blue CALIFORNIA

2027 IFP Trio HMO Benefits at a glance

Benefit amounts reflect your costs when receiving care from in-network providers.

		Bronze 7500 Trio HMO	Blue Shield Bronze 60 Trio HMO	Blue Shield Silver 70 Trio HMO	Silver 70 Off Exchange Trio HMO	Blue Shield Silver 73 Trio HMO	Blue Shield Silver 87 Trio HMO	Blue Shield Silver 94 Trio HMO	Blue Shield Gold 80 Trio HMO	Blue Shield Platinum 90 Trio HMO
Plan can be purchased through		Blue Shield only	Blue Shield and Covered California	Blue Shield and Covered California	Blue Shield only	Covered California only	Covered California only	Covered California only	Blue Shield and Covered California	Blue Shield and Covered California
Deductibles and maximum out-of-pocket										
Calendar year medical deductible		$7,500 per individual / $15,000 per family[1]	$5,800 per individual / $11,600 per family[1]	$4,700 per individual / $9,400 per family[1]	$4,700 per individual / $9,400 per family[1]	$4,700 per individual / $9,400 per family[1]	$1,100 per individual / $2,200 per family[1]	$200 per individual / $400 per family[1]	$0	$0
Calendar year pharmacy deductible		Included in the medical deductible	$450 per individual / $900 per family[1]	$50 per individual / $100 per family[1]	$50 per individual / $100 per family[1]	$50 per individual / $100 per family[1]	$50 per individual / $100 per family[1]	$0	$0	$0
Calendar year out-of-pocket maximum (Individual/Family)		$11,650 per individual / $23,300 per family	$11,650 per individual / $23,300 per family	$11,650 per individual / $23,300 per family	$11,650 per individual / $23,300 per family	$9,600 per individual / $19,200 per family	$4,000 per individual / $8,000 per family	$3,000 per individual / $6,000 per family	$9,600 per individual / $19,200 per family	$5,500 per individual / $11,000 per family
Care from your providers (physician services)										
Primary care	Preventive care	$0	$0	$0	$0	$0	$0	$0	$0	$0
	Office visit (in-person or telehealth)	$65	$60	$50	$50	$50	$15	$5	$40	$20
	Virtual Blue℠ program	Not covered	Not covered	Not covered	Not covered	Not covered	Not covered	Not covered	Not covered	Not covered
Specialist	Office visit (in-person or telehealth)	$95	$100 for first 3 visits per calendar year prior to deductible, then $100 after deductible[5]	$100	$100	$100	$30	$8	$80	$45
	Virtual Blue℠ program	Not covered	Not covered	Not covered	Not covered	Not covered	Not covered	Not covered	Not covered	Not covered
Mental health / substance use disorders	Office visit (in-person or telehealth)	$65	$60	$50	$50	$50	$15	$5	$40	$20
	Virtual Blue℠ program	Not covered	Not covered	Not covered	Not covered	Not covered	Not covered	Not covered	Not covered	Not covered
Labs and tests (diagnostic X-ray, imaging, pathology, and laboratory services)										
Laboratory and pathology services at a laboratory center		$65	$50	$50	$50	$50	$35	$10	$40	$25
Basic imaging services (including X-rays and ultrasounds) at an outpatient radiology center		$115	40% (subject to deductible)	$95	$95	$95	$50	$10	$85	$35
Emergency and urgent care services										
Emergency room	Physician services	50%	$0	$0	$0	$0	$0	$0	$0	$0
	Facility services (waived if admitted to the hospital)	50% (subject to deductible)	40% (subject to deductible)	$400 per visit	$400 per visit	$400 per visit	$200 per visit	$50 per visit	$350 per visit	$225 per visit
Urgent care center services	(in-person or telehealth)	$65 per visit	$60 per visit	$50 per visit	$50 per visit	$50 per visit	$15 per visit	$5 per visit	$40 per visit	$20 per visit
Care at the hospital (inpatient services and outpatient department in a hospital setting)										
Inpatient	Physician services	50%	40% (subject to deductible)	30%	30%	30%	20%	10%	$0	$0
	Facility services	50% (subject to deductible)	40% (subject to deductible)	30% (subject to deductible)	30% (subject to deductible)	30% (subject to deductible)	20% (subject to deductible)	10% (subject to deductible)	$375 per day (up to 5 days per admission)	$325 per day (up to 5 days per admission)
Outpatient	Physician services	$150 per surgery	40% (subject to deductible)	30%	30%	30%	20%	10%	$75 per visit	$50 per visit
	Facility services	50% (subject to deductible)	40% (subject to deductible)	30%	30%	30%	20%	10%	20%	10%
Dental and vision care for kids (pediatric dental and vision for children up to age 19)										
Dental	Oral exam	$0	$0	$0	$0	$0	$0	$0	$0	$0
	Preventive cleaning	$0	$0	$0	$0	$0	$0	$0	$0	$0
	Topical fluoride	$0	$0	$0	$0	$0	$0	$0	$0	$0
Vision	Comprehensive eye exam	$0	$0	$0	$0	$0	$0	$0	$0	$0
