blue of california

Summary of Benefits

Trader Joe's Company
Effective July 1, 2023
EPO Plan

Custom EPO 25-500

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: 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. This is an Exclusive Provider Organization (EPO) plan. You must receive all Covered Services from a Participating Provider, 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/traderjoes.

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*	$500
	Family coverage	$500: individual
		$1,500: 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 Notes section at the end of this Summary of Benefits.

	When using a Participating Provider[3]
Individual coverage	$3,500
Family coverage	$3,500: individual
	$7,000: 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 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	$25/visit	
Specialist care office visit	$35/visit	
Office visit for allergy serum injection	$0	
Physician home visit	$25/visit	
Physician or surgeon services in an Outpatient Facility	20%	✔
Physician or surgeon services in an inpatient facility	20%	✔
Other professional services		
Other practitioner office visit *Includes nurse practitioners, physician assistants, and therapists.*	$25/visit	
Acupuncture services *Up to 30 visits per Member, per Calendar Year.*	$25/visit	
Chiropractic services *Up to 30 visits per Member, per Calendar Year.*	$25/visit	
Teladoc 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	
• Artificial insemination- six natural (without ovum/egg [oocyte or ovarian tissue] stimulation)	$0	
Podiatric services	$25/visit	
Medical nutrition therapy, not related to diabetes	20%	✔
Pregnancy and maternity care		
Physician office visits: prenatal and postnatal	$25/visit	
Abortion and abortion-related services	$0	

Benefits[5]	Your payment	
	When using a Participating Provider[3]	**CYD[2] applies**
Emergency Services		
Emergency room services	$125/visit plus 20%	
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.		
Emergency room Physician services	20%	✔
Urgent care center services	$25/visit	
Ambulance services	20%	✔
This payment is for emergency or authorized transport.		
Outpatient Facility services		
Ambulatory Surgery Center	$250/surgery	✔
Outpatient Department of a Hospital: surgery	$250/surgery	✔
Outpatient Department of a Hospital: treatment of illness or injury, radiation therapy, chemotherapy, and necessary supplies	$0	✔
Inpatient facility services		
Hospital services and stay	$500/admission plus 20%	✔
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	$500/admission plus 20%	✔
• Physician inpatient services	20%	✔
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	$500/admission plus 20%	✔
Outpatient Facility services	$250/surgery	✔
Physician services	20%	✔

Benefits[5]	Your payment	
	When using a Participating Provider[3]	**CYD[2] applies**
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, 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.		
Laboratory services		
Includes diagnostic Papanicolaou (Pap) test.		
• Laboratory center	$25/visit	
• Outpatient Department of a Hospital	20%	
X-ray and imaging services		
Includes diagnostic mammography.		
• Outpatient radiology center	$25/visit	
• Outpatient Department of a Hospital	20%	
Other outpatient diagnostic testing		
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.		
• Office location	$25/visit	
• Outpatient Department of a Hospital	20%	
Radiological and nuclear imaging services		
• Outpatient radiology center	$25/visit	
• Outpatient Department of a Hospital	20%	
Rehabilitative and Habilitative Services		
Includes physical therapy, occupational therapy, and respiratory therapy.		
Office location	$25/visit	
Outpatient Department of a Hospital	$25/visit	
Speech Therapy services		
Office location	20%	✔
Outpatient Department of a Hospital	20%	✔
Durable medical equipment (DME)		
DME	20%	✔
Breast pump	$0	
Orthotic equipment and devices	20%	✔
Prosthetic equipment and devices	20%	✔

Benefits[5]	Your payment	
	When using a Participating Provider[3]	**CYD[2] applies**
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.*	20%	✔
Home infusion and home injectable therapy services		
Home infusion agency services *Includes home infusion drugs, medical supplies, and visits by a nurse.*	20%	✔
Hemophilia home infusion services *Includes blood factor products.*	20%	✔
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	20%	✔
Hospital-based SNF	20%	✔
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	
Other services and supplies		
Diabetes care services		
• Devices, equipment, and supplies	20%	✔
• Self-management training	$25/visit	
• Medical nutrition therapy	$25/visit	
Dialysis services	$0	✔
PKU product formulas and special food products	20%	✔
Allergy serum billed separately from an office visit	$0	
Hearing aid services		
• Hearing aids and equipment *Covers 2 hearing aids per member per 36 months.*	20%	✔

Mental Health and Substance Use Disorder Benefits	Your payment	
Mental health and substance use disorder Benefits are provided through Blue Shield's Mental Health Service Administrator (MHSA).	**When using a MHSA Participating Provider[3]**	**CYD[2] applies**
Outpatient services		
Office visit, including Physician office visit	$0	
Teladoc mental health and substance use disorder (behavioral health) consultation[7]	$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	$0	✔
Hospital services	$500/admission plus 20%	✔
Residential Care	$500/admission plus 20%	✔

Prior Authorization

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

- Radiological and nuclear imaging services
- Outpatient mental health services, except office visits and office-based opioid treatment
- Inpatient facility services
- Hospice program services

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.

Notes

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.

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.

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.

"Allowable Amount" is defined in the EOC. In addition:

- Coinsurance is calculated from the Allowable Amount or Benefit maximum, whichever is less.

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 Allowable Amount 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 Allowable Amount, and charges for services above any Benefit maximum.

Any Deductibles count towards the OOPM. Any amounts you pay that count towards the medical Calendar Year 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.

