blue of california

1 employee

100 employees

Coverage for every size of small business

2017 packages for small business, 1-100 employees

Effective January 1, 2017


DINER
ANTIQUES

Helping California's small businesses grow with the right health coverage

Whether it's a budding one-person operation or a booming 100-employee enterprise, small businesses across California share the same need for a healthy and productive workforce.

That's why we offer a wide range of small business health plans with solutions for controlling costs and promoting a healthy workforce.

Inside, you'll find the latest updates to our 2017 small business portfolio, including:

- **The addition of HMO plan-pairing options – For the first time Blue Shield small business customers may purchase both Trio ACO HMO plans and Access+ HMO plans side by side.**
- **Customers who have HSA-compatible PPO plans now have greater convenience with the option of HealthEquity as the HSA administrator.**

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This way to access high-quality health care

network choice and breadth

enhance employee satisfaction to protect your bottom line

offer wellness and discount programs (that you'll really use!)

offer a more comprehensive benefits package with dental, vision and life insurance*

trusted for more than 75 years

Why choose Blue Shield?

* Blue Shield vision and life insurance plans are underwritten by Blue Shield of California Life & Health Insurance Company.

Choose the option that best suits your business

At Blue Shield of California, our mission is to ensure all Californians have access to high-quality health care at an affordable price. We offer your employees access to a broad range of hospitals, physicians, specialists, pharmacies, dental and vision professionals and other providers.

Blue Shield of California offers two packages to small businesses outside of Covered California for Small Business, as described in this brochure. You select a package, and then select plans within that package to offer your employees and their dependents. You can offer plans from the **Off-Exchange Package** or the **Mirror Package**, but not both.

The Blue Shield Off-Exchange Package for Small Business

This package includes up to 31 plans to offer employees:

- Preferred provider organization (PPO) plans
- Health savings account (HSA)-compatible PPO high-deductible health plans (HDHPs)
- Health maintenance organization (HMO) plans

Our health plans are available at a variety of metal levels. Each metal level – Platinum, Gold, Silver and Bronze – offers a different level of coverage. The HMO plans offer a choice in the size of provider networks through the Access+ HMO (full network), Local Access+ HMO (narrow network), and Trio ACO HMO (accountable care organization, most narrow network) plans, so that you can pick the option that suits your company best.

The Blue Shield Mirror Package

This package offers up to seven plans: PPO plans at every metal level and our Trio ACO HMO plans at the Platinum, Gold and Silver metal levels. The Mirror package offers the same standardized plans directly from Blue Shield of California that are offered on Covered California for Small Business.

Note: Federal tax credits are available through Covered California for Small Business to those small business employers that qualify and purchase their coverage on Covered California for Small Business. Talk to Covered California for Small Business (877) 453-9198, your plan representative, or your broker to discuss your options.

Participation requirements

Check with your broker on our latest participation requirements!

Off-Exchange Package participation requirements

Whether you plan to offer only Blue Shield plans or Blue Shield alongside another carrier, you must have 65% of the total number of eligible employees enrolled in a Blue Shield healthcare plan(s).

Alongside another carrier:

If you choose to offer the Blue Shield Off-Exchange Package alongside another carrier's plan, then there are a few more requirements to keep in mind. Along with the minimum 65% employee participation requirement, at least 50% and at least five of the total number of enrolled employees must be in a Blue Shield plan.

Let's use this example:

		Sample Company ABC	Your Company
1	Total number of employees eligible for coverage	**20**	
2	Subtract number of valid waivers (Medicare, MediCal, Military, covered by spouse's group coverage only)	**-2**	
3	Number of eligible employees (subtract line 2 from line 1)	**18**	
4	Multiply the number of eligible employees by .65 to determine that minimum participation is met.	**18 x.65 = 11.7, rounded to 12** As long as 12+ eligibles enroll for health coverage, then the participation requirement is met.	

Using the same numbers as above, use the 12 enrolled number as your minimum threshold and multiply 12 x .5 = 6.

Six then meets the minimum of at least five and 50%. Six employees must enroll in a Blue Shield plan to meet underwriting participation requirements for a group this size.

If the group contributes 100% of premiums for medical coverage, then 100% of eligible employees must enroll (except those waiving due to other group coverage through another employer).

Mirror Package participation requirements

General participation requirements:

- A minimum of one eligible employee and at least 70% of all eligible employees must enroll in the Blue Shield plan(s), including any specialty benefits plans offered. Please note: Life insurance plans require a minimum of two eligible employees.

Specialty plan participation requirements

Specialty benefits plan participation requirements are the same as the Off-Exchange medical plan participation requirement at 65% of the total number of eligible employees enrolled. If the group contributes 100% of premiums for specialty benefits,[1] then 100% of eligible employees must enroll (except for those waiving due to other group specialty coverage through another employer). Blue Shield dental, vision* and life* insurance plans must be the sole carrier for these plans even when Blue Shield medical plans are offered alongside another carrier's medical plans.

The Blue Shield of California Off-Exchange Package for Small Business was designed to make it easy for you to offer quality healthcare coverage to your employees.

1 When employer contribution for life insurance is 100%, 100% enrollment is required; no waivers permitted, even for coverage through another employer.

* Blue Shield vision and life insurance plans are underwritten by Blue Shield of California Life & Health Insurance Company.

Coverage for the entire family

Family health plan rating

Family rating applies to all of our Small Business package offerings

If you have an employee with health plan coverage that covers more than three dependent children under the age of 21, the total family rate for that coverage will include the rates for the employee, his or her spouse or domestic partner, and a maximum of three* of the oldest covered children. Additional dependent children (under 21) will have a rate of $0.

Here is an example to illustrate this scenario. (Rates are shown for example only and do not reflect the rates of any products offered by Blue Shield.)

Family coverage: subscriber, dependent spouse/domestic partner, four dependent children		
	Lisa Williams: Adult 1 – 47 years old	Rate: $290
	David Williams: Adult 2 – 46 years old	Rate: $280
	Laura Williams: Child 1 – 17 years old	Rate: $133
	John Williams: Child 2 – 14 years old	Rate: $133
	Jeff Williams: Child 3 – 9 years old	Rate: $133
	Lucas Williams: Child 4 – 7 years old	**Rate: $0**

Dental and vision plan tier rating

Small business dental and vision plans are rated on a tier-level basis. The following four tiers apply to dental and vision rating: Employee Only, Employee + Spouse or Domestic Partner, Employee + Children, and Family.

We encourage you to contact your broker to discuss any questions you might have about the rate structure for coverage.

Pediatric vision and dental coverage is included with all Blue Shield small business medical plans

PPO and HSA Blue Shield medical plans include PPO pediatric dental and vision coverage for age-eligible members. HMO Blue Shield medical plans include network PPO pediatric dental and vision coverage for age-eligible members. Both pediatric dental and vision benefits provided by a non-network provider for non-emergency services are not eligible for coverage under Blue Shield HMO medical plans.

Supplemental infertility coverage

Blue Shield of California offers supplemental coverage for infertility treatment for PPO plans. (The coverage is part of the HMO plans.) This supplemental coverage can be purchased only with a Blue Shield of California health plan.

Please see page 37 for more details.

* If a member has any dependent children above the age of 21, they would not be counted as part of the three additional dependent children. They would be charged at the rate for their age.

Rating region standardization

There are 19 standardized rating regions in California.

Blue Shield bases the rating on the employer location by ZIP code for all plans, including medical, dental and vision plans.

This map of California breaks out the standardized rating regions applicable to all of our Small Business plan packages:

- **Rating region 1** **Rural North/Sierra**
  Alpine, Del Norte, Siskiyou, Modoc, Lassen, Shasta, Trinity, Humboldt, Tehama, Plumas, Nevada, Sierra, Mendocino, Lake, Butte, Glenn, Sutter, Yuba, Colusa, Amador, Calaveras, Tuolumne
- **Rating region 2** **Wine Country**
  Napa, Sonoma, Solano, Marin
- **Rating region 3** **Greater Sacramento Region**
  Sacramento, Placer, El Dorado, Yolo
- **Rating region 4** **San Francisco**
  San Francisco
- **Rating region 5** **Contra Costa**
  Contra Costa
- **Rating region 6** **Alameda**
  Alameda
- **Rating region 7** **Santa Clara**
  Santa Clara
- **Rating region 8** **San Mateo**
  San Mateo
- **Rating region 9** **Monterey Bay**
  Santa Cruz, Monterey, San Benito
- **Rating region 10** **Central Valley North**
  San Joaquin, Stanislaus, Merced, Mariposa, Tulare
- **Rating region 11** **Central Valley South**
  Madera, Fresno, Kings
- **Rating region 12** **South Coast**
  San Luis Obispo, Santa Barbara, Ventura
- **Rating region 13** **Southern Desert**
  Mono, Inyo, Imperial
- **Rating region 14** **Kern**
  Kern
- **Rating region 15** **Los Angeles East**
  Los Angeles ZIP codes starting with 906-912, 915, 917, 918, 935
- **Rating region 16** **Los Angeles West**
  Los Angeles not including ZIP codes above
- **Rating region 17** **Inland Empire**
  San Bernardino, Riverside
- **Rating region 18** **Orange County**
  Orange County
- **Rating region 19** **San Diego**
  San Diego

Keeping employees well with great programs

Online registration provides members access to valuable online tools and resources to manage their health.

Wellness discount programs[*,1] – Blue Shield offers a variety of member discounts on massage sessions, gym memberships, LASIK eye surgery, and even a popular weight management program. Online discounts of up to 40% off retail items (many with free shipping) include vitamins and supplements, yoga and fitness equipment, and much more.

- **Discount Provider Network**[2] – Take 20% off the published retail prices when you use a participating provider in the Discount Vision Program network for exams, frames, lenses and more.
- **Alternative Care Discount Program** – Get 25% off usual and customary fees for acupuncture, massage therapy, and chiropractic services, plus get discounts on health and wellness products, with free shipping on most items.
- **MESVision Optics** – Take advantage of competitive prices on contact lenses,[3] sunglasses, readers, and eyecare accessories, with free shipping on orders over $50.
- **QualSight LASIK** – Save on LASIK surgery at more than 45 surgery centers in California. Services include pre-screening, a pre-operative exam, and postoperative visits.
- **NVISION Laser Eye Centers** – Receive a 15% discount on LASIK surgery from experienced surgeons with offices in Southern California and Sacramento.
- **Hearing-aid discount** – Save 30% to 60% off manufacturers' suggested retail prices on major brands through EPIC Hearing Service.
- **Weight Watchers** – Get discounts on three- and 12-month subscriptions, monthly passes, and at-home kits.
- **24 Hour Fitness** – Enjoy waived enrollment, processing, and initiation fees and discounts on monthly membership dues.
- **ClubSport and Renaissance ClubSport** – Obtain a 60% discount on enrollments when joining with a month-to-month agreement. Enrollment fees are waived when joining with a 12-month agreement. There is a one-time $25 processing fee when you enroll.
- **NurseHelp 24/7** – Speak with registered nurses anytime, day or night, and get answers to your health-related questions, or go online to have a one-on-one chat. The NurseHelp 24/7℠ phone number is conveniently located on the back of the Blue Shield member ID card.

wellvolution

- **Wellvolution** – A well-being solution for real people with real lives, Wellvolution® is the next generation in wellness programs. Starting with **mywellvolution.com**, all Wellvolution members get access to the Well-Being Tracker™ platform including the Well-Being Assessment and the Daily Challenge® program. These two components are a great start for helping members to improve their health one small step at a time.

  Trio ACO HMO members also receive exclusive access to Walkadoo™, which includes a wireless activity monitor for the subscriber at no additional charge and mobile app (Moves) walking program that introduces participants to a realistic and convenient way to add movement to their day. Game dynamics allow users to interact socially to sustain engagement.

