blue of california

# Summary of Benefits

**Group Plan**
**HMO Plan**

## Local Access+ HMO® Facility Coinsurance 30-30%

This Summary of Benefits shows the amount you will pay for Covered Benefits under this Blue Shield of California Plan. It is only a summary and it is included as part of the Evidence of Coverage (EOC).[1] Please read both documents carefully for details.

### Medical Provider Network: Local Access+ HMO Network

This Plan uses a specific network of Health Care Providers, called the Local Access+ HMO provider network. Medical Groups, Independent Practice Associations (IPAs), and Physicians in this network are called Participating Providers. You must select a Primary Care Physician from this network to provide your primary care and help you access services, but there are some exceptions. Please review your Evidence of Coverage for details about how to access care under this Plan. You can find Participating Providers in this network at blueshieldca.com.

### Calendar Year Deductibles (CYD)[2]

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

| | | When using a Participating Provider[3] |
|---|---|---|
| **Calendar Year medical Deductible** | *Individual coverage* | $0 |
| | *Family coverage* | $0: individual |
| | | $0: Family |

### Calendar Year Out-of-Pocket Maximum[4]

An Out-of-Pocket Maximum is the most a Member will pay for Covered Benefits each Calendar Year. Any exceptions are listed in the EOC.

| | When using a Participating Provider[3] |
|---|---|
| *Individual coverage* | $3,500 |
| *Family coverage* | $3,500: individual |
| | $7,000: Family |

### No Annual or Lifetime Dollar Limit

Under this Plan there is no annual or lifetime dollar limit on the amount Blue Shield will pay for Covered Benefits.

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| Benefits[5] | Your payment | |
|---|---|---|
| | When using a Participating Provider[3] | CYD[2] applies |
| **Preventive Health Services[6]** | | |
| Preventive Health Services | $0 | |
| California Prenatal Screening Program | $0 | |
| **Physician services** | | |
| Primary care office visit | $30/visit | |
| Access+ specialist care office visit (self-referral) | $45/visit | |
| Other specialist care office visit (referred by PCP) | $30/visit | |
| Physician home visit | $30/visit | |
| Physician or surgeon services in an Outpatient Facility | $0 | |
| Physician or surgeon services in an inpatient facility | $0 | |
| **Other professional services** | | |
| Other practitioner office visit<br>*Includes nurse practitioners, physician assistants, therapists, and podiatrists.* | $30/visit | |
| Teladoc Health consultation | $0 | |
| Family planning | | |
| • Counseling, consulting, and education | $0 | |
| • Injectable contraceptive, diaphragm fitting, intrauterine device (IUD), implantable contraceptive, and related procedure. | $0 | |
| • Tubal ligation | $0 | |
| • Vasectomy | $0 | |
| Medical nutrition therapy, not related to diabetes | $0 | |
| **Infertility Services** | | |
| Physician or surgeon services in an Outpatient Facility | $0 | |
| Artificial Inseminations limited to 6 per lifetime | $0 | |
| Oocyte (egg) retrieval limited to 3 per lifetime | | |
| • Ambulatory Surgery Center | 15% | |
| • Outpatient Department of a Hospital | 30% | |
| In vitro fertilization (IVF) | $0 | |
| Embryo transfer | | |
| • Ambulatory Surgery Center | 15% | |
| • Outpatient Department of a Hospital | 30% | |
| Cryopreservation limited to 1 year of storage per lifetime for each of the following: sperm, reproductive tissue, oocytes (eggs), and embryos | $0 | |

