Summary of Benefits

Platinum 90 Trio HMO

This Summary of Benefits shows the amount you will pay for Covered Services under this Blue Shield of California benefit Plan. It is only a summary and it is part of the contract for health care coverage, called the Evidence of Coverage (EOC). Please read both documents carefully for details.

Provider Network: Trio ACO HMO Network

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

Calendar Year Deductibles (CYD)

A Calendar Year Deductible (CYD) is the amount a Member pays each Calendar Year before Blue Shield pays for Covered Services under the benefit Plan.

<table>
<thead>
<tr>
<th>Calendar Year medical Deductible</th>
<th>Individual coverage</th>
<th>$0</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Family coverage</td>
<td>$0: individual</td>
</tr>
<tr>
<td></td>
<td></td>
<td>$0: Family</td>
</tr>
</tbody>
</table>

Calendar Year Out-of-Pocket Maximum

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.

| Individual coverage | $3,350 |
| Family coverage     | $3,350: individual |
|                     | $6,700: Family |

No Lifetime Benefit Maximum

Under this benefit Plan there is no dollar limit on the total amount Blue Shield will pay for Covered Services in a Member’s lifetime.
### Benefits

<table>
<thead>
<tr>
<th>Your payment</th>
<th>When using a Participating Provider&lt;sup&gt;3&lt;/sup&gt;</th>
<th>CYD&lt;sup&gt;2&lt;/sup&gt; applies</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Preventive Health Services</strong>&lt;sup&gt;4&lt;/sup&gt;</td>
<td>$0</td>
<td></td>
</tr>
<tr>
<td>California Prenatal Screening Program</td>
<td>$0</td>
<td></td>
</tr>
<tr>
<td><strong>Physician services</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Primary care office visit</td>
<td>$15/visit</td>
<td></td>
</tr>
<tr>
<td>Trio+ specialist care office visit (self-referral)</td>
<td>$30/visit</td>
<td></td>
</tr>
<tr>
<td>Other specialist care office visit (referred by PCP)</td>
<td>$30/visit</td>
<td></td>
</tr>
<tr>
<td>Physician home visit</td>
<td>$15/visit</td>
<td></td>
</tr>
<tr>
<td>Physician or surgeon services in an Outpatient Facility</td>
<td>$25/visit</td>
<td></td>
</tr>
<tr>
<td>Physician or surgeon services in an inpatient facility</td>
<td>$0</td>
<td></td>
</tr>
<tr>
<td><strong>Other professional services</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other practitioner office visit</td>
<td>$15/visit</td>
<td></td>
</tr>
<tr>
<td>Includes nurse practitioners, physician assistants, and therapists.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Acupuncture services</td>
<td>$15/visit</td>
<td></td>
</tr>
<tr>
<td>Chiropractic services</td>
<td>Not covered</td>
<td></td>
</tr>
<tr>
<td>Teladoc consultation</td>
<td>$5/consult</td>
<td></td>
</tr>
<tr>
<td><strong>Family planning</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Counseling, consulting, and education</td>
<td>$0</td>
<td></td>
</tr>
<tr>
<td>Injectable contraceptive; diaphragm fitting, intrauterine device (IUD), implantable contraceptive, and related procedure.</td>
<td>$0</td>
<td></td>
</tr>
<tr>
<td>Tubal ligation</td>
<td>$0</td>
<td></td>
</tr>
<tr>
<td>Vasectomy</td>
<td>$25/surgery</td>
<td></td>
</tr>
<tr>
<td>Infertility services</td>
<td>Not covered</td>
<td></td>
</tr>
<tr>
<td>Podiatric services</td>
<td>$30/visit</td>
<td></td>
</tr>
<tr>
<td><strong>Pregnancy and maternity care</strong>&lt;sup&gt;4&lt;/sup&gt;</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Physician office visits: prenatal and initial postnatal</td>
<td>$0</td>
<td></td>
</tr>
<tr>
<td>Physician services for pregnancy termination</td>
<td>$25/surgery</td>
<td></td>
</tr>
<tr>
<td><strong>Emergency services</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Emergency room services</td>
<td>$150/visit</td>
<td></td>
</tr>
<tr>
<td>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.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Emergency room Physician services</td>
<td>$0</td>
<td></td>
</tr>
<tr>
<td>Benefits</td>
<td>Your payment</td>
<td>When using a Participating Provider</td>
</tr>
<tr>
<td>----------</td>
<td>--------------</td>
<td>-----------------------------------</td>
</tr>
<tr>
<td><strong>Urgent care center services</strong></td>
<td></td>
<td>$15/visit</td>
</tr>
<tr>
<td><strong>Ambulance services</strong></td>
<td></td>
<td>$150/transport</td>
</tr>
<tr>
<td></td>
<td>This payment is for emergency or authorized transport.</td>
<td></td>
</tr>
<tr>
<td><strong>Outpatient Facility services</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ambulatory Surgery Center</td>
<td></td>
<td>$100/surgery</td>
</tr>
<tr>
<td>Outpatient department of a Hospital: surgery</td>
<td></td>
<td>$100/surgery</td>
</tr>
<tr>
<td>Outpatient department of a Hospital: treatment of illness or injury, radiation therapy, chemotherapy, and necessary supplies</td>
<td></td>
<td>10%</td>
</tr>
<tr>
<td><strong>Inpatient facility services</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hospital services and stay</td>
<td></td>
<td>$250/day up to 5 days/admission</td>
</tr>
<tr>
<td>Transplant services</td>
<td></td>
<td></td>
</tr>
<tr>
<td>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.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Special transplant facility inpatient services</td>
<td></td>
<td>$250/day up to 5 days/admission</td>
</tr>
<tr>
<td>• Physician inpatient services</td>
<td></td>
<td>$0</td>
</tr>
<tr>
<td><strong>Diagnostic x-ray, imaging, pathology, and laboratory services</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>This payment is for Covered Services that are diagnostic, non-Preventive Health Services, and diagnostic radiological procedures, such as CT scans, MRIs, MRAs, and PET scans. For the payments for Covered Services that are considered Preventive Health Services, see Preventive Health Services.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Laboratory services</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Includes diagnostic Papanicolaou (Pap) test.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Laboratory center</td>
<td></td>
<td>$15/visit</td>
</tr>
<tr>
<td>• Outpatient department of a Hospital</td>
<td></td>
<td>$15/visit</td>
</tr>
<tr>
<td>X-ray and imaging services</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Includes diagnostic mammography.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Outpatient radiology center</td>
<td></td>
<td>$30/visit</td>
</tr>
<tr>
<td>• Outpatient department of a Hospital</td>
<td></td>
<td>$30/visit</td>
</tr>
</tbody>
</table>
### Benefits