  – **QuitNet** – QuitNet® is based on the latest science and best practices to help individuals overcome their addiction to tobacco. QuitNet integrates many intervention modalities, including online and mobile support from experts and peers, telephone-based coaching from a tobacco treatment specialist, personalized email and SMS text support, and pharmaceutical quit aids.

- **Teladoc** – With U.S. board-certified doctors available 24/7/365, Teladoc can help members resolve issues through phone or video consults. Visit **teladoc/bsc.com** to learn more.

- **Condition management programs** – These programs offer nurse support as well as education and self-management tools for members with asthma, diabetes, coronary artery disease, heart failure, and chronic obstructive pulmonary disease.

Get covered right down to your identity

As an eligible Blue Shield medical plan member, you can now get identity protection services such as identity repair assistance, identity theft insurance and credit monitoring for you and your covered family members. It makes good sense, and it's no charge.

You can access these services by calling **(855) 904-5733**, 6 a.m. to 6 p.m., Monday through Saturday or 24/7 at **blueshieldca.allclearid.com**.

For more information about these programs, go to **blueshieldca.com** today.

* Discount program services are not a covered benefit of Blue Shield health plans and none of the terms or conditions of Blue Shield health plans applies. See endnotes on page 43.

Off-Exchange Package for Small Business

Complete your coverage with dental, vision and life! See page 29.

Our plan names align closely with Covered California for Small Business. The names make it easy to understand the benefits each plan offers.

The plan names follow this format:

Metal tier + network name + product type + deductible + copay + suffix (Off-Exchange)

Blue Shield of California Off-Exchange Package for Small Business (31 plans* to choose from)

PPO	HSA-HDHP	HMO
Platinum Full PPO 0/10 OffEx	Silver Full PPO Savings 2000/20% OffEx	Platinum Access+ HMO 0/25 OffEx*
Platinum Full PPO 150/15 OffEx	Bronze PPO Savings 4700/40% OffEx	Platinum Local Access+ HMO 0/25 OffEx*
Gold Full PPO 0/20 OffEx	Bronze Full PPO Savings 5500/40% OffEx	Platinum Trio ACO HMO 0/25 OffEx†
Gold Full PPO 250/30 OffEx		Platinum Access+ HMO 0/20 OffEx*
Gold Full PPO 750/20 OffEx		Platinum Local Access+ HMO 0/20 OffEx*
Gold Full PPO 1000/35 OffEx		Platinum Trio ACO HMO 0/20 OffEx†
Silver Full PPO 1300/45 OffEx		Platinum Access+ HMO 0/30 OffEx*
Silver Full PPO 1700/40 OffEx		Platinum Local Access+ HMO 0/30 OffEx*
Bronze Full PPO 3750/65 OffEx		Platinum Trio ACO HMO 0/30 OffEx†
Bronze Full PPO 5100/60 OffEx		Gold Access+ HMO 500/35 OffEx*
		Gold Local Access+ HMO 750/30 OffEx*
		Gold Trio ACO HMO 750/30 OffEx†
		Gold Access+ HMO 1700/30 OffEx*
		Gold Local Access+ HMO 1700/30 OffEx*
		Gold Trio ACO HMO 1700/30 OffEx†
		Silver Access+ HMO 1700/55 OffEx*
		Silver Local Access+ HMO 1700/55 OffEx*
		Silver Trio ACO HMO 1700/55 OffEx†

PPO plans

Our Off-Exchange PPO plans are available with our Full PPO Network that includes providers in all 58 California counties and also offer the flexibility for your employees to see non-network providers. Direct access to network physicians and specialists means no referrals are necessary. These plans also come with a wide range of deductible options.

* The Blue Shield of California Off-Exchange Package for Small Businesses has 31 plans, 18 of which are HMO plans with a choice of the Access+, Local Access+ or Trio ACO HMO network. If you are an employer located in certain California counties whose eligible employees live or work in the Local Access+ HMO service area, you have the option of choosing any of the Local Access+ HMO plans or any of the Access+ HMO plans, but not both. Customers may, however, offer Access+ HMO plans with Trio ACO HMO plans. The Trio ACO HMO plans have the same benefits as our Access+ HMO plans. Please review the Benefit Summary Guide (A16609) for detailed information regarding the Access+ HMO and Local Access+ HMO service areas.

† Please review the Benefit Summary Guide (A16609) or the Trio ACO HMO brochure (A47414) for detailed information regarding the Trio ACO HMO service area.

Off-Exchange Package for Small Business (continued)

By selecting HealthEquity as your HSA administrator, you no longer have to find your own third-party HSA administrator.

HSA-compatible HDHPs*

Many small businesses opt for high-deductible PPO plan coverage for their employees. Deductibles are higher, but monthly rates are lower, and the plans come with an option of opening a health savings account (HSA) to help pay for qualified medical expenses.

Match your HSA-compatible plan with HealthEquity!

Customers may now offer HealthEquity as the HSA administrator for these two plans:

- Bronze Full PPO Savings 4500/30% OffEx
- Bronze Full PPO Savings 5500/40% OffEx

Choosing HealthEquity is an exciting option. Blue Shield will share eligibility and claims data with HealthEquity for a seamless process.

Choose HealthEquity administration by checking the respective box on the Master Group Application when newly enrolling, or on the Request for Contract Change when renewing coverage.

Enrollment is automatic for enrolled employees. They will receive HealthEquity cards directly and will have single sign-on access from Blue Shield's member site to HealthEquity's site.

HealthEquity will bill groups directly for their monthly administration fee.

Who is HealthEquity?

HealthEquity is one of the nation's oldest and largest dedicated health savings custodians. It helps individuals and families build health savings, and employers spend less on benefits through innovative integrated healthcare account administration and investment platforms backed by 24/7/365 service, personalized savings strategies and consumer education.

* Although most consumers who enroll in a HDHP are eligible to open an HSA, members should consult with a financial adviser to determine if a HSA/HDHP is a good financial fit for them. Blue Shield does not offer tax advice or HSAs. HSAs are offered through financial institutions. For more information about HSAs, eligibility, and the law's current provisions, consumers should ask their financial or tax adviser. HSA plan features may vary by institution and may be subject to change by those institutions.

You may offer Trio ACO HMO and Access + HMO together for added savings and flexibility!

HMO plans

Nine of our plans for small business offered off exchange are HMO plans. These plans are available with one of three HMO provider network options: Access+ HMO, Local Access+ HMO, or Trio ACO HMO. Out-of-pocket costs are predictable. If you are an employer located in certain California counties whose eligible employees live or work in the Local Access+ HMO service area, you have the option of choosing any of the Access+ HMO plans or any of the Local Access+ HMO plans, but not both. Customers may choose both Access+ HMO plans and Trio ACO HMO plans. All specialties and levels of care are included in all three plans: the Access+ HMO, Local Access+ HMO, and Trio ACO HMO plans.

Access+ HMO, Local Access+ HMO, and Trio ACO HMO provider counts:

- The Access+ HMO plan gives members access to more than 38,000 doctors and 320 hospitals.
- The Local Access+ HMO plan gives members access to more than 17,000 doctors and 320 hospitals.
- The Trio ACO HMO plan is available in 22 counties and gives members access to 10,000 physicians from the Access+ provider network.

Blue Shield's Off-Exchange Full PPO plans are available in all 58 California counties.

- **Rating region 1** **Rural North/Sierra**
  Alpine, Del Norte, Siskiyou, Modoc, Lassen, Shasta, Trinity, Humboldt, Tehama, Plumas, Nevada, Sierra, Mendocino, Lake, Butte, Glenn, Sutter, Yuba, Colusa, Amador, Calaveras, Tuolumne
- **Rating region 2** **Wine Country**
  Napa, Sonoma, Solano, Marin
- **Rating region 3** **Greater Sacramento Region**
  Sacramento, Placer, El Dorado, Yolo
- **Rating region 4** **San Francisco**
  San Francisco
- **Rating region 5** **Contra Costa**
  Contra Costa
- **Rating region 6** **Alameda**
- **Rating region 7** **Santa Clara**
  Santa Clara
- **Rating region 8** **San Mateo**
  San Mateo
- **Rating region 9** **Monterey Bay**
  Santa Cruz, Monterey, San Benito
- **Rating region 10** **Central Valley North**
  San Joaquin, Stanislaus, Merced, Mariposa, Tulare
- **Rating region 11** **Central Valley South**
  Madera, Fresno, Kings
- **Rating region 12** **South Coast**
  San Luis Obispo, Santa Barbara, Ventura
- **Rating region 13** **Southern Desert**
  Mono, Inyo, Imperial
- **Rating region 14** **Kern**
  Kern
- **Rating region 15** **Los Angeles East**
  Los Angeles ZIP codes starting with 906-912, 915, 917, 918, 935
- **Rating region 16** **Los Angeles West**
  Los Angeles not including ZIP codes above
- **Rating region 17** **Inland Empire**
  San Bernardino, Riverside
- **Rating region 18** **Orange County**
  Orange County
- **Rating region 19** **San Diego**
  San Diego

Off-Exchange Full PPO plans

(Full PPO network available in all 58 counties)

Benefits			PLATINUM	
			Platinum Full PPO 0/10 OffEx	Platinum Full PPO 150/15 OffEx
Calendar-year medical deductible (Copayments for covered services from participating providers accrue to both the participating and non-participating provider calendar-year medical deductibles.)		**Participating providers** (per individual/per family)[5]	$0 per individual/ $0 per family	$150 per individual/ $300 per family
		Non-participating providers (per individual/per family)[5]	$0 per individual/ $0 per family	$300 per individual/ $600 per family
Calendar-year out-of-pocket maximum (Includes the medical plan deductible. Copayments for covered services from participating providers accrue to both the participating and non-participating provider calendar-year out-of-pocket maximums.)		**Participating providers** (per individual/per family)[5]	$2,500 per individual/ $5,000 per family	$3,000 per individual/ $6,000 per family
		Non-participating providers (per individual/per family)[5]	$5,000 per individual/ $10,000 per family	$8,000 per individual/ $16,000 per family
Office visit – primary care doctor		**Participating providers** (per individual/per family)[5]	$10 per visit	$15 per visit (not subject to the calendar-year medical deductible)
		Non-participating providers (per individual/per family)[5]	40%	40%
Preventive health benefits		**Participating providers** (per individual/per family)[5]	No charge[1,3]	No charge[1,3]
		Non-participating providers (per individual/per family)[5]	Not covered	Not covered
Inpatient hospitalization[6] (Coinsurance percentage of up to $2,000/ day + excess charges over $2,000/day for non-participating providers)		**Participating providers** (per individual/per family)[5]	10%	10% (after deductible)
		Non-participating providers (per individual/per family)[5]	40%	40% (after deductible)
Emergency room services not resulting in admission		**Participating providers** (per individual/per family)[5]	$100 per visit + 10%	$100 per visit + 10% (after deductible)
		Non-participating providers (per individual/per family)[5]	$100 per visit + 10%	$100 per visit + 10% (after deductible)
Prenatal and preconception physician office visits		**Participating providers** (per individual/per family)[5]	No charge	No charge (initial visit not subject to the calendar-year medical deductible)
		Non-participating providers (per individual/per family)[5]	40%	40% (after deductible)
Calendar-year pharmacy deductible (Separate from the calendar-year medical deductible. Accrues for the calendar-year out-of-pocket maximum.)		**Participating providers** (per individual/per family)[5]	None	None
		Non-participating providers (per individual/per family)[5]	Not covered	Not covered
Retail prescriptions[2] (up to a 30-day supply)	**Tier 1 drugs**	**Participating providers** (per individual/per family)[5]	$5 per prescription[8]	$5 per prescription[8]
		Non-participating providers (per individual/per family)[5]	Not covered	Not covered
	Tier 2 drugs	**Participating providers** (per individual/per family)[5]	$30 per prescription[8]	$30 per prescription[8]
		Non-participating providers (per individual/per family)[5]	Not covered	Not covered
	Tier 3 drugs	**Participating providers** (per iIndividual/per family)[5]	$50 per prescription[8]	$50 per prescription[8]
		Non-participating providers (per individual/per family)[5]	Not covered	Not covered
	Tier 4 drugs	**Participating providers** (per individual/per family)[5]	30% up to $250 per prescription	30% up to $250 per prescription
		Non-participating providers (per individual/per family)[5]	Not covered	Not covered
Chiropractic[1,4,7] Up to 12 visits per member per calendar year.		**Participating providers** (per individual/per family)[5]	50%[4]	50%[4] (not subject to the calendar-year medical deductible)
		Non-participating providers (per individual/per family)[5]		
Acupuncture by a licensed acupuncturist		**Participating providers** (per individual/per family)[5]	$25 per visit	$25 per visit
		Non-participating providers (per individual/per family)[5]	40%	40% (after deductible)
Teladoc		**Participating providers** (per individual/per family)	$5 copay	$5 copay
		Non-participating providers (per individual/per family)	Not covered	Not covered

See endnotes on page 41. Pending regulatory approval.