| Benefits[5] | Your payment | |
|---|---|---|
| | When using a Participating Provider[3] | CYD[2] applies |
| **Pregnancy and maternity care** | | |
| Physician office visits: prenatal and postnatal | $0 | |
| Abortion and abortion-related services | $0 | |
| **Emergency Services** | | |
| Emergency room services | $150/visit | |
| *If admitted to the Hospital, this payment for emergency room services does not apply. Instead, you pay the Participating Provider payment under Inpatient facility services/ Hospital services and stay.* | | |
| Emergency room Physician services | $0 | |
| **Urgent care center services** | $30/visit | |
| **Ambulance services** | $100/transport | |
| *This payment is for emergency or authorized transport.* | | |
| **Outpatient Facility services** | | |
| Ambulatory Surgery Center | 15% | |
| Outpatient Department of a Hospital: surgery | 30% | |
| Outpatient Department of a Hospital: treatment of illness or injury, radiation therapy, chemotherapy, and necessary supplies | $0 | |
| **Inpatient facility services** | | |
| Hospital services and stay | 30% | |
| Transplant services | | |
| *This payment is for all covered transplants except tissue and kidney. For tissue and kidney transplant services, the payment for Inpatient facility services/ Hospital services and stay applies.* | | |
| • Special transplant facility inpatient services | 30% | |
| • Physician inpatient services | $0 | |
| **Diagnostic x-ray, imaging, pathology, and laboratory services** | | |
| *This payment is for Covered Benefits that are diagnostic, non-Preventive Health Services, and diagnostic radiological procedures. For the payments for Covered Benefits that are considered Preventive Health Services, see Preventive Health Services.* | | |
| Laboratory and pathology services | | |
| *Includes diagnostic Papanicolaou (Pap) test.* | | |
| • Laboratory center | $0 | |
| • Outpatient Department of a Hospital | $0 | |

| Benefits[5] | Your payment | |
|---|---|---|
| | When using a Participating Provider[3] | CYD[2] applies |
| Basic imaging services<br>*Includes plain film X-rays, ultrasounds, and diagnostic mammography.* | | |
| • Outpatient radiology center | $0 | |
| • Outpatient Department of a Hospital | $0 | |
| Other outpatient non-invasive diagnostic testing<br>*Testing to diagnose illness or injury such as vestibular function tests, EKG, cardiac monitoring, non-invasive vascular studies, sleep medicine testing, muscle and range of motion tests, EEG, and EMG.* | | |
| • Office location | $0 | |
| • Outpatient Department of a Hospital | $0 | |
| Advanced imaging services<br>*Includes diagnostic radiological and nuclear imaging such as CT scans, MRIs, MRAs, and PET scans.* | | |
| • Outpatient radiology center | $0 | |
| • Outpatient Department of a Hospital | $0 | |
| **Rehabilitative and Habilitative Services**<br>*Includes physical therapy, occupational therapy, respiratory therapy, and speech therapy services.* | | |
| Office location | $30/visit | |
| Outpatient Department of a Hospital | $30/visit | |
| **Durable medical equipment (DME)** | | |
| DME | 50% | |
| Breast pump | $0 | |
| Orthotic equipment and devices | $0 | |
| Prosthetic equipment and devices | $0 | |
| **Home health care services**<br>*Up to 100 visits per Member, per Calendar Year, by a home health care agency. All visits count towards the limit, including visits during any applicable Deductible period. Includes home visits by a nurse, Home Health Aide, medical social worker, physical therapist, speech therapist, or occupational therapist, and medical supplies.* | $30/visit | |
| **Home infusion and home injectable therapy services** | | |
| Home infusion agency services<br>*Includes home infusion drugs, medical supplies, and visits by a nurse.* | $0 | |
| Hemophilia home infusion services<br>*Includes blood factor products.* | $0 | |