<table>
<thead>
<tr>
<th>Benefits</th>
<th>Your payment</th>
<th>When using a Participating Provider</th>
<th>CYD applies</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Other outpatient diagnostic testing</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Testing to diagnose illness or injury such as vestibular function tests, EKG, ECG, cardiac monitoring, non-invasive vascular studies, sleep medicine testing, muscle and range of motion tests, EEG, and EMG.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Office location</td>
<td></td>
<td>$30/visit</td>
<td></td>
</tr>
<tr>
<td>• Outpatient department of a Hospital</td>
<td></td>
<td>$30/visit</td>
<td></td>
</tr>
<tr>
<td><strong>Radiological and nuclear imaging services</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Outpatient radiology center</td>
<td></td>
<td>$75/visit</td>
<td></td>
</tr>
<tr>
<td>• Outpatient department of a Hospital</td>
<td></td>
<td>$75/visit</td>
<td></td>
</tr>
<tr>
<td><strong>Rehabilitative and Habilitative Services</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Includes Physical Therapy, Occupational Therapy, Respiratory Therapy, and Speech Therapy services. There is no visit limit for Rehabilitative or Habilitative Services.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Office location</td>
<td></td>
<td>$15/visit</td>
<td></td>
</tr>
<tr>
<td>Outpatient location of a Hospital</td>
<td></td>
<td>$15/visit</td>
<td></td>
</tr>
<tr>
<td><strong>Durable medical equipment (DME)</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>DME</td>
<td></td>
<td>10%</td>
<td></td>
</tr>
<tr>
<td>Breast pump</td>
<td></td>
<td>$0</td>
<td></td>
</tr>
<tr>
<td>Orthotic equipment and devices</td>
<td></td>
<td>10%</td>
<td></td>
</tr>
<tr>
<td>Prosthetic equipment and devices</td>
<td></td>
<td>10%</td>
<td></td>
</tr>
<tr>
<td><strong>Home health services</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>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, except hemophilia and home infusion nursing visits.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Home health agency services</td>
<td></td>
<td>$20/visit</td>
<td></td>
</tr>
<tr>
<td>Includes home visits by a nurse, Home Health Aide, medical social worker, physical therapist, speech therapist, or occupational therapist.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Home visits by an infusion nurse</td>
<td></td>
<td>$20/visit</td>
<td></td>
</tr>
<tr>
<td>Home health medical supplies</td>
<td></td>
<td>$0</td>
<td></td>
</tr>
<tr>
<td>Home infusion agency services</td>
<td></td>
<td>$0</td>
<td></td>
</tr>
<tr>
<td>Hemophilia home infusion services</td>
<td></td>
<td>$0</td>
<td></td>
</tr>
<tr>
<td>Includes blood factor products.</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
## Benefits