GOLD				SILVER	
Gold Full PPO 0/20 OffEx	**Gold Full PPO 250/30 OffEx**	**Gold Full PPO 750/20 OffEx**	**Gold Full PPO 1000/35 OffEx**	**Silver Full PPO 1300/45 OffEx**	**Silver Full PPO 1700/40 OffEx**
$0 per individual/ $0 per family	$250 per individual/ $500 per family	$750 per individual/ $1,500 per family	$1,000 per individual/ $2,000 per family	$1,300 per individual/ $2,600 per family	$1,700 per individual/ $3,400 per family
$0 per individual/ $0 per family	$500 per individual/ $1,000 per family	$1,500 per individual/ $3,000 per family	$2,000 per individual/ $4,000 per family	$2,600 per individual/ $5,200 per family	$3,400 per individual/ $6,800 per family
$6,800 per individual/ $13,600 per family	$6,800 per individual/ $13,600 per family	$6,500 per individual/ $13,000 per family	$6,500 per individual/ $13,000 per family	$6,800 per individual/ $13,600 per family	$6,800 per individual/ $13,600 per family
$10,000 per individual/ $20,000 per family	$10,000 per individual/ $20,000 per family	$10,000 per individual/ $20,000 per family	$10,000 per individual/ $20,000 per family	$10,000 per individual/ $20,000 per family	$10,000 per individual/ $20,000 per family
$20 per visit	$30 per visit (not subject to the calendar-year medical deductible)	$20 per visit (not subject to the calendar-year medical deductible)	$35 per visit (not subject to the calendar-year medical deductible)	$45 per visit (not subject to the calendar-year medical deductible)	$40 per visit (not subject to the calendar-year medical deductible)
40%	40% (after deductible)	40% (after deductible)	40% (after deductible)	50% (after deductible)	50% (after deductible)
No charge[1,3]	No charge[1,3]	No charge[1,3]	No charge[1,3]	No charge[1,3]	No charge[1,3]
Not covered	Not covered	Not covered	Not covered	Not covered	Not covered
30%	20% (after deductible)	20% (after deductible)	20% (after deductible)	40% (after deductible)	30% (after deductible)
40%	40% (after deductible)	40% (after deductible)	40% (after deductible)	50% (after deductible)	50% (after deductible)
$250 per visit + 30%	$200/visit + 20%, (after deductible)	$100 per visit + 20% (after deductible)	$100 per visit + 20% (after deductible)	$250 per visit + 40% (after deductible)	$250 per visit + $30% (after deductible)
$250 per visit + 30%	$200/visit + 20%, (after deductible)	$100 per visit + 20% (after deductible)	$100 per visit + 20% (after deductible)	$250 per visit + 40% (after deductible)	$250 per visit + $30% (after deductible)
No charge	No charge (initial visit not subject to the calendar-year medical deductible)	No charge (initial visit not subject to the calendar-year medical deductible)	No charge (initial visit not subject to the calendar-year medical deductible)	No charge (initial visit not subject to the calendar-year medical deductible)	No charge (initial visit not subject to the calendar-year medical deductible)
40%	40% (after deductible)	40% (after deductible)	40% (after deductible)	50% (after deductible)	50% (after deductible)
None	None	$200 per individual/ $400 per family	$500 per individual/ $1000 per family	$250 per individual/ $500 per family	$300 per individual/ $600 per family
Not covered	Not covered	Not covered	Not covered	Not covered	Not covered
$15 per prescription[8]	$15 per prescription[8]	$10 per prescription[8]	$5 per prescription[8]	$15 per prescription[8]	$15 per prescription[8]
Not covered	Not covered	Not covered	Not covered	Not covered	Not covered
$40 per prescription[8]	$40 per prescription[8]	$30 per prescription[8]	$30 per prescription[8]	$55 per prescription[8]	$50 per prescription[8]
Not covered	Not covered	Not covered	Not covered	Not covered	Not covered
$60 per prescription[8]	$60 per prescription[8]	$50 per prescription[8]	$50 per prescription[8]	$75 per prescription[8]	$75 per prescription[8]
Not covered	Not covered	Not covered	Not covered	Not covered	Not covered
30% up to $250 per prescription	30% up to $250 per prescription	30% up to $250 per prescription	30% up to $250 per prescription	30% up to $250 per prescription	30% up to $250 per prescription
Not covered	Not covered	Not covered	Not covered	Not covered	Not covered
50%[4]	50%[4] (not subject to the calendar-year medical deductible)	50%[4] (not subject to the calendar-year medical deductible)	50%[4] (not subject to the calendar-year medical deductible)	50%[4] (not subject to the calendar-year medical deductible)	50%[4] (not subject to the calendar-year medical deductible)
$25 per visit (after deductible)	$25 per visit (after deductible)	$25 per visit (after deductible)	$25 per visit (after deductible)	$25 per visit (after deductible)	$25 per visit (after deductible)
40%	40% (after deductible)	40% (after deductible)	40% (after deductible)	50% (after deductible)	50% (after deductible)
$5 copay	$5 copay	$5 copay	$5 copay	$5 copay	$5 copay
Not covered	Not covered	Not covered	Not covered	Not covered	Not covered

continued

Off-Exchange Full PPO plans (continued)

(Full PPO network available in all 58 counties)

Benefits			BRONZE	
			Bronze Full PPO 3750/65 OffEx	Bronze Full PPO 5100/60 OffEx
Calendar-year medical deductible (Copayments for covered services from participating providers accrue to both the participating and non-participating provider calendar-year medical deductibles.)		**Participating providers** (per individual/per family)[5]	$3,750 per individual/ $7,500 per family	$5,100 per individual/ $10,200 per family
		Non-participating providers (per individual/per family)[5]	$7,500 per individual/ $15,000 per family	$5,100 per individual/ $10,200 per family
Calendar-year out-of-pocket maximum (Includes the medical plan deductible. Copayments for covered services from participating providers accrue to both the participating and non-participating provider calendar-year out-of-pocket maximums.)		**Participating providers** (per individual/per family)[5]	$6,800 per individual/ $13,600 per family	$6,800 per individual/ $13,600 per family
		Non-participating providers (per individual/per family)[5]	$10,000 per individual/ $20,000 per family	$10,000 per individual/ $20,000 per family
Office visit – primary care doctor		**Participating providers** (per individual/per family)[5]	$65 per visit (subject to deductible)	$60 per visit (first 3 visits not subject to deductible, remaining visits subject to deductible)
		Non-participating providers (per individual/per family)[5]	50% (subject to deductible)	50% (subject to deductible)
Preventive health benefits		**Participating providers** (per individual/per family)[5]	No charge[1,3] (not subject to the calendar-year medical deductible)	No charge[1,3] (not subject to the calendar-year medical deductible)
		Non-participating providers (per individual/per family)[5]	Not covered	Not covered
Inpatient hospitalization[6] (Coinsurance percentage of up to $2,000/day + excess charges over $2,000/day for non-participating providers)		**Participating providers** (per individual/per family)[5]	10% (after deductible)	15% (after deductible)
		Non-participating providers (per individual/per family)[5]	50% (after deductible)	50% (after deductible)
Emergency room services not resulting in admission		**Participating providers** (per individual/per family)[5]	50% (after deductible)	$200 per visit + 15% (after deductible)
		Non-participating providers (per individual/per family)[5]	50% (after deductible)	$200 per visit + 15% (after deductible)
Prenatal and preconception physician office visits		**Participating providers** (per individual/per family)[5]	No charge (initial visit not subject to the calendar-year medical deductible)	No charge (initial visit not subject to the calendar-year medical deductible)
		Non-participating providers (per individual/per family)[5]	50% (after deductible)	50% (after deductible)
Calendar-year pharmacy deductible (Separate from the calendar-year medical deductible. Accrues for the calendar-year out-of-pocket maximum.)		**Participating providers** (per individual/per family)[5]	$225 per individual/$450 per family	$200 per individual/$400 per family
		Non-participating providers (per individual/per family)[5]	Not covered	Not covered
Retail prescriptions[2] (up to a 30-day supply)	**Tier 1 drugs**	**Participating providers** (per individual/per family)[5]	$15 per prescription[8]	$15 per prescription[8]
		Non-participating providers (per individual/per family)[5]	Not covered	Not covered
	Tier 2 drugs	**Participating providers** (per individual/per family)[5]	$50 per prescription[8]	$50 per prescription[8]
		Non-participating providers (per individual/per family)[5]	Not covered	Not covered
	Tier 3 drugs	**Participating providers** (per iIndividual/per family)[5]	$75 per prescription[8]	$75 per prescription[8]
		Non-participating providers (per individual/per family)[5]	Not covered	Not covered
	Tier 4 drugs	**Participating providers** (per individual/per family)[5]	30% up to $500 per prescription	30% up to $500 per prescription
		Non-participating providers (per individual/per family)[5]	Not covered	Not covered
Chiropractic[1,4,7] Up to 12 visits per member per calendar year.		**Participating providers** (per individual/per family)[5]	50%[4] (not subject to the calendar-year medical deductible)	50%[4] (not subject to the calendar-year medical deductible)
		Non-participating providers (per individual/per family)[5]		
Acupuncture by a licensed acupuncturist		**Participating providers** (per individual/per family)[5]	$25 per visit (after deductible)	$25 per visit (after deductible)
		Non-participating providers (per individual/per family)[5]	50% (after deductible)	50% (after deductible)
Teladoc		**Participating providers** (per individual/per family)[5]	$5 copay	$5 copay
		Non-participating providers (per individual/per family)[5]	Not covered	Not covered

See endnotes on page 41. Pending regulatory approval.

