



# Changes to your health plan

Effective January 1, 2027, there will be some changes to your plan's costs and benefits. We are notifying you in advance so you can make informed decisions about your health coverage. Please visit [blueshieldca.com/policies](https://blueshieldca.com/policies) for updated terms and conditions of coverage.

## Cost share changes

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

### Calendar year medical deductible changes

| Description of change                                |                                                | 2026 (this year)                      | What's changing?<br>2027 (renewal year) |
|------------------------------------------------------|------------------------------------------------|---------------------------------------|-----------------------------------------|
| Your calendar year medical deductible has decreased. | <b>When using a participating provider</b>     | Individual/Family<br>\$1,400/\$2,800  | Individual/Family<br>\$1,100/\$2,200    |
| Your calendar year medical deductible has increased. | <b>When using a non-participating provider</b> | Individual/Family<br>\$7,000/\$14,000 | Individual/Family<br>\$11,500/\$23,000  |

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

| Description of change                                   |                                            | 2026 (this year)                     | What's changing?<br>2027 (renewal year) |
|---------------------------------------------------------|--------------------------------------------|--------------------------------------|-----------------------------------------|
| Your calendar year out-of-pocket maximum has increased. | <b>When using a participating provider</b> | Individual/Family<br>\$3,350/\$6,700 | Individual/Family<br>\$4,000/\$8,000    |

## Pharmacy prescription drug cost share changes

| Benefit section and description of change                                                                          |                     | 2026 (this year)                                      | What's changing?<br>2027 (renewal year)               |
|--------------------------------------------------------------------------------------------------------------------|---------------------|-------------------------------------------------------|-------------------------------------------------------|
| <b>Retail pharmacy prescription drugs</b><br>Your copay for tier 1, tier 2, and tier 3 drugs has increased.        | <b>Tier 1 drugs</b> | \$8/prescription, pharmacy deductible does not apply  | \$10/prescription, pharmacy deductible does not apply |
|                                                                                                                    | <b>Tier 2 drugs</b> | \$25/prescription, pharmacy deductible applies        | \$30/prescription, pharmacy deductible applies        |
|                                                                                                                    | <b>Tier 3 drugs</b> | \$45/prescription, pharmacy deductible applies        | \$50/prescription, pharmacy deductible applies        |
| <b>Home delivery pharmacy prescription drugs</b><br>Your copay for tier 1, tier 2, and tier 3 drugs has increased. | <b>Tier 1 drugs</b> | \$24/prescription, pharmacy deductible does not apply | \$30/prescription, pharmacy deductible does not apply |
|                                                                                                                    | <b>Tier 2 drugs</b> | \$75/prescription, pharmacy deductible applies        | \$90/prescription, pharmacy deductible applies        |
|                                                                                                                    | <b>Tier 3 drugs</b> | \$135/prescription, pharmacy deductible applies       | \$150/prescription, pharmacy deductible applies       |

## Medical benefit cost share changes

| Benefit section and summary of change                                                                                                                                                | Benefit category                               | 2026 (this year)    | What's changing?<br>2027 (renewal year) |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------|---------------------|-----------------------------------------|
| <b>Physician services</b><br>Your copay for these services has increased.                                                                                                            | <b>Specialist care office visit</b>            | \$25/visit          | \$30/visit                              |
| <b>Diagnostic x-ray, imaging, pathology, and laboratory services</b><br>Your copay for these services has increased.<br>Your non-participating provider maximum limit has decreased. | <b>Laboratory and pathology services:</b>      |                     |                                         |
|                                                                                                                                                                                      | <b>When using a participating provider</b>     |                     |                                         |
|                                                                                                                                                                                      | <b>Laboratory center</b>                       | \$30/visit          | \$35/visit                              |
|                                                                                                                                                                                      | <b>Outpatient department of a hospital</b>     | \$30/visit          | \$35/visit                              |
|                                                                                                                                                                                      | <b>When using a non-participating provider</b> |                     |                                         |
|                                                                                                                                                                                      | <b>Outpatient department of a hospital</b>     | 50% up to \$500/day | 50% up to \$350/day                     |

