| Prescription Drug Benefits[8,9] | Your payment | | | | |
|---|---|---|---|---|---|
| *A separate Calendar Year pharmacy Deductible applies.* | **When using a Participating Pharmacy[3]** | | **CYD[2] applies** | **When using a Non-Participating Pharmacy[4]** | **CYD[2] applies** |
| | **Level A** | **Level B** | | | |
| **Retail pharmacy prescription Drugs** | | | | | |
| *Per prescription, up to a 30-day supply.* | | | | | |
| Contraceptive Drugs and devices | $0 | $0 | | Not covered | |
| Tier 1 Drugs | $25/prescription | $30/prescription | | Not covered | |
| Tier 2 Drugs | $50/prescription | $70/prescription | ✔ | Not covered | |
| Tier 3 Drugs | $80/prescription | $110/prescription | ✔ | Not covered | |
| Tier 4 Drugs | 30% up to $250/prescription | 30% up to $250/prescription | ✔ | Not covered | |
| **Retail pharmacy prescription Drugs** | | | | | |
| *Per prescription, for a 90-day supply.* | | | | | |
| Contraceptive Drugs and devices | $0 | $0 | | Not covered | |
| Tier 1 Drugs | $75/prescription | $90/prescription | | Not covered | |
| Tier 2 Drugs | $150/prescription | $210/prescription | ✔ | Not covered | |
| Tier 3 Drugs | $240/prescription | $330/prescription | ✔ | Not covered | |
| Tier 4 Drugs | 30% up to $750/prescription | 30% up to $750/prescription | ✔ | Not covered | |
| **Mail service pharmacy prescription Drugs** | | | | | |
| *Per prescription, for a 31-90-day supply.* | | | | | |
| Contraceptive Drugs and devices | $0 | | | Not covered | |
| Tier 1 Drugs | $50/prescription | | | Not covered | |
| Tier 2 Drugs | $100/prescription | | ✔ | Not covered | |
| Tier 3 Drugs | $160/prescription | | ✔ | Not covered | |
| Tier 4 Drugs | 30% 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% | |

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

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

| Pediatric Benefits | Your payment | | | |
|---|---|---|---|---|
| *Pediatric Benefits are available through the end of the month in which the Member turns 19.* | **When using a Participating Provider[3]** | **CYD[2] applies** | **When using a Non-Participating Provider[4]** | **CYD[2] applies** |
| Eyewear/materials | | | | |
| *One eyeglass frame and eyeglass lenses, or contact lenses instead of eyeglasses, up to the Benefit per Calendar Year. Any exceptions are noted below.* | | | | |
| • Contact lenses | | | | |
| Non-elective (Medically Necessary) - hard or soft | $0 | | All charges above $225 | |
| *Up to two pairs per eye per Calendar Year.* | | | | |
| Elective (cosmetic/convenience) | | | | |
| Standard and non-standard, hard | $0 | | All charges above $75 | |
| *Up to a 3 month supply for each eye per Calendar Year based on lenses selected.* | | | | |
| Standard and non-standard, soft | $0 | | All charges above $75 | |
| *Up to a 6 month supply for each eye per Calendar Year based on lenses selected.* | | | | |
| • Eyeglass frames | | | | |
| Collection frames | $0 | | All charges above $40 | |
| Non-collection frames | All charges above $150 | | All charges above $40 | |
| • Eyeglass lenses | | | | |
| *Lenses include choice of glass or plastic lenses, all lens powers (single vision, bifocal, trifocal, lenticular), fashion or gradient tint, scratch coating, oversized, and glass-grey #3 prescription sunglasses.* | | | | |
| Single vision | $0 | | All charges above $25 | |
| Lined bifocal | $0 | | All charges above $35 | |
| Lined trifocal | $0 | | All charges above $45 | |
| Lenticular | $0 | | All charges above $45 | |
| Optional eyeglass lenses and treatments | | | | |
| • Ultraviolet protective coating (standard only) | $0 | | Not covered | |
| • Polycarbonate lenses | $0 | | Not covered | |
| • Standard progressive lenses | $55 | | Not covered | |

## Pediatric Benefits

| *Pediatric Benefits are available through the end of the month in which the Member turns 19.* | Your payment: When using a Participating Provider[3] | CYD[2] applies | When using a Non-Participating Provider[4] | CYD[2] applies |
|---|---|---|---|---|
| • 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 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

## Notes

**10 Pediatric Dental Coverage:**

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

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

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

**11 Pediatric Vision Coverage:**

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

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

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

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

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

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