Effective: July 01, 2025

Northern California Pipe Trades

H&W Trust Fund Retiree PPO Plan

Summary of Benefits

Find your doctor

Go to **blueshieldca.com/pponetwork** and select the type of provider you need. Enter your location, then click Continue.

blue california

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Summary of Benefits

Northern California Pipe Trades H&W Trust Fund
Effective July 1, 2025
PPO Plan

Custom PPO Retiree

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

Medical Provider Network: Full PPO Network

This Plan uses a specific network of Health Care Providers, called the Full PPO provider network. Providers in this network are called Participating Providers. You pay less for Covered Services when you use a Participating Provider than when you use a Non-Participating Provider. 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 Services under the Plan. Blue Shield pays for some Covered Services before the Calendar Year Deductible is met, as noted in the Benefits chart below.

		When using a Participating[3] or Non-Participating[4] Provider
Calendar Year medical Deductible	*Individual coverage*	$100
	Family coverage	$100: individual $200: Family

Calendar Year Out-of-Pocket Maximum[5]

An Out-of-Pocket Maximum is the most a Member will pay for Covered Services each Calendar Year. Any exceptions are listed in the Notes section at the end of this Summary of Benefits.

	When using a Participating Provider[3]	When using any combination of Participating[3] or Non-Participating[4] Providers
Individual coverage	$750	$1,500
Family coverage	$750: individual $1,500: Family	$1,500: individual $3,000: Family

No Annual or Lifetime Dollar Limit

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

Benefits[6]	Your payment			
	When using a Participating Provider[3]	CYD[2] applies	When using a Non-Participating Provider[4]	CYD[2] applies
Preventive Health Services[7]				
California Prenatal Screening Program	$0		$0	
Annual routine physical examination office visit	$10/visit		30%	✔
Colorectal cancer screening	$0		30%	✔
Osteoporosis screening	10%		30%	✔
Routine laboratory services	$10/visit		30%	✔
Vision and hearing screening	$10/visit		30%	✔
Medically necessary immunizations (according to age schedule)	$10/visit		30%	✔
Well Baby office visits	$10/visit		30%	✔
Well Baby routine laboratory services and immunizations	$10/visit		30%	✔
Well Baby vision and hearing screening	$10/visit		30%	✔
Physician services				
Primary care office visit	$20/visit		30%	✔
Specialist care office visit	$20/visit		30%	✔
Physician home visit	10%		30%	✔
Physician or surgeon services in an Outpatient Facility	$0	✔	30%	✔
Physician or surgeon services in an inpatient facility	$0	✔	30%	✔
Other professional services				
Other practitioner office visit	$20/visit		30%	✔
Includes nurse practitioners, physician assistants, therapists, and podiatrists.				
Acupuncture services	$10/visit	✔	$10/visit	✔
Up to 24 visits per Member, per Calendar Year.				
Chiropractic services	$10/visit	✔	30%	✔
Up to 24 visits per Member, per Calendar Year.				
Teladoc consultation	$5/consult		Not covered	
Family planning				
• Counseling, consulting, and education	$10/visit		Not covered	
• Injectable contraceptive	$25/injection		Not covered	
• Diaphragm fitting	10%	✔	Not covered	
• Intrauterine device (IUD)	50%	✔	Not covered	
• Insertion and/or removal of intrauterine device	10%	✔	Not covered	
• Implantable contraceptive	10%		Not covered	

Benefits[6]	Your payment			
	When using a Participating Provider[3]	CYD[2] applies	When using a Non-Participating Provider[4]	CYD[2] applies
• Tubal ligation	10%	✔	Not covered	
• Vasectomy	10%	✔	Not covered	
Medical nutrition therapy, not related to diabetes	$0	✔	30%	✔
Pregnancy and maternity care				
Physician office visits: prenatal and postnatal	$0	✔	30%	✔
Abortion and abortion-related services	$0		$0	
Emergency Services				
Emergency room services *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.*	$20/visit		$20/visit	
Emergency room Physician services	$100/visit	✔	$100/visit	✔
Urgent care center services	$20/visit		30%	✔
Ambulance services *This payment is for emergency or authorized transport.*	$50/transport	✔	$50/transport	✔
Outpatient Facility services				
Ambulatory Surgery Center	$35/surgery	✔	30% Subject to a Benefit maximum of $350/day	✔
Outpatient Department of a Hospital: surgery	$35/surgery	✔	30% Subject to a Benefit maximum of $350/day	✔
Outpatient Department of a Hospital: treatment of illness or injury, radiation therapy, chemotherapy, and necessary supplies	10%	✔	30% Subject to a Benefit maximum of $350/day	✔
Inpatient facility services				
Hospital services and stay	$150/admission	✔	30% Subject to a Benefit maximum of $600/day	✔

