



# Changes to your health plan

Effective January 1, 2026, there will be some changes to your plan’s costs and benefits. We are notifying you in advance so you can make informed decisions about your health coverage. Please visit [blueshieldca.com/policies](https://blueshieldca.com/policies) for updated terms and conditions of coverage.

### Cost share changes

Copayment (or copay), coinsurance, and deductible are your share of the cost (“cost share”) when using covered services. This section contains cost changes when using a participating provider, unless otherwise stated. Refer to your *Summary of Benefits (SOB)* for further details.

### Calendar year medical deductible changes

| Description of change                        | What’s changing?             |                                      |
|----------------------------------------------|------------------------------|--------------------------------------|
|                                              | 2025 (this year)             | 2026 (renewal year)                  |
| Your calendar year deductible has increased. | Individual/Family<br>\$0/\$0 | Individual/Family<br>\$1,400/\$2,800 |

### Calendar year out-of-pocket maximum changes

| Description of change                                   | What’s changing?                     |                                      |
|---------------------------------------------------------|--------------------------------------|--------------------------------------|
|                                                         | 2025 (this year)                     | 2026 (renewal year)                  |
| Your calendar year out-of-pocket maximum has increased. | Individual/Family<br>\$3,000/\$6,000 | Individual/Family<br>\$3,350/\$6,700 |

### Calendar year pharmacy deductible changes

| Description of change                                 | What’s changing?             |                                 |
|-------------------------------------------------------|------------------------------|---------------------------------|
|                                                       | 2025 (this year)             | 2026 (renewal year)             |
| Your calendar year pharmacy deductible has increased. | Individual/Family<br>\$0/\$0 | Individual/Family<br>\$50/\$100 |

## Pharmacy prescription drug cost share changes

| Benefit section and description of change                                                                                                      |                     | What's changing?                                                 |                                                           |
|------------------------------------------------------------------------------------------------------------------------------------------------|---------------------|------------------------------------------------------------------|-----------------------------------------------------------|
|                                                                                                                                                |                     | 2025 (this year)                                                 | 2026 (renewal year)                                       |
| <b>Retail pharmacy prescription drugs</b><br>Your copay for tier 1 drugs has increased.<br>The pharmacy deductible for tier 2-4 drugs applies. | <b>Tier 1 drugs</b> | \$5/prescription                                                 | \$8/prescription                                          |
|                                                                                                                                                | <b>Tier 2 drugs</b> | \$25/prescription, pharmacy deductible does not apply            | \$25/prescription, pharmacy deductible applies            |
|                                                                                                                                                | <b>Tier 3 drugs</b> | \$45/prescription, pharmacy deductible does not apply            | \$45/prescription, pharmacy deductible applies            |
|                                                                                                                                                | <b>Tier 4 drugs</b> | 15% up to \$150/prescription, pharmacy deductible does not apply | 15% up to \$150/prescription, pharmacy deductible applies |
| <b>Mail pharmacy prescription drugs</b><br>Your copay for tier 1 drugs has increased.<br>The pharmacy deductible for tier 2-4 drugs applies.   | <b>Tier 1 drugs</b> | \$15/prescription                                                | \$24/prescription                                         |
|                                                                                                                                                | <b>Tier 2 drugs</b> | \$75/prescription, pharmacy deductible does not apply            | \$75/prescription, pharmacy deductible applies            |
|                                                                                                                                                | <b>Tier 3 drugs</b> | \$135/prescription, pharmacy deductible does not apply           | \$135/prescription, pharmacy deductible applies           |
|                                                                                                                                                | <b>Tier 4 drugs</b> | 15% up to \$450/prescription, pharmacy deductible does not apply | 15% up to \$450/prescription, pharmacy deductible applies |

## Medical benefit cost share changes

| Benefit section and summary of change                                                          |                                                                                      | What's changing?                       |                                 |
|------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------|----------------------------------------|---------------------------------|
|                                                                                                |                                                                                      | 2025 (this year)                       | 2026 (renewal year)             |
| <b>Emergency services</b><br>Your copay for these services has increased.                      | <b>Emergency room services</b>                                                       | \$150/visit                            | \$200/visit                     |
| <b>Inpatient facility services</b><br>The calendar year deductible for these services applies. | <b>Hospital services and stay</b>                                                    | 20%, medical deductible does not apply | 20%, medical deductible applies |
|                                                                                                | <b>Transplant services:</b><br><b>Special transplant facility inpatient services</b> | 20%, medical deductible does not apply | 20%, medical deductible applies |