	Glasses (collection frames)6	$0	$0	$0	$0	$0	$0	$0	$0	$0
	Contacts (hard or soft, elective or non-elective)	$0	$0	$0	$0	$0	$0	$0	$0	$0
Prescription drugs from your local network pharmacy or Amazon Pharmacy home delivery										
Contraceptive drugs and devices	30-day supply	$0	$0	$0	$0	$0	$0	$0	$0	$0
	90-day home delivery supply	$0	$0	$0	$0	$0	$0	$0	$0	$0
Tier 1	30-day supply	$15 per prescription	$20 per prescription	$20 per prescription	$20 per prescription	$20 per prescription	$10 per prescription	$3 per prescription	$19 per prescription	$10 per prescription
	90-day home delivery supply	$45 per prescription	$60 per prescription	$60 per prescription	$60 per prescription	$60 per prescription	$30 per prescription	$9 per prescription	$57 per prescription	$30 per prescription
Tier 2	30-day supply	$115 per prescription (subject to deductible)	40% (up to $500 per prescription and subject to pharmacy deductible)	$65 per prescription (subject to pharmacy deductible)	$65 per prescription (subject to pharmacy deductible)	$65 per prescription (subject to pharmacy deductible)	$30 per prescription (subject to pharmacy deductible)	$10 per prescription	$60 per prescription	$25 per prescription
	90-day home delivery supply	$345 per prescription (subject to deductible)	40% (up to $1,500 per prescription and subject to pharmacy deductible)	$195 per prescription (subject to pharmacy deductible)	$195 per prescription (subject to pharmacy deductible)	$195 per prescription (subject to pharmacy deductible)	$90 per prescription (subject to pharmacy deductible)	$30 per prescription	$180 per prescription	$75 per prescription
Tier 3	30-day supply	50% (up to $500 per prescription and subject to deductible)	40% (up to $500 per prescription and subject to pharmacy deductible)	$95 per prescription (subject to pharmacy deductible)	$95 per prescription (subject to pharmacy deductible)	$95 per prescription (subject to pharmacy deductible)	$50 per prescription (subject to pharmacy deductible)	$15 per prescription	$90 per prescription	$45 per prescription
	90-day home delivery supply	50% (up to $1,500 per prescription and subject to deductible)	40% (up to $1,500 per prescription and subject to pharmacy deductible)	$285 per prescription (subject to pharmacy deductible)	$285 per prescription (subject to pharmacy deductible)	$285 per prescription (subject to pharmacy deductible)	$150 per prescription (subject to pharmacy deductible)	$45 per prescription	$270 per prescription	$135 per prescription
Tier 4	30-day supply	50% (up to $500 per prescription and subject to deductible)	40% (up to $500 per prescription and subject to pharmacy deductible)	20% (up to $250 per prescription and subject to pharmacy deductible)	20% (up to $250 per prescription and subject to pharmacy deductible)	20% (up to $250 per prescription and subject to pharmacy deductible)	15% (up to $150 per prescription and subject to pharmacy deductible)	10% (up to $150 per prescription)	20% (up to $250 per prescription)	10% (up to $250 per prescription)
	90-day home delivery supply	50% (up to $1,500 per prescription and subject to deductible)	40% (up to $1,500 per prescription and subject to pharmacy deductible)	20% (up to $750 per prescription and subject to pharmacy deductible)	20% (up to $750 per prescription and subject to pharmacy deductible)	20% (up to $750 per prescription and subject to pharmacy deductible)	15% (up to $450 per prescription and subject to pharmacy deductible)	10% (up to $450 per prescription)	20% (up to $750 per prescription)	10% (up to $750 per prescription)
Additional features										
Health savings account eligible	Consult with your financial or tax advisor if you have questions about health savings accounts.	Yes	Yes	No	No	No	No	No	No	No
Out of state care coverage	BlueCard® Program service area	Limited coverage - refer to the Evidence of Coverage	Limited coverage - refer to the Evidence of Coverage	Limited coverage - refer to the Evidence of Coverage	Limited coverage - refer to the Evidence of Coverage	Limited coverage - refer to the Evidence of Coverage	Limited coverage - refer to the Evidence of Coverage	Limited coverage - refer to the Evidence of Coverage	Limited coverage - refer to the Evidence of Coverage	Limited coverage - refer to the Evidence of Coverage
Other professional services	Teladoc Health consultation	$0 $20 per visit (12 visits per member per calendar year)	$0 Not Covered	$0 Not Covered	$0 Not Covered	$0 Not Covered	$0 Not Covered	$0 Not Covered	$0 Not Covered	$0 Not Covered
	Chiropractic services									