Benefits[6]	Your payment			
	When using a Participating Provider[3]	CYD[2] applies	When using a Non-Participating Provider[4]	CYD[2] applies
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	$150/admission	✔	Not covered	
• Physician inpatient services	$0	✔	Not covered	
Bariatric surgery services, designated California counties *This payment is for bariatric surgery services for residents of designated California counties. For bariatric surgery services for residents of non-designated California counties, the payments for Inpatient facility services/ Hospital services and stay and Physician inpatient and surgery services apply for inpatient services; or, if provided on an outpatient basis, the Outpatient Facility services and outpatient Physician services payments apply.*				
Inpatient facility services	$150/admission	✔	Not covered	
Outpatient Facility services	$35/surgery	✔	Not covered	
Physician services	$0	✔	Not covered	
Diagnostic x-ray, imaging, pathology, and laboratory services *This payment is for Covered Services that are diagnostic, non-Preventive Health Services, and diagnostic radiological procedures. For the payments for Covered Services that are considered Preventive Health Services, see Preventive Health Services.*				
Laboratory and pathology services *Includes diagnostic Papanicolaou (Pap) test.*				
• Laboratory center	$20/visit	✔	30%	✔
• Outpatient Department of a Hospital	$20/visit	✔	30% Subject to a Benefit maximum of $350/day	✔
Basic imaging services *Includes plain film X-rays, ultrasounds, and diagnostic mammography.*				
• Outpatient radiology center	$20/visit	✔	30%	✔

Benefits[6]	Your payment			
	When using a Participating Provider[3]	CYD[2] applies	When using a Non-Participating Provider[4]	CYD[2] applies
• Outpatient Department of a Hospital	$20/visit	✔	30% Subject to a Benefit maximum of $350/day	✔
Other outpatient non-invasive diagnostic testing *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	$20/visit	✔	30%	✔
• Outpatient Department of a Hospital	$20/visit	✔	30% Subject to a Benefit maximum of $350/day	✔
Advanced imaging services *Includes diagnostic radiological and nuclear imaging such as CT scans, MRIs, MRAs, and PET scans.*				
• Outpatient radiology center	$0	✔	30%	✔
• Outpatient Department of a Hospital	$0	✔	30% Subject to a Benefit maximum of $350/day	✔
Rehabilitative and Habilitative Services *Includes physical therapy, occupational therapy, and respiratory therapy.*				
Office location	$20/visit	✔	30%	✔
Outpatient Department of a Hospital	$20/visit	✔	30% Subject to a Benefit maximum of $350/day	✔
Speech Therapy services				
Office location	$20/visit	✔	$20/visit	✔
Outpatient Department of a Hospital	$20/visit	✔	30% Subject to a Benefit maximum of $350/day	✔
Durable medical equipment (DME)				
DME	10%	✔	30%	✔
Breast pump	Not covered		Not covered	

Benefits[6]	Your payment			
	When using a Participating Provider[3]	CYD[2] applies	When using a Non-Participating Provider[4]	CYD[2] applies
Orthotic equipment and devices	10%	✔	30%	✔
Prosthetic equipment and devices	10%	✔	30%	✔
Home health care services *Up to 100 visits per Member, per Calendar Year, by a home health care agency. All visits count towards the limit, including visits during any applicable Deductible period. Includes home visits by a nurse, Home Health Aide, medical social worker, physical therapist, speech therapist, or occupational therapist, and medical supplies.*	10%	✔	Not covered	
Home infusion and home injectable therapy services				
Home infusion agency services *Includes home infusion drugs, medical supplies, and visits by a nurse.*	10%	✔	Not covered	
Hemophilia home infusion services *Includes blood factor products.*	10%	✔	Not covered	
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	10%	✔	10%	✔
Hospital-based SNF	$150/admission	✔	30% Subject to a Benefit maximum of $600/day	✔
Hospice program services				
Pre-Hospice consultation	$0		Not covered	
Routine home care	$0		Not covered	
24-hour continuous home care	10%	✔	Not covered	
Short-term inpatient care for pain and symptom management	10%	✔	Not covered	
Inpatient respite care	$0		Not covered	
Other services and supplies				
Diabetes care services				
• Devices, equipment, and supplies	10%	✔	30%	✔
• Self-management training	$20/visit		30%	✔