### 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.

<table>
<thead>
<tr>
<th>Type of SNF</th>
<th>Your payment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Freestanding SNF</td>
<td>$150/day up to 5 days/admission</td>
</tr>
<tr>
<td>Hospital-based SNF</td>
<td>$150/day up to 5 days/admission</td>
</tr>
</tbody>
</table>

### 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.

<table>
<thead>
<tr>
<th>Type of Service</th>
<th>Your payment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospice program services</td>
<td>$0</td>
</tr>
</tbody>
</table>

### Other services and supplies

- **Diabetes care services**
  - Devices, equipment, and supplies: 10%
  - Self-management training: $0
- **Dialysis services**: 10%
- **PKU product formulas and Special Food Products**: $0
- **Allergy serum billed separately from an office visit**: 10%

### Mental Health and Substance Use Disorder Benefits

Mental health and substance use disorder Benefits are provided through Blue Shield’s Mental Health Services Administrator (MHSA).

<table>
<thead>
<tr>
<th>Type of Service</th>
<th>Your payment</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Outpatient services</strong></td>
<td></td>
</tr>
<tr>
<td>Office visit, including Physician office visit</td>
<td>$15/visit</td>
</tr>
<tr>
<td>Other outpatient services, including intensive outpatient care, 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</td>
<td>$15/visit</td>
</tr>
<tr>
<td>Partial Hospitalization Program</td>
<td>$15/visit</td>
</tr>
<tr>
<td>Psychological Testing</td>
<td>$15/visit</td>
</tr>
<tr>
<td><strong>Inpatient services</strong></td>
<td></td>
</tr>
<tr>
<td>Physician inpatient services</td>
<td>$0</td>
</tr>
<tr>
<td>Hospital services</td>
<td>$250/day up to 5 days/admission</td>
</tr>
</tbody>
</table>

(CYD stands for Calendar Year Deductible, which is applied to the benefits as specified.)
# Mental Health and Substance Use Disorder Benefits

Mental health and substance use disorder Benefits are provided through Blue Shield's Mental Health Services Administrator (MHSA).

<table>
<thead>
<tr>
<th>Benefit</th>
<th>Your payment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Residential Care</td>
<td>Your payment</td>
</tr>
<tr>
<td>When using a MHSA Participating Provider³</td>
<td>CYD² applies</td>
</tr>
<tr>
<td>$250/day up to 5 days/admission</td>
<td></td>
</tr>
</tbody>
</table>

## Prescription Drug Benefits⁷,⁸

### When using a Participating Pharmacy³

<table>
<thead>
<tr>
<th>Benefit</th>
<th>Your payment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pharmacy Network: Rx Ultra</td>
<td></td>
</tr>
<tr>
<td>Drug Formulary: Standard Formulary</td>
<td></td>
</tr>
</tbody>
</table>

### Retail pharmacy prescription Drugs

Per prescription, up to a 30-day supply.

| Tier 1 Drugs | $5/prescription |
| Tier 2 Drugs | $15/prescription |
| Tier 3 Drugs | $25/prescription |
| Tier 4 Drugs (excluding Specialty Drugs)    | 10% up to $250/prescription |
| Contraceptive Drugs and devices             | $0                           |

### Mail service pharmacy prescription Drugs

Per prescription, up to a 90-day supply.

| Tier 1 Drugs | $15/prescription |
| Tier 2 Drugs | $45/prescription |
| Tier 3 Drugs | $75/prescription |
| Tier 4 Drugs (excluding Specialty Drugs)    | 10% up to $750/prescription |
| Contraceptive Drugs and devices             | $0                           |

### Specialty Drugs

10% up to $250/prescription

Per prescription. Specialty Drugs are covered at tier 4 and only when dispensed by a Network Specialty Pharmacy.