Small Business HSA-compatible HDHP Full PPO plans

(Full PPO network available in all 58 counties)

Benefits			SILVER	BRONZE	
			Silver Full PPO Savings 2000/20% OffEx	Bronze Full PPO Savings 4700/40% OffEx	Bronze Full PPO Savings 5500/40% OffEx
Calendar-year Integrated Medical and Pharmacy Deductible (The integrated deductible applies to both medical and pharmacy services. For family coverage, there is a separate individual deductible within the family deductible. This means that the deductible will be met for a family member when he/she meets the individual deductible or two or more family members meet the family deductible, whichever occurs first. Deductibles for participating and non-participating providers accrue separately.)		**Participating providers** (per individual/per family)[4]	$2,000 per individual on an individual plan ($2,600 per individual on a family plan) / $4,000 per family (embedded)	$4,700 per individual/ $9,400 per family (embedded)	$5,500 per individual/ $11,000 per family (embedded)
		Non-participating providers (per individual/per family)[4]	$4,000 per individual/ $8,000 per family (embedded)	$9,400 per individual/ $18,800 per family (embedded)	$5,500 per individual/ $11,000 per family (embedded)
Calendar-year out-of-pocket maximum (Includes the calendar-year medical and pharmacy deductible, physician office dollar copays and prescription drug copays. For family coverage, there is an individual out-of-pocket maximum within the family out-of-pocket maximum. This means that the out-of-pocket maximum will be met for an individual who meets the individual out-of-pocket maximum prior to the family meeting the family out-of-pocket maximum. Calendar-year out-of-pocket maximum accumulates separately for participating and non-participating providers.)		**Participating providers** (per individual/per family)[4]	$5,050 per individual/ $6,500 per family (embedded)	$6,550 per individual/ $13,100 per family (embedded)	$6,550 per individual/ $13,100 per family (embedded)
		Non-participating providers (per individual/per family)[4]	$10,000 per individual/ $20,000 per family (embedded)	$10,000 per family/ $20,000 per family (embedded)	$10,000 per individual/ $20,000 per family (embedded)
Office visit – primary care doctor		**Participating providers** (per individual/per family)[4]	20% (after deductible)	40% (after deductible)	40% (after deductible)
		Non-participating providers (per individual/per family)[4]	50% (after deductible)	50% (after deductible)	50% (after deductible)
Preventive health benefits		**Participating providers** (per individual/per family)[4]	No charge[4]	No charge[4]	No charge[4]
		Non-participating providers (per individual/per family)[4]	Not covered	Not covered	Not covered
Inpatient hospitalization[5] (Coinsurance percentage of up to $2,000/day + excess charges over $2,000/day for non-participating providers)		**Participating providers** (per individual/per family)[4]	20% (after deductible)	40% (after deductible)	40% (after deductible)
		Non-participating providers (per individual/per family)[4]	50% (after deductible)	50% (after deductible)	50% (after deductible)
Emergency room services not resulting in admission		**Participating providers** (per individual/per family)[4]	$150 per visit + 20% (after deductible)	$250 per visit + 40% (after deductible)	$200 per visit + 40% (after deductible)
		Non-participating providers (per individual/per family)[4]	$150 per visit + 20% (after deductible)	$250 per visit + 40% (after deductible)	$200 per visit + 40% (after deductible)
Prenatal and preconception physician office visits		**Participating providers** (per individual/per family)[4]	No charge – first visit only (not subject to the calendar-year medical deductible)	No charge – first visit only (not subject to the calendar-year medical deductible)	No charge – first visit only (not subject to the calendar-year medical deductible)
		Non-participating providers (per individual/per family)[4]	50% (after deductible)	50% (after deductible)	50% (after deductible)
Retail prescriptions[2] (up to a 30-day supply)	**Tier 1 drugs**	**Participating providers** (per individual/per family)[4]	$15 per prescription[7]	40% up to $500 per prescription[7]	$15 per prescription[6]
		Non-participating providers (per individual/per family)[4]	Not covered	Not covered	Not covered
	Tier 2 drugs	**Participating providers** (per individual/per family)[4]	$50 per prescription[7]	40% up to $500 per prescription[7]	$50 per prescription[6]
		Non-participating providers (per individual/per family)[4]	Not covered	Not covered	Not covered
	Tier 3 drugs	**Participating providers** (per individual/per family)[4]	$75 per prescription[7]	40% up to $500 per prescription[7]	$75 per prescription[6]
		Non-participating providers (per individual/per family)[4]	Not covered	Not covered	Not covered
	Tier 4 drugs	**Participating providers** (per individual/per family)[4]	30% up to $250 per prescription	40% up to $500 per prescription[7]	40% up to $500 per prescription
		Non-participating providers (per individual/per family)[4]	Not covered	Not covered	Not covered
Chiropractic		**Participating providers** (per individual/per family)[4]	Not covered	Not covered	Not covered
		Non-participating providers (per individual/per family)[4]	Not covered	Not covered	Not covered
Acupuncture by a licensed acupuncturist		**Participating providers** (per individual/per family)[4]	$25 per visit (after deductible)	$25 per visit (after deductible)	$25 per visit (after deductible)
		Non-participating providers (per individual/per family)[4]	50% (after deductible)	50% (after deductible)	50% (after deductible)
Teladoc		**Participating providers** (per individual/per family)[4]	$5 copay	$5 copay	$5 copay
		Non-participating providers (per individual/per family)[4]	Not covered	Not covered	Not covered

See endnotes on page 41. Pending regulatory approval.

Off-Exchange HMO plans

Blue Shield offers Small Business Off-Exchange HMO plans with three network options: Access+ HMO (the full HMO network); Local Access+ HMO (the narrow HMO network); and Trio ACO HMO (a narrow network option with select Trio ACO HMO providers).

Access+ and Local Access+ HMO plans

Our Access+ HMO plans offer groups the largest HMO network in our portfolio. Local Access+ HMO plans offer all the same benefits of our Access+ HMO plans within a select (smaller) network, resulting in a lower rate. Depending on your location, the Local Access+ HMO plans may result in more savings than Access+ HMO plans.

Trio ACO HMO plans

An accountable care organization (ACO) is a network of doctors and hospitals who work directly with payers to share responsibility for providing coordinated care to patients, working together to limit unnecessary spending.

The Trio ACO HMO option may be the perfect answer for the small business that wants to offer comprehensive, high-quality coverage at an even more affordable rate than the Local Access+ HMO plan. With coverage in 22 counties, the Trio ACO HMO plan offers a more integrated and coordinated care model at a lower rate. Remember, as of October 1, 2016, small businesses can offer the Trio ACO HMO alongside the Access+ HMO, giving them more options and savings.

Purchasing an HMO plan

To purchase an Access+ HMO, Local Access+ HMO, or Trio ACO HMO plan:

1. You, the small business employer, must be located in the plan's service area, and
2. Your eligible employees must live or work in the service area.

County listing of California for Access+ HMO, Local Access+ HMO, and Trio ACO HMO

HMO plans with the Access+ HMO network are available in the following counties:		**HMO plans with the Local Access+ HMO network are available in the following counties:**	**Trio ACO HMO is available in the following counties:**
Alameda	Sacramento	Contra Costa*	Alameda*
Butte	San Bernardino*	Kern*	Contra Costa*
Contra Costa	San Diego*	Los Angeles*	El Dorado*
El Dorado	San Francisco	Marin	Kern*
Fresno	San Joaquin	Orange	Los Angeles*
Imperial	San Luis Obispo	Riverside*	Nevada*
Kern	San Mateo	Sacramento*	Orange
Kings	Santa Barbara	San Bernardino*	Placer*
Los Angeles	Santa Clara	San Diego*	Riverside*
Madera	Santa Cruz	San Francisco	Sacramento*
Marin	Solano	San Luis Obispo	San Bernardino*
Merced	Sonoma	San Mateo*	San Diego*
Nevada*	Stanislaus	Santa Clara	San Francisco
Orange	Tulare	Santa Cruz	San Joaquin
Placer	Ventura	Sonoma	San Mateo*
Riverside	Yolo	Stanislaus	Santa Clara
		Ventura*	Santa Cruz
		Yolo	Solano*
			Stanislaus*
			Tulare*
			Ventura*
			Yolo*

* Partial county availability. Please see the Benefit Summary Guide (A16609) for a full ZIP code listing.

If you are an employer located in certain California counties whose eligible employees live or work in the Local Access+ HMO service area, you have the option of choosing the Local Access+ HMO plans or the Access+ HMO plans, but not both. Customers may, however, offer Access+ HMO plans with Trio ACO HMO plans. The Trio ACO HMO plans have the same benefits as our Access+ HMO plans.

Enrolled employees and their dependents must live or work in the Trio ACO HMO plan service area to be eligible for coverage.

Please visit blueshieldca.com/ACO for the latest service area information for these plans.

Off-Exchange HMO plans

Benefits		PLATINUM				
		Platinum Local Access+ HMO 0/25 OffEx*	Platinum Access+ HMO 0/25 OffEx*	Platinum Local Access+ HMO 0/20 OffEx* NEW	Platinum Access+ HMO 0/20 OffEx* NEW	Platinum Local Access+ HMO 0/30 OffEx* NEW
Calendar-year medical deductible		None	None	None	None	None
Calendar-year out-of-pocket maximum (For many covered services)		$2,500 per individual/ $5,000 per family	$2,500 per individual/ $5,000 per family	$1,750 per individual/ $3,500 per family	$1,750 per individual/ $3,500 per family	$3,000 per individual/ $6,000 per family
Office visit – primary care doctor		$25 per visit	$25 per visit	$20 per visit	$20 per visit	$30 per visit
Preventive health benefits		No charge	No charge	No charge	No charge	No charge
Inpatient hospitalization		$250 per day up to 3 days per admission	$250 per day up to 3 days per admission	$500 per admission	$500 per admission	$500 per day, up to 4 days
Emergency room services not resulting in admission		$250 per visit	$250 per visit	$200 per visit	$200 per visit	$250 per visit
Prenatal and preconception physician office visits		No charge	No charge	No charge	No charge	No charge
Calendar-year pharmacy deductible		None	None	None	None	None
Retail prescriptions[1,5] (up to a 30-day supply)	**Tier 1 drugs**	$5 per prescription[4]	$5 per prescription[4]	$5 per prescription[4]	$5 per prescription[4]	$5 per prescription[4]
	Tier 2 drugs	$15 per prescription[4]	$15 per prescription[4]	$15 per prescription[4]	$15 per prescription[4]	$15 per prescription[4]
	Tier 3 drugs	$25 per prescription[4]	$25 per prescription[4]	$25 per prescription[4]	$25 per prescription[4]	$25 per prescription[4]
	Tier 4 drugs	20% up to $250 per prescription	20% up to $250 per prescription	20% up to $250 per prescription	20% up to $250 per prescription	20% up to $250 per prescription
Chiropractic[3] (up to 15 visits per member per calendar year)		$15 per visit	$15 per visit	$15 per visit	$15 per visit	$15 per visit
Acupuncture		$15 per visit	$15 per visit	$15 per visit	$15 per visit	$15 per visit
Teladoc		$5 copay	$5 copay	$5 copay	$5 copay	$5 copay

See endnotes on page 42. Pending regulatory approval.

