blue of california

Summary of Benefits

Individual and Family Plan
HMO Plan

Silver 70 Off Exchange Trio HMO

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: **IFP Trio HMO Network**

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

Pharmacy Network: **Rx Ultra**

Drug Formulary: **Standard Formulary**

Calendar Year Deductibles (CYD)[2]

A Calendar Year Deductible (CYD) is the amount a Member pays each Calendar Year before Blue Shield pays for Covered Services under the Plan. Blue Shield pays for some Covered Services before the Calendar Year Deductible is met, as noted in the Benefits chart below.

		When using a Participating Provider[3]
Calendar Year medical Deductible	*Individual coverage*	$5,200
	Family coverage	$5,200: individual
		$10,400: Family
Calendar Year pharmacy Deductible	*Individual coverage*	$50
	Family coverage	$50: individual
		$100: 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	$9,800
Family coverage	$9,800: individual
	$19,600: 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	$50/visit	
Trio+ specialist care office visit (self-referral)	$90/visit	
Other specialist care office visit (referred by PCP)	$90/visit	
Physician home visit	$50/visit	
Physician or surgeon services in an Outpatient Facility	30%	
Physician or surgeon services in an inpatient facility	30%	
Other professional services		
Other practitioner office visit *Includes nurse practitioners, physician assistants, therapists, and podiatrists.*	$50/visit	
Acupuncture services	$50/visit	
Chiropractic services	Not covered	
Teladoc Health 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	
• Infertility services	Not covered	
Pregnancy and maternity care		
Physician office visits: prenatal and initial postnatal	$0	
Abortion and abortion-related services	$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.*	$400/visit	
Emergency room Physician services	$0	

Benefits[5]	Your payment	
	When using a Participating Provider[3]	**CYD[2] applies**
Urgent care center services	$50/visit	
Ambulance services *This payment is for emergency or authorized transport.*	$255/transport	
Outpatient Facility services		
Ambulatory Surgery Center	30%	
Outpatient Department of a Hospital: surgery	30%	
Outpatient Department of a Hospital: treatment of illness or injury, radiation therapy, chemotherapy, and necessary supplies	30%	
Inpatient facility services		
Hospital services and stay	30%	✔
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	30%	✔
• Physician inpatient services	30%	
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. For the payments for Covered Services that are considered Preventive Health Services, see Preventive Health Services.*		
Laboratory and pathology services *Includes diagnostic Papanicolaou (Pap) test.*		
• Laboratory center	$50/visit	
• Outpatient Department of a Hospital	$50/visit	
Basic imaging services *Includes plain film X-rays, ultrasounds, and diagnostic mammography.*		
• Outpatient radiology center	$95/visit	
• Outpatient Department of a Hospital	$95/visit	
Other outpatient non-invasive diagnostic testing *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	$95/visit	
• Outpatient Department of a Hospital	$95/visit	

Benefits[5]	Your payment When using a Participating Provider[3]	CYD[2] applies
Advanced imaging services *Includes diagnostic radiological and nuclear imaging such as CT scans, MRIs, MRAs, and PET scans.* • Outpatient radiology center • Outpatient Department of a Hospital	 $325/visit $325/visit	
Rehabilitative and habilitative services *Includes physical therapy, occupational therapy, respiratory therapy, and speech therapy services. There is no visit limit for rehabilitative or habilitative services.* Office location Outpatient Department of a Hospital	 $50/visit $50/visit	
Durable medical equipment (DME) DME Breast pump Orthotic equipment and devices Prosthetic equipment and devices	 20% $0 20% 20%	
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.*	$45/visit	
Home infusion and home injectable therapy services Home infusion agency services *Includes home infusion drugs, medical supplies, and visits by a nurse.* Hemophilia home infusion services *Includes blood factor products.*	 $0 $0 	
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 Hospital-based SNF	 30% 30%	 ✔ ✔
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	

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	$0	
• Medical nutrition therapy	$0	
Dialysis services	30%	
PKU product formulas and special food products	$0	
Allergy serum billed separately from an office visit	30%	