### Oral Anticancer Drugs

10% up to $200/prescription

Per prescription, up to a 30-day supply.

## Pediatric Benefits

Pediatric Benefits are available through the end of the month in which the Member turns 19.

### When using a Participating Dentist³

<table>
<thead>
<tr>
<th>Benefit</th>
<th>Your payment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pediatric dental⁹</td>
<td></td>
</tr>
<tr>
<td>Diagnostic and preventive services</td>
<td></td>
</tr>
<tr>
<td>• Oral exam</td>
<td>$0</td>
</tr>
<tr>
<td>• Preventive – cleaning</td>
<td>$0</td>
</tr>
</tbody>
</table>

---

⁷: References

⁸: References

⁹: References
### Pediatric Benefits

**Pediatric Benefits**

**Your payment**

<table>
<thead>
<tr>
<th>Pediatric Benefits</th>
<th>When using a Participating Dentist</th>
<th>CYD&lt;sup&gt;2&lt;/sup&gt; applies</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Pediatric Benefits are available through the end of the month in which the Member turns 19.</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Preventive – x-ray</td>
<td>$0</td>
<td></td>
</tr>
<tr>
<td>• Sealants per tooth</td>
<td>$0</td>
<td></td>
</tr>
<tr>
<td>• Topical fluoride application</td>
<td>$0</td>
<td></td>
</tr>
<tr>
<td>• Space maintainers - fixed</td>
<td>$0</td>
<td></td>
</tr>
<tr>
<td><strong>Basic services</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Restorative procedures</td>
<td></td>
<td>See Dental Copay Schedule in Evidence of Coverage</td>
</tr>
<tr>
<td>• Periodontal maintenance</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Major services</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Oral surgery</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Endodontics</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Periodontics (other than maintenance)</td>
<td></td>
<td>See Dental Copay Schedule in Evidence of Coverage</td>
</tr>
<tr>
<td>• Crowns and casts</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Prosthodontics</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Orthodontics (Medically Necessary)</strong></td>
<td></td>
<td>$1,000</td>
</tr>
</tbody>
</table>

### Pediatric Benefits

**Pediatric Benefits**

**Your payment**

<table>
<thead>
<tr>
<th>Pediatric Benefits</th>
<th>When using a Participating Provider</th>
<th>CYD&lt;sup&gt;2&lt;/sup&gt; applies</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Pediatric Benefits are available through the end of the month in which the Member turns 19.</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Pediatric vision</strong>&lt;sup&gt;10&lt;/sup&gt;</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Comprehensive eye examination</td>
<td></td>
<td></td>
</tr>
<tr>
<td>One exam per Calendar Year.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Ophthalmologic visit</td>
<td>$0</td>
<td></td>
</tr>
<tr>
<td>• Optometric visit</td>
<td>$0</td>
<td></td>
</tr>
<tr>
<td><strong>Eyewear/materials</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>One eyeglass frame and eyeglass lenses, or contact lenses instead of eyeglasses, up to the Benefit per Calendar Year. Any exceptions are noted below.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Contact lenses</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Non-elective (Medically Necessary) - hard or soft</td>
<td>$0</td>
<td></td>
</tr>
<tr>
<td>Up to two pairs per eye per Calendar Year.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Elective (cosmetic/convenience)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Standard and non-standard, hard</td>
<td>$0</td>
<td></td>
</tr>
<tr>
<td>Up to a 3 month supply for each eye per Calendar Year based on lenses selected.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Standard and non-standard, soft</td>
<td>$0</td>
<td></td>
</tr>
<tr>
<td>Up to a 6 month supply for each eye per Calendar Year based on lenses selected.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
**Pediatric Benefits**