	GOLD				SILVER	
Platinum Access+ HMO 0/30 OffEx* NEW	**Gold Local Access+ HMO 500/35 OffEx**	**Gold Access+ HMO 500/35 OffEx**	**Gold Local Access+ HMO 1700/30 OffEx***	**Gold Access+ HMO 1700/30 OffEx***	**Silver Local Access+ HMO 1700/55 OffEx***	**Silver Access+ HMO 1700/55 OffEx***
None	$500 per individual/ $1,000 per family	$500 per individual/ $1,000 per family	$1,700 per individual/ $3,400 per family	$1,700 per individual/ $3,400 per family	$1,700 per individual/ $3,400 per family	$1,700 per individual/ $3,400 per family
$3,000 per individual/ $6,000 per family	$5,600 per individual/ $11,200 per family	$5,600 per individual/ $11,200 per family	$6,000 per individual/ $12,000 per family	$6,000 per individual/ $12,000 per family	$6,800 per individual/ $13,600 per family	$6,800 per individual/ $13,600 per family
$30 per visit	$35 per visit	$35 per visit	$30 per visit	$30 per visit	$55 per visit	$55 per visit
No charge	No charge	No charge	No charge	No charge	No charge	No charge
$500 per day, up to 4 days	20%[2]	20%[2]	20%[2]	20%[2]	40%[2]	40%[2]
$250 per visit	$250 (after deductible)	$250 (after deductible)	$200 per visit (after deductible)	$200 per visit (after deductible)	$275 per visit (after deductible)	$275 per visit (after deductible)
No charge	No charge, deductible waived	No charge, deductible waived	No charge, deductible waived	No charge, deductible waived	No charge, deductible waived	No charge, deductible waived
None	None	None	$300 per individual/ $600 per family	$300 per individual/ $600 per family	$275 per individual/ $550 per family	$275 per individual/ $550 per family
$5 per prescription[4]	$15 per prescription[4]	$15 per prescription[4]	$15 per prescription[4]	$15 per prescription[4]	$15 per prescription[4]	$15 per prescription[4]
$15 per prescription[4]	$30 per prescription[4]	$30 per prescription[4]	$30 per prescription[4]	$30 per prescription[4]	$55 per prescription[4]	$55 per prescription[4]
$25 per prescription[4]	$50 per prescription[4]	$50 per prescription[4]	$50 per prescription[4]	$50 per prescription[4]	$75 per prescription[4]	$75 per prescription[4]
20% up to $250 per prescription	20% up to $250 per prescription	20% up to $250 per prescription	20% up to $250 per prescription	20% up to $250 per prescription	20% up to $250 per prescription	20% up to $250 per prescription
$15 per visit	$15 per visit	$15 per visit	$15 per visit	$15 per visit	$15 per visit	$15 per visit
$15 per visit	$15 per visit	$15 per visit	$15 per visit	$15 per visit	$15 per visit	$15 per visit
$5 copay	$5 copay	$5 copay	$5 copay	$5 copay	$5 copay	$5 copay

Off-Exchange Trio ACO HMO plans

Benefits		PLATINUM COVERAGE			GOLD COVERAGE		SILVER COVERAGE
		Platinum Trio ACO HMO 0/25 OffEx	**Platinum Trio ACO HMO 0/20 OffEx NEW**	**Platinum Trio ACO HMO 0/30 OffEx NEW**	**Gold Trio ACO HMO 500/35 OffEx**	**Gold Trio ACO HMO 1700/30 OffEx**	**Silver Trio ACO HMO 1700/55 OffEx**
Calendar-year facility deductible		None	None	None	$500 per individual/ $1,000 per family	$1,700 per individual/ $3,400 per family	$1,700 per individual/ $3,400 per family
Calendar-year out-of-pocket maximum		$2,500 per individual/ $5,000 per family	$1,750 per individual/ $3,500 per family	$3,000 per individual/ $6,000 per family	$5,600 per individual/ $11,200 per family	$6,000 per individual/ $12,000 per family	$6,800 per individual/ $13,600 per family
Office visit – primary care doctor		$25 per visit	$20 per visit	$30 per visit	$35 per visit	$30 per visit	$55 per visit
Preventive health benefits		No charge	No charge	No charge	No charge	No charge	No charge
Inpatient hospitalization		$250 per day up to 3 days per admission	$500 per admission	$500 per day, up to 4 days	20%[2]	20%[2]	40%[2]
Emergency room services not resulting in admission		$250 per visit	$200 per visit	$250 per visit	$250 per visit (after deductible)	$200 per visit (after deductible)	$275 per visit (after deductible)
Prenatal and preconception physician office visits		No charge	No charge	No charge	No charge, deductible waived	No charge, deductible waived	No charge, deductible waived
Calendar-year pharmacy deductible		None	None	None	None	$300 per individual/ $600 per family	$275 per individual/ $550 per family
Retail prescriptions[1,4,5] (up to a 30-day supply)	**Tier 1 drugs**	$5 per prescription	$5 per prescription	$5 per prescription	$15 per prescription	$15 per prescription	$15 per prescription
	Tier 2 drugs	$15 per prescription	$15 per prescription	$15 per prescription	$30 per prescription	$30 per prescription	$55 per prescription
	Tier 3 drugs	$25 per prescription	$25 per prescription	$25 per prescription	$50 per prescription	$50 per prescription	$75 per prescription
	Tier 4 drugs	20% up to $250 per prescription	20% up to $250 per prescription	20% up to $250 per prescription	20% up to $250 per prescription	20% up to $250 per prescription	20% up to $250 per prescription
Chiropractic[3] (up to 15 visits per member per calendar year)		$15 per visit	$15 per visit	$15 per visit	$15 per visit	$15 per visit	$15 per visit
Acupuncture Services (office location)		$15 per visit	$15 per visit	$15 per visit	$15 per visit	$15 per visit	$15 per visit
Teladoc		$5 copay	$5 copay	$5 copay	$5 copay	$5 copay	$5 copay

See endnotes on page 42.

Mirror Package for Small Business

Our plan names align closely with Covered California for Small Business. The names make it easy to understand the benefits each plan offers.

The plan names follow this format:

Metal tier + actuarial value + product type + network + suffix (Mirror)

The **Blue Shield of California Mirror Package** offers you the opportunity to purchase the same plans that Blue Shield is offering through Covered California for Small Business, directly through your broker.

Please note that plans in the Mirror Package cannot be offered in conjunction with plans in any of our other small business plan packages. To learn more about the health insurance marketplace, visit **HealthCare.gov** or call **(800) 318-2596** or **TTY: (855) 889-4325**.

Blue Shield of California Mirror Package for Small Business (seven plans to choose from)

PPO	HMO
Blue Shield Platinum 90 PPO 0/15	Blue Shield Platinum 90 HMO 0/15
Blue Shield Gold 80 PPO 0/30	Blue Shield Gold 80 HMO 0/30
Blue Shield Silver 70 PPO 2000/45	Blue Shield Silver 70 HMO 2000/45
Blue Shield Bronze 60 PPO 6300/75	

Note: These plans are available for purchase directly through Blue Shield.

Our Mirror PPO plans are available at all metal levels and use the same PPO network as our Off-Exchange PPO plans.

Trio ACO HMO plans

Just like our Off-Exchange Trio ACO HMO plans,* the Mirror Trio ACO HMO plans are available in 22 counties offering comprehensive, high-quality coverage at a more affordable rate.

With coverage in 22 counties,† the Trio ACO HMO plan offers a more integrated and coordinated care model at a lower rate. Remember, as of October 1, 2016, small businesses can offer the Trio ACO HMO alongside the Access+ HMO, giving business owners more options and savings.

* Partial county availability. Please see the Benefit Summary Guide (A16609) for a full ZIP code listing.

PPO Mirror Plans with the Full PPO network

Benefits			Platinum 90 PPO 0/15
Calendar-year medical deductible – individual/family (Copayments for covered services from participating providers accrue to both the participating and non-participating provider calendar-year medical deductibles.)		**Participating providers** (per individual/per family)[4]	$0
		Non-participating providers (per individual/per family)[4]	$0
Calendar-year out-of-pocket maximum – individual/family (Includes the medical plan deductible. Copayments for covered services from participating providers accrue to both the participating and non-participating provider calendar-year out of pocket maximums.)		**Participating providers** (per individual/per family)[4]	$4,000/$8,000
		Non-participating providers (per individual/per family)[4]	$8,000/$16,000
Office visit – primary care		**Participating providers** (per individual/per family)[4]	$15
		Non-participating providers (per individual/per family)[4]	50%
Urgent Care		**Participating providers** (per individual/per family)[4]	$15
		Non-participating providers (per individual/per family)[4]	50%
Preventive health benefits		**Participating providers** (per individual/per family)[4]	No charge[3]
		Non-participating providers (per individual/per family)[4]	Not covered
Inpatient hospitalization (up to $2000/day + excess charges over $2000/day for non-participating providers.)		**Participating providers** (per individual/per family)[4]	10%
		Non-participating providers (per individual/per family)[4]	50%
Emergency room services		**Participating providers** (per individual/per family)[4]	$150
		Non-participating providers (per individual/per family)[4]	$150
Prenatal and preconception physician office visits		**Participating providers** (per individual/per family)[4]	No charge
		Non-participating providers (per individual/per family)[4]	50%
Calendar-year pharmacy deductible		**Participating providers** (per individual/per family)[4]	$0
		Non-participating providers (per individual/per family)[4]	Not covered
Retail prescriptions[1,4,5] (up to a 30-day supply)	**Tier 1 drugs**	**Participating pharmacy** (per individual/per family)[4]	$5[2,7]
		Non-participating pharmacy (per individual/per family)[4]	Not covered
	Tier 2 drugs	**Participating pharmacy** (per individual/per family)[4]	$15[2,7]
		Non-participating pharmacy (per individual/per family)[4]	Not covered
	Tier 3 drugs	**Participating providers** (per individual/per family)[4]	$25[2,7]
		Non-participating providers (per individual/per family)[4]	Not covered
	Tier 4 drugs	**Participating pharmacy** (per individual/per family)[4]	10% up to $250 max[2,7]
		Non-participating pharmacy (per individual/per family)[4]	Not covered
Chiropractic		**Participating providers** (per individual/per family)[4]	Not covered
		Non-participating providers (per individual/per family)[4]	Not covered
Acupuncture		**Participating providers** (per individual/per family)[4]	$15
		Non-participating providers (per individual/per family)[4]	50%
Teladoc		**Participating providers** (per individual/per family)[4]	$5
		Non-participating providers (per individual/per family)[4]	Not covered

See endnotes on page 42. Pending regulatory approval.

Gold 80 PPO 0/30	Silver 70 PPO 2000/45	Bronze 60 PPO 6300/75
$0	$2,000/$4,000	$6,300/$12,600
$0	$4,000/$8,000	$6,300/$12,600
$6,750/$13,500	$6,800/$13,600	$6,800/$13,600
$10,000/$20,000	$10,000/$20,000	$10,000/$20,000
$30	$45	$75 (first three visits not subject to the calendar-year medical deductible)
50%	50% (subject to deductible)	50% (subject to deductible)
$30	$45	$75 (first three visits not subject to the calendar-year medical deductible)
50%	50% (subject to deductible)	Not covered
No charge[3]	No charge[3]	No charge[3]
Not covered	Not covered	Not covered
20%	20% (subject to deductible)	100% (subject to deductible)
50%	50% (subject to deductible)	50% (subject to deductible)
$325	$350	100% (subject to deductible)
$325	$350	100% (subject to deductible)
No charge	No charge	No charge
50%	50% (subject to deductible)	50% (subject to deductible)
$0	$250/$500	$500/$1,000
Not covered	Not covered	Not covered
$15[2,7]	$15[2,7]	100% up to $500 max (subject to Rx deductible)[2,6]
Not covered	Not covered	Not covered
$55[2,7]	$55 (subject to Rx deductible)[2,7]	100% up to $500 max (subject to Rx deductible)[2,6]
Not covered	Not covered	Not covered
$75[2,7]	$85 (subject to Rx deductible)[2,7]	100% up to $500 max (subject to Rx deductible)[2,6]
Not covered	Not covered	Not covered
20% up to $250 max[2,7]	20% up to $250 max (subject to Rx deductible)[2,7]	100% up to $500 max (subject to Rx deductible)[2,6]
Not covered	Not covered	Not covered
Not covered	Not covered	Not covered
Not covered	Not covered	Not covered
$30	$45	$75 (first three visits not subject to the calendar-year medical deductible)
50%	50% (subject to deductible)	50% (subject to deductible)
$5	$5	$5 (first three visits not subject to the calendar-year medical deductible)
Not covered	Not covered	Not covered

HMO Mirror Plans

Benefits		Platinum 90 HMO 0/15	Gold 80 HMO 0/30	Silver 70 HMO 2000/45
Calendar-year medical deductible – individual/family		$0	$0	$2,000/$4,000
Calendar year out-of-pocket maximum – individual/family		$4,000/$8,000	$6,750/$13,500	$6,800/$13,600
Office visit – primary care		$15	$30	$45
Urgent care visit		$15	$30	$45
Preventive health benefits		No charge	No charge	No charge
Inpatient hospitalization		$250 per day up to five days per admission	$600 per day up to five days per admission	20% (subject to deductible)
Emergency room services		$150	$325	$350
Prenatal and preconception physician office visits		No charge	No charge	No charge
Calendar-year pharmacy deductible		None	None	$250/$500
Retail prescriptions (up to a 30-day supply)	**Tier 1 drugs**	$5[1,4,5]	$15[1,4,5]	$15[1,4,5]
	Tier 2 drugs	$15[1,4,5]	$55[1,4,5]	$55 (subject to Rx deductible)[1,4,5]
	Tier 3 drugs	$25[1,4,5]	$75[1,4,5]	$85 (subject to Rx deductible)[1,4,5]
	Tier 4 drugs	10% up to a max of $250[1,4,5]	20% up to a max of $250[1,4,5]	20% up to a max of $250 (subject to Rx deductible)[1,4,5]
Chiropractic		Not covered	Not covered	Not covered
Acupuncture		$15	$30	$45
Teladoc		$5	$5	$5

See endnotes on page 42. Pending regulatory approval.