|                                                                                                                              |                                                                                                                                                                                                                                                                     |                     |                     |
|------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------|---------------------|
| <b>Diagnostic x-ray, imaging, pathology, and laboratory services</b><br>Your maximum limit for these services has decreased. | <b>Basic imaging services:</b><br><b>When using a non-participating provider</b>                                                                                                                                                                                    |                     |                     |
|                                                                                                                              | <b>Outpatient department of a hospital</b>                                                                                                                                                                                                                          | 50% up to \$500/day | 50% up to \$350/day |
|                                                                                                                              | <b>Other outpatient non-invasive diagnostic testing:</b><br><b>When using a non-participating provider</b>                                                                                                                                                          |                     |                     |
|                                                                                                                              | <b>Outpatient department of a hospital</b>                                                                                                                                                                                                                          | 50% up to \$500/day | 50% up to \$350/day |
| <b>Mental health or substance use disorder benefits</b><br>Your maximum limit for this service has been added to the SOB.    | <b>Advanced imaging services:</b><br><b>When using a non-participating provider</b>                                                                                                                                                                                 |                     |                     |
|                                                                                                                              | <b>Outpatient department of a hospital</b>                                                                                                                                                                                                                          | 50% up to \$500/day | 50% up to \$350/day |
|                                                                                                                              | <b>Other outpatient services, including intensive outpatient care, electroconvulsive therapy, transcranial magnetic stimulation, behavioral health treatment for pervasive developmental disorder, or autism.</b><br><b>When using a non-participating provider</b> |                     |                     |
|                                                                                                                              | <b>Outpatient department of a hospital</b>                                                                                                                                                                                                                          | 50%                 | 50% up to \$500/day |

## Benefit changes and clarifications

Changes to your benefits/services will be reflected in your EOC/SOB.

NOTE: Underlines below indicate added text.

### Benefit changes

These are changes made to your benefits coverage.

| Section name                                        | Description of the change(s)                                                                                                                                                                                                    |
|-----------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Notes: Outpatient prescription drug coverage</b> | Added a cap on your cost share for insulin.<br>"Insulin. You will not pay more than \$35 for a 30-day supply of formulary insulin prescription drugs from a participating pharmacy."                                            |
| <b>Preventive health services</b>                   | As of January 1, 2025, we cover preventive care items and services recommended by the California Department of Public Health in addition to federal agencies, such as the United States Preventive Service Task Force (USPSTF). |
| <b>Definitions: Intensive outpatient program</b>    | We increased coverage for intensive outpatient treatment of mental health or substance abuse disorders. Your plan used to cover up to nine hours a week, and now it may cover up to nineteen hours a week.                      |

**Mental health or substance use disorder benefits:  
Other outpatient mental health and substance use disorder services**

The list of treatments that are **not** covered include the following:

“Benefits do not include treatment not supported by current generally accepted standards of mental health and substance use disorder care, including:

- Outdoor, youth, or wilderness programs and accommodations;
- Equine assisted therapy;
- Treatment for the purpose of providing respite or day care;
- Educational services; or
- Any other treatment or other facilities that provide primarily a supportive environment and address long-term social needs.

In addition, benefits do not include reimbursement of a parent, legal guardian, or conservator for participation in such treatment or programs.”

## Administrative/language clarifications

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

| Section name                                                                                                                 | Description of the change(s)                                                                                                                                                                                                                                                           |
|------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Address change:<br/>Paying for coverage</b>                                                                               | The address for mailing premium payments has been updated to:<br>Blue Shield of California<br>P.O. Box 60532<br>City of Industry, CA 91716-0532                                                                                                                                        |
| <b>Mental health or substance use disorder benefits:<br/>Outpatient mental health and substance use disorder services</b>    | Revised to clarify that coverage includes: <ul style="list-style-type: none"><li>• “<u>Neuropsychological</u> and psychological testing to diagnose a mental health condition <u>and/or to assess the health of certain brain functions.”</u></li></ul>                                |
| <b>Prescription drug benefits:<br/>Obtaining outpatient prescription drugs from the home delivery participating pharmacy</b> | The terms “mail order pharmacy” or “mail service pharmacy” have been updated to “home delivery pharmacy.”                                                                                                                                                                              |
| <b>Multiple sections</b>                                                                                                     | To adopt the state-regulated standardized template for plan documents (for example, the EOC), we (1) revised certain defined terms, (2) replaced the <i>Exclusions and limitations</i> section, and (3) replaced <i>Your bill of rights</i> and <i>Your responsibilities</i> sections. |

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