- Eyeglass frames
  - Collection frames
  - Non-collection frames
- 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
  - Lined bifocal
  - Lined trifocal
  - Lenticular
- Optional eyeglass lenses and treatments
  - Ultraviolet protective coating (standard only)
  - Polycarbonate lenses
  - Standard progressive lenses
  - Premium progressive lenses
  - Anti-reflective lens coating (standard only)
  - Photochromic - glass lenses
  - Photochromic - plastic lenses
  - High index lenses
  - Polarized lenses
- Low vision testing and equipment
  - Comprehensive low vision exam
    - Once every 5 Calendar Years.
  - Low vision devices
    - One aid per Calendar Year.
- Diabetes management referral

<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>$0</td>
<td></td>
</tr>
<tr>
<td>All charges above $150</td>
<td></td>
</tr>
</tbody>
</table>

[^2]: CYD - Calendar Year Deductible
[^3]: Provider

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**Notes**

1. **Evidence of Coverage (EOC):**

   The Evidence of Coverage (EOC) describes the Benefits, limitations, and exclusions that apply to coverage under this benefit 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.

   *Defined terms are 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 Deductible is the amount you pay each Calendar Year before Blue Shield pays for Covered Services under the benefit Plan.

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

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.

Your payment for services from “Other Providers.” You will pay the Copayment or Coinsurance applicable to Participating Providers for Covered Services received from Other Providers. However, Other Providers do not have a contract to provide health care services to Members and so are not Participating Providers. Therefore, you will also pay all charges above the Allowable Amount. This out-of-pocket expense can be significant.

4 Calendar Year Out-of-Pocket Maximum (OOPM):

*Your payment after you reach the Calendar Year OOPM.* You will continue to pay all charges above a Benefit maximum.

Essential health benefits count towards the 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.

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 Copayment in addition to an allergy serum Copayment 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 benefit 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 benefit 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 have a later break in this coverage of 63 days or more before enrolling in Medicare Part D you could be subject to payment of higher Medicare Part D premiums.

8 Outpatient Prescription Drug Coverage:

*Brand Drug coverage when a Generic Drug is available.* If you, the Physician, or Health Care Provider, select a Brand Drug when a Generic Drug equivalent is available, you are responsible for the difference between the cost to Blue
Notes

Shield for the Brand Drug and its Generic Drug equivalent plus the tier 1 Copayment or Coinsurance. This difference in cost will not count towards any Calendar Year pharmacy Deductible, medical Deductible, or the Calendar Year Out-of-Pocket Maximum.

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 Member payment.

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.

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.

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 $99.06.
- warehouse pricing, then the Allowable Amount will be up to $103.64.

Participating Providers using wholesale pricing are identified in the provider directory.

Benefit Plans may be modified to ensure compliance with State and Federal requirements.
Discrimination is against the law

Blue Shield of California complies with applicable state laws and federal civil rights laws, and does not discriminate on the basis of race, color, national origin, ancestry, religion, sex, marital status, gender, gender identity, sexual orientation, age, or disability. Blue Shield of California does not exclude people or treat them differently because of race, color, national origin, ancestry, religion, sex, marital status, gender, gender identity, sexual orientation, age, or disability.

Blue Shield of California:

• Provides aids and services at no cost to people with disabilities to communicate effectively with us such as:
  - Qualified sign language interpreters
  - Written information in other formats (including large print, audio, accessible electronic formats, and other formats)
• Provides language services at no cost to people whose primary language is not English such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, contact the Blue Shield of California Civil Rights Coordinator.

If you believe that Blue Shield of California has failed to provide these services or discriminated in another way on the basis of race, color, national origin, ancestry, religion, sex, marital status, gender, gender identity, sexual orientation, age, or disability, you can file a grievance with:

Blue Shield of California
Civil Rights Coordinator
P.O. Box 629007
El Dorado Hills, CA 95762-9007

Phone: (844) 831-4133 (TTY: 711)
Fax: (844) 696-6070
Email: BlueShieldCivilRightsCoordinator@blueshieldca.com

You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, our Civil Rights Coordinator is available to help you. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue SW.
Room 509F, HHH Building
Washington, DC 20201
(800) 368-1019; TTY: (800) 537-7697

Complaint forms are available at www.hhs.gov/ocr/office/file/index.html.
Notice of the Availability of Language Assistance Services
Blue Shield of California

IMPORTANT: Can you read this letter? If not, we can have somebody help you read it. You may also be able to get this letter written in your language. For help at no cost, please call right away at the Member/Customer Service telephone number on the back of your Blue Shield ID card, or (866) 346-7198.