The value of offering specialty coverage

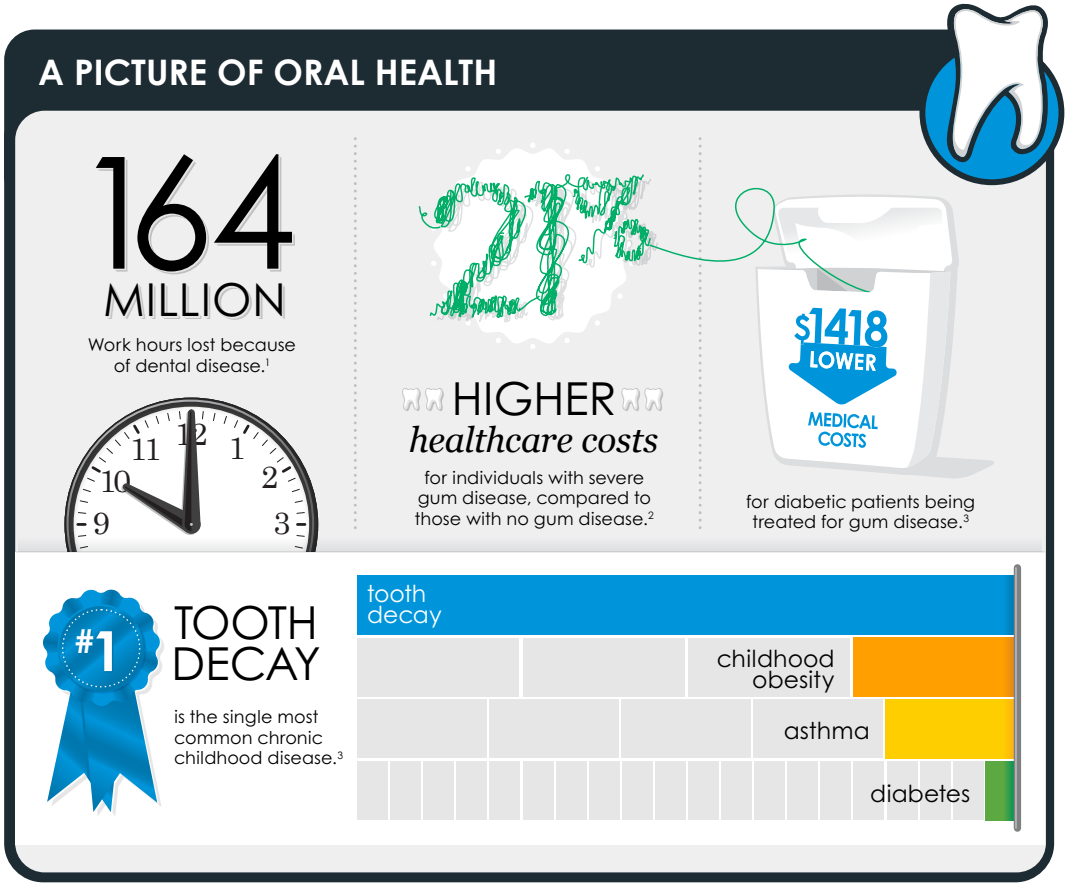
Complete your coverage with dental, vision and life insurance

No health coverage package is complete without dental, vision and life insurance.

With fully integrated billing and administration on all Blue Shield specialty plans, you'll be helping your employees stay happier, healthier and more productive. All specialty plans can be purchased with or without a Blue Shield health coverage package.

Advantages worth smiling about

Broad dental provider networks and a wide range of plans make it easy to meet your company's needs.



1 Charles Bertolami, American Dental Education Association and Herman Robert Fox, Dean of the New York University College of Dentistry. Roll Call, Inc. April 23, 2009.

2 "Stress, Depression, Cortisol, and Periodontal Disease," Journal of Periodontology. November 2007.

3 Claims study. Dr. Clay Hedlund, CIGNA dental director and Dr. Marjorie Jeffcoat, Dean Emeritus and professor, University of Pennsylvania School of Dental Medicine. Presented at International Association for Dental Research. April 2009.

Blue Shield dental plans offer a variety of benefit levels, rate options, and plan flexibility. Dental coverage may help employees avoid many preventable health problems that can be harmful to their overall wellness and productivity.

- Your employees have convenient access to quality dental coverage to support their oral health. The dental PPO and INO networks include more than 51,000 providers in California (among the top five networks in the state!) and nearly 298,000 nationwide, and the dental HMO network includes more than 22,800 providers in California.[1]
- Our dental plans (except voluntary plans) require a 50% employer contribution and 65% employee participation. Voluntary dental plans don't require employer contributions.

Dental Smile Rollover Rewards program!

Employees have another way to achieve savings while maintaining their health through the Dental Smile Rollover Rewards program. It's automatically a part of their dental PPO plan or dental INO plan.

It's easy

All your employees need to do is visit their dentist at least once a year, and, if at the end of the year, their paid dental claims are below the claim threshold, they'll receive their rewards. And if they see a dentist in their PPO network,* versus a non-network dentist, they'll receive an additional boost to their rewards amount.

The reward amount is based on the dental plan's calendar-year maximum and the program's annual claim threshold for your employee plan(s). Any rewards your employee earns will rollover in the form of calendar-year maximum funds and raise their calendar-year maximum for the next benefit year.

Here's how it works

1. Your employees visit their dentist at least once during the benefit year.
2. At the end of the benefit year, if their claims are less than their annual claim threshold, they'll earn their annual reward.
3. If all your employee claims were for network dentists, they will earn an additional $100 reward.
4. Your employees' annual reward, up to the program's reward maximum, will be added to their calendar-year maximum for the next benefit year.

* In Network Only (INO) plan members will automatically receive the network reward. INO plans do not cover non-network charges unless they are for emergency services. Emergency services do not count toward the reward.

The Blue Shield advantage

- Dual and Triple Options: With Dual Option, you can provide employees with a choice between any two dental plans, including voluntary plans. With Triple Option, you can offer any two dental HMO plans with a dental PPO or INO, or three dental HMO plans.
- No waiting periods so employees begin accessing care after the effective date.[2]
- Reduced out-of-pocket costs when employees use a network dentist, so they pay less.

Dental PPO Smile plans

Key features:

- Plans with orthodontic coverage include a $1,000 calendar-year, not lifetime, maximum for children and adults.
- Plans with dental implant benefits are available to all sizes of small-business employers.
- Diagnostic and preventive service are covered at 100% when using network providers.
- Oral cancer screening are covered as a diagnostic and preventive service.
- You have a choice of calendar-year maximum plans up to $2,000.

Dental INO Smile plans

The Smile In-Network Only (INO) dental plan portfolio* provides a choice of options to help protect your employees' oral health and your bottom line. INO plans pay benefits on a coinsurance basis but with no non-network coverage. The INO network includes all the same providers as the dental PPO network.[1] The advantage of INO plans is access to a large network at reduced prices, with the same key features listed above for dental PPO plans.

An INO plan lets you tailor dental coverage for your employees by selecting options at either a $1,500 or $2,500 calendar-year maximum on a voluntary or contributory basis and with or without orthodontia coverage.

Dental HMO plans

Dental HMO plans give your employees access to cost-effective care through the network dental provider of their choice.

Blue Shield's dental HMO plans – DHMO Basic, DHMO Plus and DHMO Deluxe – offer basic-, middle- and rich-level benefits, respectively, in addition to a voluntary option through DHMO Voluntary. Dental HMO plans are designed to help members take more control of their dental costs.[1]

Key features:

- No charge for covered diagnostic and preventive services, such as full mouth X-rays, cleanings and sealants
- Orthodontic benefits for adults and children
- No waiting periods
- Virtually no claim forms
- No deductible and no calendar-year maximums
- Covered specialty-care services available with referral from a dental provider

* Underwritten by Blue Shield of California Life & Health Insurance Company

1 Dental providers in and out of California are available through a contracted dental plan administrator.

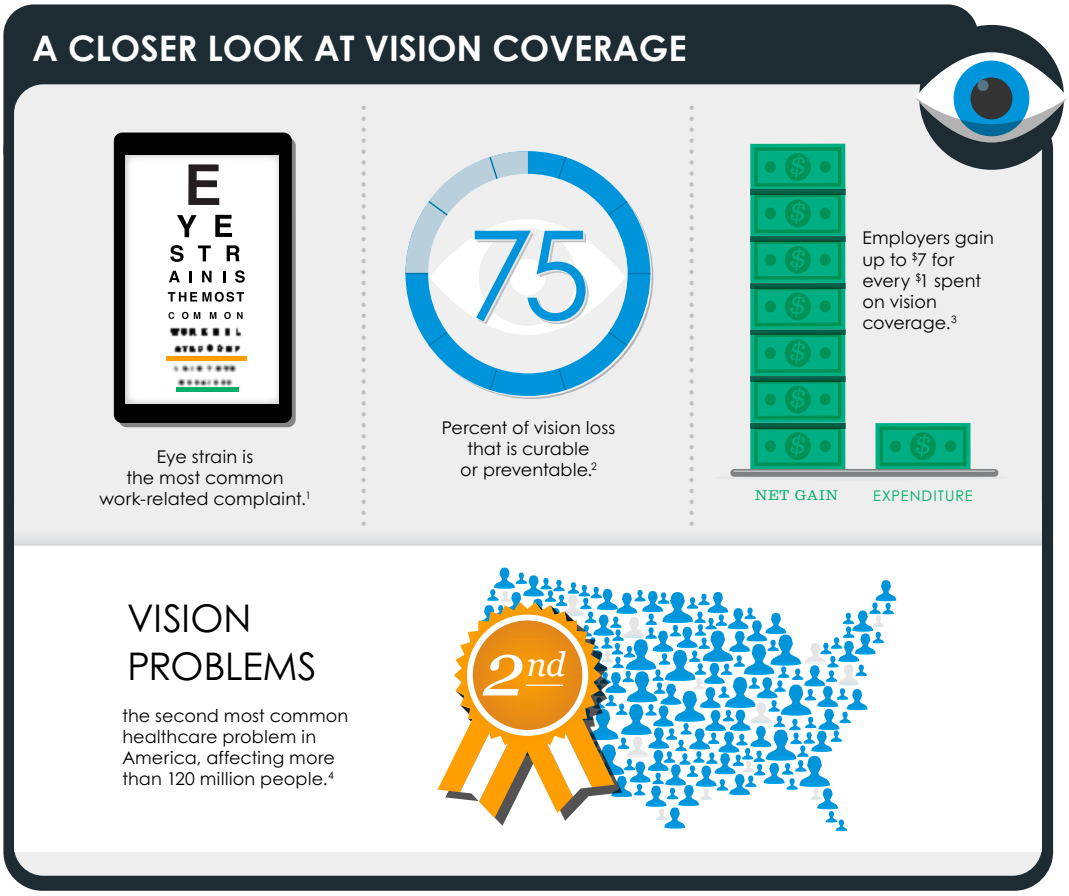
2 The voluntary dental PPO and voluntary INO plans have a 12-month waiting period for "major" services. For groups with prior coverage including "major" benefits for 12 months or more, the 12-month waiting period will be waived.