| Benefits[5] | Your payment | |
|---|---|---|
| | When using a Participating Provider[3] | CYD[2] applies |
| **Skilled Nursing Facility (SNF) services** | | |
| *Up to 100 days per Member, per benefit period, except when provided as part of a Hospice program. All days count towards the limit, including days during any applicable Deductible period and days in different SNFs during the Calendar Year.* | | |
| Freestanding SNF | 30% | |
| Hospital-based SNF | 30% | |
| **Hospice program services** | $0 | |
| *Includes pre-Hospice consultation, routine home care, 24-hour continuous home care, short-term inpatient care for pain and symptom management, and inpatient respite care.* | | |
| **Other services and supplies** | | |
| Diabetes care services | | |
| • Devices, equipment, and supplies | 20% | |
| • Self-management training | $30/visit | |
| • Medical nutrition therapy | $30/visit | |
| Dialysis services | $0 | |
| PKU product formulas and special food products | $0 | |
| Allergy serum billed separately from an office visit | 50% | |

| Mental Health or Substance Use Disorder Benefits | Your payment | |
|---|---|---|
| | When using a Participating Provider[3] | CYD[2] applies |
| **Outpatient services** | | |
| Office visit, including Physician office visit | $30/visit | |
| Teladoc Health mental health | $0 | |
| Other outpatient services, including intensive outpatient care, electroconvulsive therapy, transcranial magnetic stimulation, Behavioral Health Treatment for pervasive developmental disorder or autism in an office setting, home, or other non-institutional facility setting, and office-based opioid treatment | $0 | |
| Partial Hospitalization Program | $0 | |
| Psychological Testing | $0 | |
| **Inpatient services** | | |
| Physician inpatient services | $0 | |
| Hospital services | 30% | |
| Residential Care | 30% | |

## Notes

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

The Evidence of Coverage (EOC) describes the Benefits, limitations, and exclusions that apply to coverage under this Plan. Please review the EOC for more details of coverage outlined in this Summary of Benefits. You can request a copy of the EOC at any time.

*Capitalized terms are defined in the EOC.* Refer to the EOC for an explanation of the terms used in this Summary of Benefits.

**2 Calendar Year Deductible (CYD):**

*Calendar Year Deductible explained.* A Calendar Year Deductible is the amount you pay each Calendar Year before Blue Shield pays for Covered Benefits under the Plan.

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

**3 Using Participating Providers:**

*Participating Providers have a contract to provide health care services to Members.* When you receive Covered Benefits from a Participating Provider, you are only responsible for the Copayment or Coinsurance, once any Calendar Year Deductible has been met.

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

*Calendar Year Out-of-Pocket Maximum explained.* The Out-of-Pocket Maximum is the most you are required to pay for Covered Benefits in a Calendar Year. Once you reach your Out-of-Pocket Maximum, Blue Shield will pay 100% of the Allowed Charges for Covered Benefits for the rest of the Calendar Year.

*Your payment after you reach the Calendar Year OOPM.* You will continue to pay all charges for services that are not covered, charges above the Allowed Charges, and charges for services above any Benefit maximum.

*Family coverage has an individual OOPM within the Family OOPM.* This means that the OOPM will be met for an individual with Family coverage who meets the individual OOPM prior to the Family meeting the Family OOPM within a Calendar Year.

**5 Separate Member Payments When Multiple Covered Benefits are Received:**

Each time you receive multiple Covered Benefits, you might have separate payments (Copayment or Coinsurance) for each service. When this happens, you may be responsible for multiple Copayments or Coinsurance. For example, you may owe an office visit payment in addition to an allergy serum payment when you visit the doctor for an allergy shot.

**6 Preventive Health Services:**

If you only receive Preventive Health Services during a Physician office visit, there is no Copayment or Coinsurance for the visit. If you receive both Preventive Health Services and other Covered Benefits during the Physician office visit, you may have a Copayment or Coinsurance for the visit.