| Benefit section and summary of change                                                                                |                                                          | 2025 (this year)                       | What's changing?<br>2026 (renewal year) |
|----------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------|----------------------------------------|-----------------------------------------|
| <b>Diagnostic X-ray, imaging, pathology, and laboratory services</b><br>Your copay for these services has increased. | <b>Laboratory and pathology services:</b>                |                                        |                                         |
|                                                                                                                      | <b>Laboratory center</b>                                 | \$20/visit                             | \$30/visit                              |
|                                                                                                                      | <b>Outpatient department of a hospital</b>               | \$20/visit                             | \$30/visit                              |
|                                                                                                                      | <b>Basic imaging services:</b>                           |                                        |                                         |
|                                                                                                                      | <b>Outpatient radiology center</b>                       | \$40/visit                             | \$50/visit                              |
|                                                                                                                      | <b>Outpatient department of a hospital</b>               | \$40/visit                             | \$50/visit                              |
|                                                                                                                      | <b>Other outpatient non-invasive diagnostic testing:</b> |                                        |                                         |
|                                                                                                                      | <b>Outpatient radiology center</b>                       | \$40/visit                             | \$50/visit                              |
|                                                                                                                      | <b>Outpatient department of a hospital</b>               | \$40/visit                             | \$50/visit                              |
| <b>Skilled nursing facility (SNF) services</b><br>The calendar year deductible for these services applies.           | <b>Office location</b>                                   | 20%, medical deductible does not apply | 20%, medical deductible applies         |
|                                                                                                                      | <b>Outpatient department of a hospital</b>               | 20%, medical deductible does not apply | 20%, medical deductible applies         |
| <b>Mental health and substance use disorder benefits</b><br>The calendar year deductible for these services applies. | <b>Inpatient services:</b>                               |                                        |                                         |
|                                                                                                                      | <b>Hospital services</b>                                 | 20%, medical deductible does not apply | 20%, medical deductible applies         |
|                                                                                                                      | <b>Residential care</b>                                  | 20%, medical deductible does not apply | 20%, medical deductible applies         |

## Benefit changes and clarifications

Changes to your benefits/services will be reflected in your *Summary of Benefits (SOB)* or *Evidence of Coverage (EOC)*. NOTE: Underlines below indicate added text.

### Benefit changes

These are changes made to your coverage for certain medical and pharmacy services.

| Section name                                       | Description of the change(s)                                                                                                                                                                                                                                                                                                                                          |
|----------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Care outside of California/<br>out-of-area service | These sections in the EOC have been revised to clarify that out-of-area covered healthcare services are restricted to emergency services, urgent services, and out-of-area follow-up care. Any other services will not be covered when processed through an inter-plan arrangement unless the services and out-of-state provider are prior authorized by Blue Shield. |
| General exclusions and<br>limitations table        | This table in the EOC has been revised to add exclusion 32.<br><u>32   Drugs and services that you are not legally obligated to pay, or for which you are not charged. This exclusion does not apply to preventive health services, or FDA-approved contraceptive drugs and devices, or drugs with a USPSTF rating of A or B.</u>                                     |

### Administrative/language clarifications

These are revisions made to your EOC or SOB to help make your coverage easier to understand, but do not impact your coverage or how your benefits/services work.

| Section name                             | Description of the change(s)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |
|------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Prior authorization and<br>PCP referrals | This section in the EOC was revised to clarify time for Blue Shield to make a decision for prior authorization or exception requests within five business days <u>but not to exceed seven calendar days.</u>                                                                                                                                                                                                                                                                                                                                                                   |
| Claims emergency or<br>urgent services   | This section in the EOC was revised to clarify the number of days for claim processing reimbursement as follows:<br><u>Blue Shield will process your claim within 30 calendar days of receipt if it is not missing any required information. If your claim is missing any required information, you or your provider will be notified and asked to submit the missing information. Blue Shield cannot process your claim until we receive the missing information. Once the missing information is received, Blue Shield will have 30 calendar days to process your claim.</u> |
| Pediatric vision benefits                | Correction to the pediatric vision Customer Service phone number. The correct phone number is as follows: <b>(877) 601-9083.</b>                                                                                                                                                                                                                                                                                                                                                                                                                                               |

| Section name                                                                                               | Description of the change(s)                                                                                                                                                                                                   |
|------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Benefit administrators</b>                                                                              | Blue Shield is no longer working with a mental health service administrator to provide mental health and substance use disorder services. Blue Shield Behavioral Health will manage the behavioral health benefit for members. |
| <b>Prescription drug benefits:<br/>Prior authorization/<br/>exception request/step<br/>therapy process</b> | This section in the EOC has been revised to clarify that prior authorization may be granted for one year, <u>however, the timeframe may be greater or less, depending on the medication.</u>                                   |
| <b>Address correction:<br/>Pediatric dental benefits:<br/>dental Customer Service</b>                      | The address for contacting Customer Service has been updated in your 2026 EOC. The updated address is as follows:<br><br>Blue Shield of California<br>Dental Plan Administrator<br>P.O. Box 272540<br>Chico, CA 95927-2540     |

**Please note:** This document is not a contract. For complete benefit descriptions, terms and conditions, exclusions, and limitations of the health plan, please read your EOC.