Benefits[6]	Your payment			
	When using a Participating Provider[3]	CYD[2] applies	When using a Non-Participating Provider[4]	CYD[2] applies
• Medical nutrition therapy	$20/visit		30%	✔
Dialysis services	10%	✔	30% Subject to a Benefit maximum of $300/day	✔
PKU product formulas and special food products	10%	✔	10%	✔
Allergy serum billed separately from an office visit	10%	✔	30%	✔

Mental Health Benefits	Your payment			
Mental health Benefits are provided through Blue Shield's Mental Health Service Administrator (MHSA).	When using a MHSA Participating Provider[3]	CYD[2] applies	When using a MHSA Non-Participating Provider[4]	CYD[2] applies
Outpatient services				
Office visit, including Physician office visit	$10/visit		30%	✔
Teladoc mental health	$5/consult		Not covered	
Other outpatient services, including intensive outpatient care	$0		30%	✔
Behavioral health treatment in an office setting	$0	✔	30%	✔
Behavioral health treatment in home or other non-institutional facility	$0	✔	30%	✔
Partial Hospitalization Program	$0	✔	30% Subject to a Benefit maximum of $350/day	✔
Psychological Testing	$0	✔	30%	✔
Inpatient services				
Physician inpatient services	$0	✔	30%	✔
Hospital services	$150/admission	✔	30% Subject to a Benefit maximum of $600/day	✔
Residential Care for mental health condition	$150/admission	✔	30% Subject to a Benefit maximum of $600/day	✔

Substance Use Disorder Benefits

Substance use disorder Benefits are provided through Blue Shield's Mental Health Service Administrator (MHSA).	Your payment: When using a MHSA Participating Provider[3]	Your payment: CYD[2] applies	Your payment: When using a MHSA Non-Participating Provider[4]	Your payment: CYD[2] applies
Outpatient services				
Office visit, including Physician office visit	$10/visit		30%	✔
Teladoc mental health	$5/consult		Not covered	
Other outpatient services, including intensive outpatient care and office-based opioid treatment	$0		30%	✔
Behavioral health treatment in an office setting	$0	✔	30%	✔
Behavioral health treatment in home or other non-institutional facility	$0	✔	30%	✔
Partial Hospitalization Program	$0	✔	30% of up to $350/day plus 100% of additional charges	✔
Psychological Testing	$0	✔	30%	✔
Inpatient services				
Physician inpatient services	$0	✔	30%	✔
Hospital services	$0	✔	30% of up to $600/day plus 100% of additional charges	✔
Residential care for substance use disorder condition	$0	✔	30% of up to $600/day plus 100% of additional charges	✔

Prior Authorization

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

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

Please review the Evidence of Coverage for more about Benefits that require prior authorization.

Notes

1 Evidence of Coverage (EOC):

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

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

2 Calendar Year Deductible (CYD):

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

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

Covered Services not subject to the Calendar Year medical Deductible. Some Covered Services received from Participating Providers are paid by Blue Shield before you meet any Calendar Year medical Deductible. These Covered Services do not have a check mark (✔) next to them in the "CYD applies" column in the Benefits chart above.

This Plan has a combined Participating Provider and Non-Participating Provider Calendar Year Deductible.

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

3 Using Participating Providers:

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

Teladoc. Teladoc mental health and substance use disorder consultations are provided through Teladoc. These services are not administered by Blue Shield's Mental Health Service Administrator (MHSA).

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

- Coinsurance is calculated from the Allowable Amount.

4 Using Non-Participating Providers:

Non-Participating Providers do not have a contract to provide health care services to Members. When you receive Covered Services from a Non-Participating Provider, you are responsible for:

- the Copayment or Coinsurance (once any Calendar Year Deductible has been met), and
- any charges above the Allowable Amount.

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

- Coinsurance is calculated from the Allowable Amount, which is subject to any stated Benefit maximum.
- Charges above the Allowable Amount do not count towards the Out-of-Pocket Maximum, and are your responsibility for payment to the provider. This out-of-pocket expense can be significant.

Notes

5 Calendar Year Out-of-Pocket Maximum (OOPM):

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

Your payment after you reach the Calendar Year OOPM. You will continue to pay all charges for services that are not covered and charges above the Allowable Amount.