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

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# Outpatient Prescription Drug Rider

**Group Rider**
**HMO/POS**

## Enhanced Rx - Value Formulary $15/30/50 with $0 Pharmacy Deductible Summary of Benefits

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

| | |
|---|---|
| **Pharmacy Network:** | **Rx Ultra** |
| **Drug Formulary:** | **Value Formulary** |

### Calendar Year Pharmacy Deductible(CYPD)[1]

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

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

| **Prescription Drug Benefits[3,4]** | **Your payment** | |
|---|---|---|
| | **When using a Participating Pharmacy[2]** | **CYPD[1] applies** |
| **Retail pharmacy prescription Drugs** | | |
| *Per prescription, up to a 30-day supply.* | | |
| Contraceptive Drugs and devices | $0 | |
| Tier 1 Drugs | $15/prescription | |
| Tier 2 Drugs | $30/prescription | |
| Tier 3 Drugs | $50/prescription | |
| Tier 4 Drugs | 20% up to $250/prescription | |
| **Retail pharmacy prescription Drugs** | | |
| *Per prescription, for a 90-day supply.* | | |
| Contraceptive Drugs and devices | $0 | |
| Tier 1 Drugs | $45/prescription | |
| Tier 2 Drugs | $90/prescription | |
| Tier 3 Drugs | $150/prescription | |
| Tier 4 Drugs | 20% up to $750/prescription | |
| **Mail service pharmacy prescription Drugs** | | |
| *Per prescription, for a 31-90-day supply.* | | |
| Contraceptive Drugs and devices | $0 | |
| Tier 1 Drugs | $30/prescription | |

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| Prescription Drug Benefits[3,4] | Your payment | |
|---|---|---|
| | When using a Participating Pharmacy[2] | CYPD[1] applies |
| Tier 2 Drugs | $60/prescription | |
| Tier 3 Drugs | $100/prescription | |
| Tier 4 Drugs | 20% up to $500/prescription | |

## Notes

**1 Calendar Year Pharmacy Deductible (CYPD):**

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

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

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

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

**2 Using Participating Pharmacies:**

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

*Participating Pharmacies and Drug Formulary.* You can find a Participating Pharmacy and the Drug Formulary by visiting https://www.blueshieldca.com/wellness/drugs/formulary#heading2.

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

**3 Outpatient Prescription Drug Coverage:**

**Medicare Part D-creditable coverage-**

This prescription Drug coverage is on average equivalent to or better than the standard benefit set by the federal government for Medicare Part D (also called creditable coverage). Because this prescription Drug coverage is creditable, you do not have to enroll in Medicare Part D while you maintain this coverage; however, you should be aware that if you do not enroll in Medicare Part D within 63 days following termination of this coverage, you could be subject to Medicare Part D premium penalties.

**4 Outpatient Prescription Drug Coverage:**

*Brand Drug coverage when a Generic or Biosimilar Drug is available.* If you, the Physician, or Health Care Provider select a Brand Drug when a Generic Drug equivalent or Biosimilar Drug is available, you are responsible for the difference between the cost to Blue Shield for the Brand Drug and its Generic Drug equivalent or Biosimilar Drug plus the applicable tier Copayment or Coinsurance of the Brand Drug. This difference in cost will not count towards any Calendar Year Pharmacy Deductible, medical Deductible, or the Calendar Year Out-of-Pocket Maximum. If you or

## Notes

your Physician believes a Brand Drug is Medically Necessary, either person may request a Medical Necessity Review. If approved, the Brand Drug will be covered at the applicable Drug tier Copayment or Coinsurance.

See the Obtaining outpatient prescription Drugs at a Participating Pharmacy section for more information about how a brand contraceptive may be covered without a Copayment or Coinsurance.

*Short-Cycle Specialty Drug program.* This program allows initial prescriptions for select Specialty Drugs to be filled for a 15-day supply with your approval. When this occurs, the Copayment or Coinsurance will be pro-rated.

*Specialty Drugs.* Specialty Drugs are only available from a Network Specialty Pharmacy, up to a 30-day supply.

*Oral Anticancer Drugs.* You pay up to $250 for oral Anticancer Drugs from a Participating Pharmacy, up to a 30-day supply. Oral Anticancer Drugs from a Participating Pharmacy are not subject to any Deductible.