Clear advantages to protect vision

With one of the largest vision plan provider networks[1] in and out of California, we make it easy for your employees to access vision care from independent eyecare professionals, as well as major retail providers.

The vision network[1] includes more than 29,000 ophthalmologists, optometrists, and opticians nationwide, including more than 6,900 in California. Retail providers include LensCrafters, Site for Sore Eyes, For Eyes Optical, and Target Optical, plus wholesale locations including Walmart and Sam's Club, and warehouse provider Costco (membership required).

Our wide range of affordable vision plans give your employees the option to choose any vision provider they want, or save money by using a network provider.



1 "Vision in Business," Vision Council of America, July 2007.
2 The Cost Utility of Eye Care and the ICO Advocacy Program, International Council on Ophthalmology, June 2008.
3 "Vision Care: Focusing on the Workplace Benefit," Vision Council of America, Fall 2008.
4 "Vision Disorders in Public Health," Kleinstein, Robert N., 1984.

Blue Shield advantages

Many plan choices based on frequency of benefits, copayments, allowances, and contact lens coverage option

No waiting periods so employees can begin accessing care after the effective date

Online option: Our network includes a convenient online provider, MESVisionOptics.com, which allows members to shop for contact lenses, readers, and other accessories 24/7

Rich plan options offering $150 frame allowances with additional lens enhancements and plans that include an allowance for both glasses and contact lenses in the same benefit period.

Easy administration

Vision plans are available with or without a Blue Shield medical plan, and vision enrollment does not need to match other Blue Shield plan enrollments.

Our small business vision plans (except voluntary plans[2]) require only a 25% employer contribution and 65% employee participation. Voluntary vision plans don't require employer contributions and require at least three participating employees.

There's a **two-year rate guarantee** for all new vision groups, providing added financial predictability for budgeting and planning purposes.

Choosing the right vision plan is easy

What's in a name?

The plan family names – Enhanced, Preferred and Ultimate – refer to the frequency of coverage for eye exams, lenses and frames.

Plan family	Benefit category		
	Eye exam	Materials	Frame allowance + contact lens allowance (Plus plans)
	Frequency of benefit, every:		
Enhanced	12 months	24 months	24 months
Preferred	12 months	12 months	24 months
Ultimate	12 months	12 months	12 months

Numbers in the plan names correlate to dollar amounts for eye exam copayment, materials copayment (lenses, frames and low-vision aids), frame allowance, and for Plus plans, additional contact lens allowance.

For example, the Preferred Vision Plus 0/25/150/120 plan offers:

- $0 eye exam copayment
- $25 for materials
- $150 frame allowance
- $120 contact lens allowance

Key features for our vision plans

- $0 or $15 copayments for eye exams
- Plans with $150 frame allowance cover the three most common lens enhancements – progressive lenses (no-line bifocals), photochromic lenses (automatically darken in sunlight), and anti-reflective coating (reduces glare)

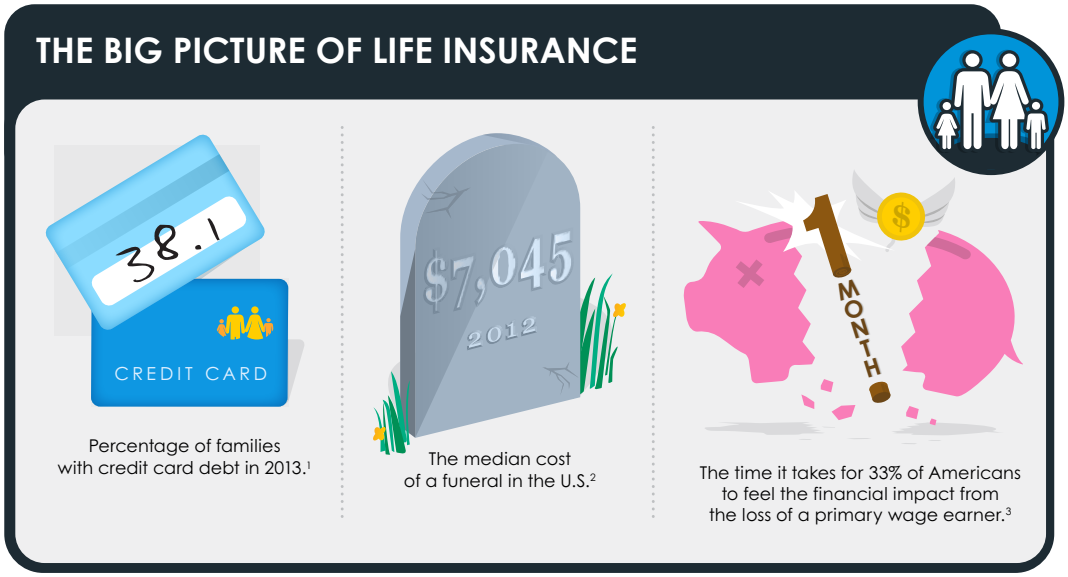
1 Vision providers in and out of California are available through a contracted vision plan administrator.
2 Voluntary plans require three or more enrolled employees.

Protecting your family with group life insurance

Life and accidental death and dismemberment (AD&D) insurance are integral parts of a comprehensive benefits package and time-honored ways for employers to help employees protect their families from the financial challenges that can arise from the death or disability of a loved one.

Affordable life insurance underwritten by Blue Shield of California Life & Health Insurance Company (Blue Shield Life) gives your employees added security during uncertain economic times and life-changing events.

Our life insurance portfolio includes flexible plan options to offer your employees the opportunity to obtain coverage to help ensure that immediate expenses, as well as longer-term obligations, can be met in the event of death or serious accident.



1 "Changes in U.S. Family Finances from 2010 to 2013: Evidence from the Survey of Consumer Finances," Federal Reserve Bulletin, September 2014.
2 "Trends and Statistics," National Funeral Directors Association, 2012.
3 "Facts from LIMRA," LIMRA, 2014.

Plan design options

- Flat amount – All employees are covered at the same flat amount, e.g., $60,000.
- Multiples of salary – All employees are covered for the same multiple of salary up to a maximum amount, e.g., two times annual earnings up to the maximum benefit amount, depending on group size.
- Graded schedule – Employees are divided into classes that have different levels of benefits, e.g., executive, management, and staff levels. The benefit amount for each class must be no more than 2.5 times that of the next lower class. Each class can have its own flat amount or multiple of salary.

Active, full-time (at least 30 hours per week) permanent employees, and their dependents (if optional dependent life insurance is chosen), are eligible for coverage. All employee and dependent benefits terminate at retirement.

Eligible employees	Benefit amount[1] (no evidence of insurability is required)
2 – 9	• Minimum benefit $15,000 • Maximum benefit $30,000
10 – 24[2]	• Minimum benefit $15,000 • Maximum benefit $100,000
25 – 50[2]	• Minimum benefit $15,000 • Maximum benefit $150,000
51 – 100[2]	• Minimum benefit $15,000 • Maximum benefit $150,000 and $175,000 or $200,000

The guaranteed issue amount is equal to the maximum benefit.

1 Coverage amounts are available in plan options of $5,000 increments within the specified guarantee issue range based on the number of eligible employees.

2 Composite rating for groups of 10 or more eligible employees.

Supplemental coverage

Infertility coverage

Blue Shield of California offers supplemental coverage for infertility treatment. This supplemental coverage can be purchased only with a Blue Shield of California health plan. If the group is offering multiple Blue Shield of California medical plan options to its employees, it must offer this supplemental coverage with all PPO and HSA-eligible PPO medical plan options. For example, if a group wishes to offer supplemental infertility coverage for its employees and currently offers one HMO and two PPO plans, the group must offer the same supplemental infertility benefit for both PPO plans. Infertility coverage is included in Blue Shield's HMO plans.

Covered California for Small Business

For groups who purchase medical coverage through Covered California for Small Business and want to also offer the supplemental infertility benefit, they will need to purchase the Mirror PPO plan with the infertility coverage directly from Blue Shield. If you are purchasing coverage through Covered California for Small Business and are interested in purchasing the PPO plan and infertility coverage, please contact your broker or Blue Shield directly.

Supplemental infertility coverage at a glance

The following procedures are limited per lifetime as shown:

- Six natural (without ovum [egg] stimulation) artificial inseminations
- Three stimulated (with ovum [egg] stimulation) artificial inseminations
- One gamete intrafallopian transfer (GIFT)
- Cryopreservation is limited to one retrieval and one year of storage
- EXCLUDED: in vitro fertilization (IVF), intracytoplasmic sperm injection (ICSI), and zygote intrafallopian transfer (ZIFT)

Please refer to the plan contract and the *Evidence of Coverage* (EOC) for a detailed description of covered benefits, limitations and exclusions.

New group submission checklist

Please be advised that this is just a guideline and that other documentation may be required.

- ☐ Business check in amount of first month's premium **or** completed Check-By-Fax Form for first month's premium.
- ☐ Master group application **(please use current version – outdated versions will not be accepted)**.
- ☐ Sole proprietor, partner, or corporate officer statement (Owner Affidavit) – to be completed by all eligible owners.
- ☐ Employee application **(please use current version – outdated versions will not be accepted).**
- ☐ Refusal of Coverage form (for eligible employees declining coverage or employees declining coverage for eligible dependents).
- ☐ Prior carrier bill including the page that lists all members on the previous policy (if applicable).
- ☐ Most recently filed DE9C. Please reconcile to note each employee's status; if any employee is terminated, please indicate the employee's termination date.
- ☐ If there is a new hire who is not listed on the DE9C, please provide payroll from date of hire **or** W-4 if new hire has not been working long enough to be on payroll yet.
- ☐ If owner is not on the DE9C, please provide most recent K-1 or Schedule C (if they have filed an extension, please provide a copy of the extension and the previous year's K-1 or Schedule C).
- ☐ Fictitious Business Name Filing is required if the group uses a DBA name, or if there is more than one business name reflecting on any document or ownership paperwork submitted.
- ☐ Legal documents **(see UW Guidelines)** – Articles of Incorporation, Statement of Information, Partnership Agreement, etc. that list the names of **all corporate officers/owners/directors.**

Standalone specialty benefits

The new group submission checklist applies to dental, vision* and life insurance* when provided alongside Blue Shield medical plans. For a simplified checklist of submission requirements when purchasing dental, vision or life insurance without a Blue Shield medical plan offering, contact your Blue Shield sales representative.

* Underwritten by Blue Shield of California Life & Health Insurance Company.

Helpful hints for a complete submission

Small employer medical plan eligibility:

- Effective January 1, 2014, small groups with only owners (no employees) are no longer eligible for small group coverage. To qualify as a small employer, the employer must employ at least one eligible W-2 "common law employee."
- Husband-and-wife-only sole proprietor businesses are no longer eligible for small group medical coverage.

Small employer specialty* benefits only plan eligibility:

- The employer must employ at least one eligible W-2 "common law employee" for dental and vision coverage.
- An owner-only small group (no employees) is eligible for dental, vision and life insurance policies when purchased without Blue Shield medical plans.
- Two eligible employees or owners are required for life coverage.
- Husband-and-wife-only sole proprietor businesses continue to be eligible for standalone small group specialty benefits coverage.