IMPORTANTANTE: ¿Puede leer esta carta? Si no, podemos hacer que alguien le ayude a leerla. También puede recibir esta carta en su idioma. Para ayuda sin cargo, por favor llame inmediatamente al teléfono de Servicios al miembro/cliente que se encuentra al reverso de su tarjeta de identificación de Blue Shield o al (866) 346-7198. (Spanish)

重要通知：您能读懂這封信嗎？如果不能，我們可以請人幫您閱讀。這封信也可以用您所講的語言書寫。如需免費幫助，請立即撥打登列在您的Blue Shield ID卡背面的 會員/客戶服務部的電話，或者撥打電話 (866) 346-7198。 (Chinese)

QUAN TRỌNG: Quý vị có thể đọc lá thư này không? Nếu không, chúng tôi có thể nhờ người giúp quý vị đọc thư. Quý vị cũng có thể nhân lá thư này được viết bằng ngôn ngữ của quý vị. Để được hỗ trợ miễn phí, vui lòng gọi ngay đến Ban Dịch vụ Hỏi ién/Khách hàng theo số 0 mặt sau thể ID Blue Shield của quý vị hoặc theo số (866) 346-7198. (Vietnamese)

MAHALAGA: Nababasa mo ba ang sulat na ito? Kung hindi, maari kaming kumuna ng isang tao ng matulungan ka upang mabasa ito. Maari ka ring makakuha ng sulat na ito na nakasulat sa iyang wika. Para sa libreng tulong, mangyaring tumawag kaagad sa numero ng telepono ng Miyembro/Customer Service sa likod ng iyang Blue Shield ID kard, o (866) 346-7198. (Tagalog)

Baa’ ákohwiindindoogi: Díí naaltsoosísh yiínta’go bínígah? Doo bínígahgóó éí, naaltsoosísh ‘í’ yiíóoltíídíí’ tó niíhe hóló. Díí naaltsoosísh aldó’ t’áá Diné k’ehjí ádoolnííí nínízingó bínígah. Doo bááh ilínígó shiká’ adowoól nínízingó niíhí ‘í’ béeesh bee hodiílníí dóó námboo éí díí Blue Shield bee néího’dilzingi bine’dée’ bikáá’ éí doogadó éí (866) 346-7198 ji’ hodiílníí. (Navajo)

 중요: 이 서신을 읽을 수 있으세요? 읽으실 경우, 도움을 드릴 수 있는 사람이 있습니다. 또한 다른 언어로 작성된 이 서신을 받으실 수도 있습니다. 무료로 도움을 받으시려면 Blue Shield ID 카드 뒷면의 회원/고객 서비스 전화번호 또는 (866) 346-7198로 지금 전화하세요. (Korean)

ՔՐԱՅԵՆՈՒԹՅՈՒՆ. Կարողանում ենք դկարտեր պահ նախատեսանել: Եթե ոչ, այնքան էլ զբաղվե՞ք այս կարգախոսակցական նախագծի հետ: Եթե բացակայում է նախագծիս շարունակության արդյունքը, երբեմն հետապատասխանատեր: Թվային հերթական տեքստ պահպանականության ազդեցությունը պահպանականության բնության հետազոտությունները, որոնք բերվում են դեռ Blue Shield ID բազուկ հետիւյս մասամբ, կամ (866) 346-7198 հետազոտություն: (Armenian)

ВАЖНО: Не может прочесть данное письмо? Мы поможем вам, если необходимо. Вы также можете получить это письмо написанное на вашем родном языке. Позвоните в Службу клиентской/членской поддержки прямо сейчас по телефону, указанному сзади идентификационной карты Blue Shield, или по телефону (866) 346-7198, и вам помогут совершенно бесплатно. (Russian)

重要：お客様は、この手紙を読むことができませんか？もし読むことができない場合、弊社が、お客様をサポートする人物を手配いたします。また、お客様の母国語で書かれた手紙をお送りすることも可能です。無料のサポートを希望される場合は、Blue Shield IDカードの裏面に記載されている会員/お客様サービスの電話番号、または、(866) 346-7198にお電話をおかけください。 (Japanese)