*Retail pharmacy.* You may receive up to a 90-day supply for maintenance Drugs at a Participating Pharmacy when you pay the applicable Copayment or Coinsurance for each 30-day supply.

*Mail service Drugs.* You pay the applicable 30-day retail pharmacy Copayment or Coinsurance for a 30-day supply or less from the mail service pharmacy.

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

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# Acupuncture and Chiropractic Services Rider

**Group Rider**
**HMO/POS**

## Summary of Benefits

This Summary of Benefits shows the amount you will pay for Covered Benefits under this acupuncture and chiropractic services Benefit.

| Benefits | Your Payment | |
|---|---|---|
| *Covered Benefits must be determined as Medically Necessary by American Specialty Health Plans of California, Inc. (ASH Plans).*<br><br>*Up to 30 visits per Member, per Calendar Year. The 30 visit maximum is for acupuncture and chiropractic services combined.*<br><br>*Services are not subject to the Calendar Year Deductible and do count towards the Calendar Year Out-of-Pocket Maximum.* | **When using an ASH Participating Provider** | **When using a Non-Participating Provider** |
| **Acupuncture Services** | | |
| Office visit | $10/visit | Not covered |
| **Chiropractic Services** | | |
| Office visit | $10/visit | Not covered |
| Chiropractic Appliances | All charges above $50 | Not covered |

Benefit Plans may be modified to ensure compliance with State and Federal Requirements.

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## Introduction

In addition to the Benefits listed in your Evidence of Coverage, your rider provides coverage for acupuncture and chiropractic services as described in this supplement. The Benefits covered under this rider must be received from an American Specialty Health Plans of California, Inc. (ASH Plans) Participating Provider. These acupuncture and chiropractic Benefits are separate from your health Plan, but the general provisions, limitations, and exclusions described in your Evidence of Coverage do apply. A referral from your Primary Care Physician is not required.

All Covered Benefits, except for (1) the initial examination and treatment by an ASH Participating Provider; and (2) Emergency Services, must be determined as Medically Necessary by ASH Plans.

Note: ASH Plans will respond to all requests for Medical Necessity review within five business days from receipt of the request.

Covered Benefits received from providers who are not ASH Participating Providers will not be covered except for Emergency Services and in certain circumstances, in counties in California in which there are no ASH Participating Providers. If ASH Plans determines Covered Benefits from a provider other than a Participating Provider are Medically Necessary, you will be responsible for the Participating Provider Copayment amount.

## Benefits

### Acupuncture Services

Benefits are available for Medically Necessary acupuncture services for the treatment of Musculoskeletal and Related Disorders.

Benefits include an initial examination, acupuncture and adjunctive therapy, and subsequent office visits for the treatment of:

- headaches (tension-type and migraines);
- hip or knee joint pain associated with osteoarthritis (OA);
- other extremity joint pain associated with OA or mechanical irritation;
- other pain syndromes involving the joints and associated soft tissues;
- back and neck pain; and
- nausea associated with pregnancy, surgery, or chemotherapy.

### Chiropractic Services

Benefits are available for Medically Necessary chiropractic services for the treatment of Musculoskeletal and Related Disorders.

Benefits include an initial examination, subsequent office visits and the following services:

- spinal and extra-spinal joint manipulation (adjustments);
- adjunctive therapy such as electrical muscle stimulation or therapeutic exercises;
- plain film x-ray services; and
- chiropractic supports and appliances.

Visits for acupuncture and chiropractic services are limited to a per Member per Calendar Year maximum as

shown on the Summary of Benefits. Benefits must be provided in an office setting. You will be referred to your Primary Care Physician for evaluation of conditions not related to a Musculoskeletal and Related Disorder and for other services not covered under this rider such as diagnostic imaging (e.g. CAT scans or MRIs).

Note: You should exhaust the Benefits covered under this rider before accessing the same services through the "Alternative Care Discount Program," which is a wellness discount program. For more information about the Alternative Care Discount Program, visit www.blueshieldca.com.