Mental Health and Substance Use Disorder Benefits	Your payment	
	When using a Participating Provider[3]	CYD[2] applies
Outpatient services		
Office visit, including Physician office visit	$50/visit	
Teladoc Health mental health	$0	
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	30%	
Hospital services	30%	✔
Residential care	30%	✔

Prescription Drug Benefits[7,8]	Your payment	
A separate Calendar Year pharmacy Deductible applies.	When using a Participating Pharmacy[3]	CYD[2] applies
Retail pharmacy prescription Drugs		
Per prescription, up to a 30-day supply.		
Contraceptive Drugs and devices	$0	
Tier 1 Drugs	$19/prescription	
Tier 2 Drugs	$60/prescription	✔
Tier 3 Drugs	$90/prescription	✔
Tier 4 Drugs	20% up to $250/prescription	✔

Prescription Drug Benefits[7,8]	Your payment	
A separate Calendar Year pharmacy Deductible applies.	**When using a Participating Pharmacy[3]**	**CYD[2] applies**
Mail service pharmacy prescription Drugs		
Per prescription, for a 90-day supply.		
Contraceptive Drugs and devices	$0	
Tier 1 Drugs	$57/prescription	
Tier 2 Drugs	$180/prescription	✔
Tier 3 Drugs	$270/prescription	✔
Tier 4 Drugs	20% up to $750/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%	
• 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	
• 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	

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

This Plan has a separate medical Deductible and pharmacy 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.

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):

Calendar Year Out-of-Pocket Maximum explained. The Out-of-Pocket Maximum is the most you are required to pay for Covered Services in a Calendar Year. Once you reach your Out-of-Pocket Maximum, Blue Shield will pay 100% of the Allowed Charges for Covered Services for the rest of the Calendar Year.

Your payment after you reach the Calendar Year OOPM. You will continue to pay all charges for services that are not covered, charges above the Allowed Charges, and charges for services above any Benefit maximum.

Any Deductibles count towards the OOPM. Any amounts you pay that count towards the Calendar Year medical or pharmacy Deductible also count towards the Calendar Year Out-of-Pocket Maximum.

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.

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 payment in addition to an allergy serum payment 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.

7 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.

8 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.

Notes

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.

Mail service Drugs. You may receive up to a 90-day supply for maintenance Drugs from the mail service pharmacy when you pay the applicable retail pharmacy Copayment or Coinsurance for each 30-day supply.

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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.

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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.

NOTICES AVAILABLE ONLINE

Nondiscrimination and Language Assistance Services

Blue Shield complies with applicable state and federal civil rights laws. We also offer language assistance services at no additional cost.

View our nondiscrimination notice and language assistance notice: **blueshieldca.com/notices**. You can also call for language assistance services: **(866) 346-7198 (TTY: 711)**.

If you are unable to access the website above and would like to receive a copy of the nondiscrimination notice and language assistance notice, please call Customer Service at **(888) 256-3650 (TTY: 711)**.

Servicios de asistencia en idiomas y avisos de no discriminación

Blue Shield cumple con las leyes de derechos civiles federales y estatales aplicables. También, ofrecemos servicios de asistencia en idiomas sin costo adicional.

Vea nuestro aviso de no discriminación y nuestro aviso de asistencia en idiomas en **blueshieldca.com/notices**. Para obtener servicios de asistencia en idiomas, también puede llamar al **(866) 346-7198 (TTY: 711)**.

Si no puede acceder al sitio web que aparece arriba y desea recibir una copia del aviso de no discriminación y del aviso de asistencia en idiomas, llame a Servicio al Cliente al **(888) 256-3650 (TTY: 711)**.

非歧視通知和語言協助服務

Blue Shield 遵守適用的州及聯邦政府的民權法。同時，我們免費提供語言協助服務。

如需檢視我司的非歧視通知和語言幫助通知，請造訪 **blueshieldca.com/notices**。您還可致電尋求語言協助服務：**(866) 346-7198 (TTY: 711)**。

如果您無法造訪上述網站，且希望收到一份非歧視通知和語言幫助通知的副本，請致電客戶服務部，電話：**(888) 256-3650 (TTY: 711)**。