This chart provides details on plan deductibles, copayments, and coinsurance amounts for common services when using network providers. It is not a contract. For complete plan details, including non-network benefits (PPO plans only), refer to the Evidence of Coverage (EOC) available from **blueshieldca.com/policies** or call us at **(888) 256-3650**.

FOOTNOTES

1. Family coverage has an individual deductible within the family deductible. Blue Shield will pay benefits for an individual member on the family plan once the member meets the individual deductible amount. Blue Shield will pay benefits for all covered family members once the family deductible is satisfied. The family deductible can be satisfied when two family members meet their individual deductibles, or when the combined deductible contributions of three or more members reaches the family deductible limit.
2. For individual plans, you pay the full contracted rate (or "allowable amount") for services subject to the deductible until you reach the $2,800 individual deductible, after which Blue Shield shares costs. For family plans, each person has a $3,500 embedded individual deductible. Blue Shield begins sharing costs for that person once they meet it. Blue Shield begins sharing costs for all family members once the $5,600 family deductible is met, whether by one person or combined family spending.
3. Family coverage includes an individual out-of-pocket maximum (OOPM) within the overall family OOPM. Blue Shield pays 100% for covered services for a family member once that person meets their individual OOPM. Blue Shield pays 100% for all covered family members once the family OOPM is met. The family OOPM can be reached when two members meet their individual OOPM or when the combined OOPM amounts of three or more members reach the family limit.
4. The first three visits are available prior to meeting the calendar-year medical deductible and include a combination of primary care physician, physician home visit, urgent care, acupuncture, outpatient mental health, outpatient substance use disorder, and other practitioner visits. Subsequent visits are subject to the calendar-year medical deductible.
5. The first three visits are available for a $100 copay prior to meeting the calendar-year medical deductible. Members will pay the full contracted rate for subsequent visits until their calendar-year medical deductible has been satisfied. Then, once again, members will pay a $100 copay for specialist office visits.
6. Collection frames are pre-selected frames by the Benefit Administrator, which are fully covered with no out of pocket costs. Non-collection frames are other standard retail or designer frames with a fixed allowance.