*Brand Drug coverage when a Generic or Biosimilar Drug is available.* If you, the Physician, or Health Care Provider, select a Brand Drug when a Generic Drug equivalent or Biosimilar Drug is available, you are responsible for the difference between the cost to Blue Shield for the Brand Drug and its Generic Drug equivalent or Biosimilar Drug plus the applicable tier Copayment or Coinsurance of the Brand Drug. This difference in cost will not count towards any Calendar Year pharmacy Deductible, medical Deductible, or the Calendar Year Out-of-Pocket Maximum.

See the Obtaining outpatient prescription Drugs at a Participating Pharmacy section of the EOC for more information about how a brand contraceptive may be covered without a Copayment or Coinsurance.

*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.

*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.

*Home delivery.* You pay the applicable 30-day retail pharmacy Copayment or Coinsurance for a 30-day supply or less from the home delivery pharmacy.

*Insulin.* You will not pay more than $35 for a 30-day supply of Formulary insulin Prescription Drugs from a Participating Pharmacy.

**10 Pediatric Dental Coverage:**

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

*Orthodontic Covered Benefits.* The Copayment or Coinsurance for Medically Necessary orthodontic Covered Benefits 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.*

## Notes

**11 Pediatric Vision Coverage:**

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

*Covered Benefits 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 $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.