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 Teladoc Behavioral Health Consultations:

Teladoc mental health and substance use disorder (behavioral health) consultations are provided through Teladoc. These services are not administered by Blue Shield's Mental Health Service Administrator (MHSA). For more information, call 1-800-Teladoc (800-835-2362) or visit http://www.teladoc.com/bsc.

Plans may be modified to ensure compliance with State and Federal requirements. Pb040623

blue of california

Outpatient Prescription Drug Rider

Trader Joe's Company
Effective July 1, 2023
PPO

Custom Premier EPO Rx
Summary of Benefits

This Summary of Benefits shows the amount you will pay for covered Drugs under this prescription Drug Benefit.

Pharmacy Network:	**Rx Ultra**
Drug Formulary:	**Plus Formulary**

Calendar Year Pharmacy Deductible(CYPD)[1]

A Calendar Year Pharmacy Deductible (CYPD) is the amount a Member pays each Calendar Year before Blue Shield pays for covered Drugs under the outpatient prescription Drug Benefit. Blue Shield pays for some prescription Drugs before the Calendar Year Pharmacy Deductible is met, as noted in the Prescription Drug Benefits chart below.

		When using a Participating[2] or Non-Participating[2] Pharmacy
Calendar Year Pharmacy Deductible	*Per Member*	$0

Prescription Drug Benefits[3,4]

	Your payment			
	When using a Participating Pharmacy[2]	**CYPD[1] applies**	**When using a Non-Participating Pharmacy[2]**	**CYPD[1] applies**
Retail pharmacy prescription Drugs				
Per prescription, up to a 30-day supply.				
Contraceptive Drugs and devices	$0		Not covered	
Value-Based Tier Drugs	$0		Not covered	
Tier 1 Drugs	$10/prescription		Not covered	
Tier 2 Drugs	$25/prescription		Not covered	
Tier 3 Drugs	$40/prescription		Not covered	
Tier 4 Drugs	$40/prescription		Not covered	
Retail pharmacy prescription Drugs				
Per prescription, up to a 90-day supply from a 90-day retail pharmacy.				
Contraceptive Drugs and devices	$0		Not covered	
Value-Based Tier Drugs	$0		Not covered	
Tier 1 Drugs	$30/prescription		Not covered	
Tier 2 Drugs	$75/prescription		Not covered	
Tier 3 Drugs	$120/prescription		Not covered	

Prescription Drug Benefits[3,4]	Your payment			
	When using a Participating Pharmacy[2]	CYPD[1] applies	When using a Non-Participating Pharmacy[2]	CYPD[1] applies
Tier 4 Drugs	$120/prescription		Not covered	
Mail service pharmacy prescription Drugs				
Per prescription, up to a 90-day supply.				
Contraceptive Drugs and devices	$0		Not covered	
Value-Based Tier Drugs	$0		Not covered	
Tier 1 Drugs	$20/prescription		Not covered	
Tier 2 Drugs	$50/prescription		Not covered	
Tier 3 Drugs	$80/prescription		Not covered	
Tier 4 Drugs	$80/prescription		Not covered	

Notes

1 Calendar Year Pharmacy Deductible (CYPD):

Calendar Year Pharmacy Deductible explained. A Calendar Year Pharmacy Deductible is the amount you pay each Calendar Year before Blue Shield pays for outpatient prescription Drugs under this Benefit.

If this Benefit has a Calendar Year Pharmacy Deductible, outpatient prescription Drugs subject to the Deductible are identified with a check mark (✔) in the Benefits chart above.

Any applicable Copayment, Coinsurance and CYPD you pay counts towards the Calendar Year Out-of-Pocket Maximum.

Outpatient prescription Drugs not subject to the Calendar Year Pharmacy Deductible. Some outpatient prescription Drugs received from Participating Pharmacies are paid by Blue Shield before you meet any Calendar Year Pharmacy Deductible. These outpatient prescription Drugs do not have a check mark (✔) next to them in the "CYPD applies" column in the Prescription Drug Benefits chart above.

2 Using Participating Pharmacies:

Participating Pharmacies have a contract to provide outpatient prescription Drugs to Members. When you obtain covered prescription Drugs from a Participating Pharmacy, you are only responsible for the Copayment or Coinsurance, once any Calendar Year Pharmacy Deductible has been met.

Participating Pharmacies and Drug Formulary. You can find a Participating Pharmacy and the Drug Formulary by visiting www.blueshieldca.com/pharmacy.

Non-Participating Pharmacies. Drugs from Non-Participating Pharmacies are not covered except in emergency situations.

3 Outpatient Prescription Drug Coverage:

Medicare Part D-creditable coverage-

This 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 prescription Drug coverage is creditable, you do not have to enroll in Medicare Part D while you maintain this coverage; however, you should be

Notes

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.

4 Outpatient Prescription Drug Coverage:

Brand Drug coverage when a Generic Drug is available. If you select a Brand Drug when a Generic Drug equivalent is available, you are responsible for the difference between the cost to Blue 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. If your Physician or Health Care Provider prescribes a Brand Drug and indicates that a Generic Drug equivalent should not be substituted, you pay your applicable tier Copayment or Coinsurance. If your Physician or Health Care Provider does not indicate that a Generic Drug equivalent should not be substituted, you 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.

Benefit designs may be modified to ensure compliance with State and Federal requirements.