On the master group application:

- Please complete all fields on the Master Group Application. Commonly missed fields include employer's federal tax ID number, part-time coverage question, domestic partner coverage question, employer contribution, COBRA/Cal-COBRA questions, and accurate employee counts (be sure to verify the number of enrolling employees who are declining and waiving coverage).
- Be sure all fields on the application are completed. Commonly missed fields include employee job title, date of hire, date of birth, number of eligible dependents, and dependent information (if enrolling). Social Security numbers are required for all enrolling employees and dependents.
- Completed Refusal of Coverage forms are required for eligible dependents, including spouses/eligible domestic partners. Employees must complete a waiver for eligible dependents who are not enrolling in the plans offered.

On the check-by-fax form:

- Amount to be debited is required on the check-by-fax form. Please base this amount on the quote provided to the group for all lines of coverage selected. If you do not have a quote, please contact your Small Business Sales Team to provide a quote for you. If the final rates differ from the binder amount, the group will see the adjustment on its following billing statement.
- Group representative's signature is required on the check-by-fax form.

* Vision and life insurance plans are underwritten by Blue Shield of California Life & Health Insurance Company.

Be sure all fields on the application are completed. Commonly missed fields include employee job title, date of hire, date of birth and number of eligible dependents.

Endnotes

Endnotes for Off-Exchange Package PPO plans

1. Not subject to the calendar-year medical deductible.
2. If the member or physician requests a brand drug when a generic drug equivalent is available, the member is responsible for the difference in cost between the brand drug and its generic drug equivalent, in addition to the generic drug copayment. The difference in cost that the member must pay is not applied to the calendar-year medical or brand drug deductible and is not included in the calendar-year out-of-pocket maximum responsibility calculation.
3. Preventive Health Services, including an annual preventive care or well-baby care office visit, are not subject to the calendar-year medical deductible. Other covered non-preventive services received during, or in connection with, the preventive care or well-baby care office visit are subject to the calendar-year medical deductible and applicable member copayment/coinsurance.
4. Copayments or coinsurance for covered services accrue to the calendar-year out-of-pocket maximum except copayments or coinsurance for:
   - Charges in excess of specified benefit maximums
   - Bariatric surgery: covered travel expenses for bariatric surgery
   - Chiropractic benefits
   - Dialysis center benefits: dialysis services from a non-participating provider

   Copayments, coinsurance, and charges for services not accruing to the member's calendar-year out-of-pocket maximum continue to be the member's responsibility after the calendar-year out-of-pocket maximum is reached. Please refer to the Summary of Benefits and *Evidence of Coverage* for additional details.
5. Member is responsible for copayment in addition to any charges above allowable amounts. The coinsurance indicated is a percentage of allowable amounts. Participating providers accept Blue Shield's allowable amount as full payment for covered services. Non-participating providers can charge more than these amounts. When members use non-participating providers, they must pay the applicable copayment plus any amount that exceeds Blue Shield's allowable amount. Charges above the allowable amount do not count toward the calendar-year deductible or out-of-pocket maximum.
6. The allowable amount for non-emergency hospital services received from a non-participating hospital is $600 per day. Members are responsible for the coinsurance percentage of this $600 per day, plus all charges in excess of $600. Charges that exceed the allowable amount do not count toward the calendar-year out-of-pocket maximum.
7. Services with a day or visit limit accrue to the calendar-year day or visit limit maximum regardless of whether the calendar-year medical deductible has been met.
8. 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 a Medicare prescription drug plan while you maintain this coverage. However, you should be aware that if you have a subsequent break in this coverage of 63 days or more anytime after you were first eligible to enroll in a Medicare prescription drug plan, you could be subject to a late enrollment penalty in addition to your Part D premium.
9. This plan's prescription drug coverage provides less coverage on average than the standard benefit set by the federal government for Medicare Part D (also called non-creditable coverage). It is important to know that generally you and your employees may only enroll in a Part D plan from October 15 through December 7 of each year, and if you do not enroll when first eligible, you may be subject to payment of higher Part D premiums when you enroll at a later date. For more information about drug coverage, call the Customer Service telephone number on your member ID card, Monday through Thursday from 8 a.m. to 5 p.m. or Friday from 9 a.m. to 5 p.m.

Endnotes for HSA-compatible HDHPs

1. Not subject to the calendar-year medical deductible.
2. If the member or physician requests a brand drug when a generic drug equivalent is available, the member is responsible for the difference in cost between the brand drug and its generic drug equivalent, in addition to the generic drug copayment. The difference in cost that the member must pay is not applied to the calendar-year medical or brand drug deductible and is not included in the calendar-year out-of-pocket maximum responsibility calculation.
3. Preventive Health Services, including an annual preventive care or well-baby care office visit, are not subject to the calendar-year medical deductible. Other covered non-preventive services received during, or in connection with, the preventive care or well-baby care office visit are subject to the calendar-year medical deductible and applicable member copayment/coinsurance.
4. After the calendar-year deductible is met, the member is responsible for a copayment or coinsurance from participating providers. Participating providers accept Blue Shield's

allowable amount as full payment for covered services. Non-participating providers can charge more than these amounts which the member is responsible for in addition to the applicable copayment or coinsurance when accessing these providers, which amount can be substantial. Amounts applied to your calendar-year deductible accrue toward the out-of-pocket maximum. Charges in excess of the allowable amount do not count toward the calendar-year deductible or out-of-pocket maximum.

5. The allowable amount for non-emergency hospital services received from a non-participating hospital is $2,000 per day. Members are responsible for the coinsurance percentage of this $2,000 per day, plus all charges in excess of $2,000. Charges that exceed the allowable amount do not count toward the calendar-year out-of-pocket maximum.
6. This plan's prescription drug coverage provides less coverage on average than the standard benefit set by the federal government for Medicare Part D (also called non-creditable coverage). It is important to know that generally you may only enroll in a Part D plan from October 15 through December 7 of each year, and if you do not enroll when first eligible, you may be subject to payment of higher Part D premiums when you enroll at a later date. For more information about drug coverage, call the Customer Service telephone number on your member ID card, Monday through Thursday from 8 a.m. to 5 p.m. or Friday from 9 a.m. to 5 p.m.
7. 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 a Medicare prescription drug plan while you maintain this coverage. However, you should be aware that if you have a subsequent break in this coverage of 63 days or more anytime after you were first eligible to enroll in a Medicare prescription drug plan, you could be subject to a late enrollment penalty in addition to your Part D premium.

Endnotes for Off-Exchange and Mirror HMO plans

1. If the member or physician requests a brand drug when a generic drug equivalent is available, the member is responsible for the difference in cost between the brand drug and its generic drug equivalent, in addition to the generic drug copayment. The difference in cost that the member must pay is not applied to the calendar-year medical or brand drug deductible and is not included in the calendar-year out-of-pocket maximum responsibility calculation.
2. Subject to the calendar-year facility deductible.
3. Copayments marked with this footnote do not accrue to the calendar-year out-of-pocket maximum. Copayments and charges for services not accruing to the member's calendar-year out-of-pocket maximum continue to be the member's responsibility after the calendar-year out-of-pocket maximum is reached. Please refer to the Summary of Benefits and *Evidence of Coverage* for exact terms and conditions of coverage.
4. 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 a Medicare prescription drug plan while you maintain this coverage. However, you should be aware that if you have a subsequent break in this coverage of 63 days or more anytime after you were first eligible to enroll in a Medicare prescription drug plan, you could be subject to a late enrollment penalty in addition to your Part D premium.
5. Drugs obtained at a non-participating pharmacy are not covered, unless medically necessary for a covered emergency, including drugs for emergency contraception.

Endnotes for Mirror Package PPO plans

1. Not subject to the calendar-year medical deductible.
2. If the member or physician requests a brand drug when a generic drug equivalent is available, the member is responsible for the difference in cost between the brand drug and its generic drug equivalent, in addition to the generic drug copayment. The difference in cost that the member must pay is not applied to the calendar-year medical or brand-drug deductible and is not included in the calendar-year out-of pocket maximum responsibility calculation.
3. Preventive health services, including an annual preventive care or well-baby care office visit, are not subject to the calendar-year medical deductible. Other covered non-preventive services received during, or in connection with, the preventive care or well-baby care office visit are subject to the calendar-year medical deductible and applicable member copayment/coinsurance.
4. Member is responsible for copayment in addition to any charges above allowable amounts. The coinsurance indicated is a percentage of allowable amounts. Participating providers accept Blue Shield's allowable amount as full payment for covered services. Non-participating providers can charge more than these amounts. When members use non-participating providers, they must pay the applicable copayment plus any amount that exceeds Blue Shield's allowable amount. Charges above the allowable amount do not count toward the calendar-year deductible or out-of-pocket maximum.

5. The allowable amount for non-emergency hospital services received from a non-participating hospital is $2,000 per day. Members are responsible for the coinsurance percentage of this $2,000 per day, plus all charges in excess of $2,000. Charges that exceed the allowable amount do not count toward the calendar-year out-of-pocket maximum.
6. This plan's prescription drug coverage provides less coverage on average than the standard benefit set by the federal government for Medicare Part D (also called non-creditable coverage). It is important to know that generally you may only enroll in a Part D plan from October 15 through December 7 of each year, and if you do not enroll when first eligible, you may be subject to payment of higher Part D premiums when you enroll at a later date. For more information about drug coverage, call the Customer Service telephone number on your member ID card, Monday through Thursday from 8 a.m. to 5 p.m. or Friday from 9 a.m. to 5 p.m.
7. 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 a Medicare prescription drug plan while you maintain this coverage. However, you should be aware that if you have a subsequent break in this coverage of 63 days or more anytime after you were first eligible to enroll in a Medicare prescription drug plan, you could be subject to a late enrollment penalty in addition to your Part D premium.

Endnotes for value-added programs

1. These discount program services are not a covered benefit of the High Option Supplement plan to Medicare and Medicare PPO (with and without Rx) plans, and none of the terms or conditions of the High Option Supplement plan to Medicare and Medicare PPO (with and without Rx) plans apply.

   The networks of practitioners and facilities in the discount programs are managed by the external program administrators identified below, including any screening and credentialing of providers. Blue Shield does not review the services provided by discount program providers for medical necessity or efficacy, nor does Blue Shield make any recommendations, representations, claims, or guarantees regarding the practitioners, their availability, fees, services or products.

   Discount programs administered by or arranged through the following independent companies:
   - Alternative Care Discount Program – American Specialty Health Systems, Inc. and American Specialty Health Networks, Inc.
   - Discount Provider Network and MESVisionOptics.com – MESVision
   - Weight control – Weight Watchers North America
   - Fitness facilities – 24 Hour Fitness, ClubSport, and Renaissance ClubSport
   - LASIK – Laser Eye Care of California, LLC; QualSight, Inc.; and NVISION Laser Eye Centers

   Note: No genetic information, including family medical history, is gathered, shared, or used from these programs.
2. The Discount Provider Network is available throughout California. Coverage in other states may be limited. Find participating providers at blueshieldca.com/fap.
3. Requires a prescription from your doctor or licensed optical professional.
4. Current laws do not allow this service for members of Blue Shield Federal Employee Programs, Medicare Advantage HMO plan or Medicare Prescription Drug Plan.

Our Small Business health plans are available for groups of up to 100 employees.

Regardless of what size your small business is, you'll find a large selection of plans to meet your employees' priorities. We understand no business is too small to offer coverage, and that providing quality benefits is critical in attracting top talent and fueling productivity.

Thank you for selecting Blue Shield. You can count on our commitment to deliver the value and service you expect. Whether you're a business of one or 100, we want Blue Shield to be your first choice – today, tomorrow, and into the future.

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