See the Grievance Process portion of your EOC for information on filing a grievance, your right to seek assistance from the Department of Managed Health Care, and your rights to independent medical review.

## Member Services

For all acupuncture and chiropractic services, Blue Shield of California has contracted with ASH Plans to act as the Plan's acupuncture and chiropractic services administrator. Contact ASH Plans with questions about acupuncture and chiropractic services, ASH Participating Providers, or acupuncture and chiropractic Benefits.

Contact ASH Plans at:

1-800-678-9133
American Specialty Health Plans of California, Inc.
P.O. Box 509002
San Diego, CA 92150-9002

ASH Plans can answer many questions over the telephone.

## Exclusions

Acupuncture services do not include:

- treatment of asthma;
- treatment of addiction (including without limitation smoking cessation); or
- vitamins, minerals, nutritional supplements (including herbal supplements), or other similar products.

See the Grievance Process portion of your EOC for information on filing a grievance, your right to seek assistance from the Department of Managed Health Care, and your rights to independent medical review.

## Definitions

| | |
|---|---|
| **American Specialty Health Plans of California, Inc. (ASH Plans)** | ASH Plans is a licensed, specialized health care service plan that has entered into an agreement with Blue Shield of California to arrange for the delivery of acupuncture and chiropractic services. |
| **ASH Participating Provider** | An acupuncturist or a chiropractor under contract with ASH Plans to provide Covered Benefits to Members. |

| | |
|---|---|
| **Musculoskeletal and Related Disorders** | Musculoskeletal and Related Disorders are conditions with signs and symptoms related to the nervous, muscular, and/or skeletal systems. Musculoskeletal and Related Disorders are conditions typically categorized as: structural, degenerative, or inflammatory disorders; or biomechanical dysfunction of the joints of the body and/or related components of the muscle or skeletal systems (muscles, tendons, fascia, nerves, ligaments/capsules, discs and synovial structures) and related manifestations or conditions. Musculoskeletal and Related Disorders include Myofascial/Musculoskeletal Disorders, Musculoskeletal Functional Disorders and subluxation. |

Please be sure to retain this document. It is not a contract but is a part of your EOC.

# NOTICES AVAILABLE ONLINE

## Nondiscrimination and Language Assistance Services

Blue Shield complies with applicable state and federal civil rights laws. We also offer language assistance services at no additional cost.

View our nondiscrimination notice and language assistance notice: **blueshieldca.com/notices**. You can also call for language assistance services: **(866) 346-7198 (TTY: 711)**.

If you are unable to access the website above and would like to receive a copy of the nondiscrimination notice and language assistance notice, please call Customer Care at **(888) 256-3650 (TTY: 711)**.

## Servicios de asistencia en idiomas y avisos de no discriminación

Blue Shield cumple con las leyes de derechos civiles federales y estatales aplicables. También, ofrecemos servicios de asistencia en idiomas sin costo adicional.

Vea nuestro aviso de no discriminación y nuestro aviso de asistencia en idiomas en **blueshieldca.com/notices**. Para obtener servicios de asistencia en idiomas, también puede llamar al **(866) 346-7198 (TTY: 711)**.

Si no puede acceder al sitio web que aparece arriba y desea recibir una copia del aviso de no discriminación y del aviso de asistencia en idiomas, llame a Atención al Cliente al **(888) 256-3650 (TTY: 711)**.

## 非歧視通知和語言協助服務

Blue Shield 遵守適用的州及聯邦政府的民權法。同時，我們免費提供語言協助服務。

如需檢視我司的非歧視通知和語言幫助通知，請造訪 **blueshieldca.com/notices**。您還可致電尋求語言協助服務：**(866) 346-7198 (TTY: 711)**。

如果您無法造訪上述網站，且希望收到一份非歧視通知和語言幫助通知的副本，請致電客戶服務部，電話：**(888) 256-3650 (TTY: 711)**。