Any Deductibles count towards the OOPM. Any amounts you pay that count towards the medical Calendar Year Deductible also count towards the Calendar Year Out-of-Pocket Maximum.

This Plan has a Participating Provider OOPM as well as a combined Participating Provider and Non-Participating Provider OOPM. This means that any amounts you pay towards your Participating Provider OOPM also count towards your combined Participating and Non-Participating Provider OOPM.

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.

6 Separate Member Payments When Multiple Covered Services are Received:

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

7 Preventive Health Services:

If you only receive Preventive Health Services during a Physician office visit, a Copayment or Coinsurance may apply for the visit by a Participating Provider. If you receive both Preventive Health Services and other Covered Services during the Physician office visit, you may have a Copayment or Coinsurance for the visit.

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

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Hearing Aid Services Rider

Group Rider
Effective July 1, 2025
PPO

Northern California Pipe Trades (Retiree) Additional Hearing Aid Summary of Benefits

This Summary of Benefits shows the amount you will pay for Covered Services under this Blue Shield of California hearing aid services Benefit.

Benefits	Your Payment
Up to a $2,000 maximum per Member in any 24-month period. Services are not subject to the Calendar Year Deductible.	**When using any provider**
Hearing Aid Services	
Hearing aid examinations for the appropriate type of hearing aid and/or for fittings, counseling and adjustments Hearing aid device checks Electroacoustic evaluations for hearing aids Hearing aid instrument, monaural or binaural, including ear mold(s) and the initial battery and cords	All charges above $2,000

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

Introduction

In addition to the Benefits listed in your Evidence of Coverage, your rider provides coverage for hearing aid services, as described in this supplement. These hearing aid services Benefits are separate from your health Plan, but the general provisions, limitations, and exclusions described in your Evidence of Coverage do apply.

Because Blue Shield does not maintain a network of contracted providers for these services, the Benefits covered under this supplement can be received from any provider and you may submit a claim to Blue Shield for reimbursement.

Benefits

Benefits are available for hearing aid services as shown on the Summary of Benefits. Services are limited to a maximum payment per Member in any period, are not subject to the Calendar Year Deductible.

Blue Shield will reimburse you for Covered Services up to the maximum shown on the Summary of Benefits.

Submitting a Claim Form

Blue Shield will pay Members directly for services rendered. Claims for payment must be submitted to Blue Shield within one year after the month services were provided. Blue Shield will notify the Member of its determination within 30 days after receipt of the claim.

To submit a claim for payment, send a copy of the itemized bill, along with a completed Blue Shield claim form to:

Blue Shield
P.O. Box 272540
Chico, CA 95927-2540

Claim forms are available online at www.blueshieldca.com or Members may call Blue Shield Customer Service to obtain a form. At a minimum, each claim submission must contain the Subscriber's name, home address, group contract number, Subscriber number, a copy of the provider's bill showing the services rendered, dates of treatment and the patient's name.

Blue Shield provides an Explanation of Benefits to describe how the claim was processed and to inform the Member of any financial responsibility.

Exclusions

Benefits do not include:

- surgically implanted hearing devices;
- spare hearing aids;
- assisted listening devices or amplification devices;
- purchase of batteries or other equipment, except those covered under the terms of the initial hearing aid purchase;
- charges for a hearing aid that exceed specifications prescribed for correction of a hearing loss; or

- replacement parts for hearing aids, repair of hearing aids after the covered warranty period, and replacement of hearing aids more than once in any 24-month period.

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.

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

2025 Summary of Benefits

Blue Shield of California Medicare Rx Plan (PDP)

Group Medicare Prescription Drug Plan for Northern California Pipe Trades Trust Fund

Effective July 1, 2025 – June 30, 2026

blueshieldca.com/medicare

S2468_25_282C_M 05292025

2025 Summary of Benefits

Blue Shield of California Medicare Rx Plan

July 1, 2025 – June 30, 2026

The benefit information provided does not list every service that we cover or list every limitation or exclusion. To get a complete list of services we cover, please contact your former employer group/union or call Blue Shield of California Medicare Rx Plan Customer Service at **(888) 239-6469** [TTY: **711**], 8 a.m. to 8 p.m. PT, seven days a week.

To join **Blue Shield of California Medicare Rx Plan**, you must be entitled to Medicare Part A and/or Part B, meet your former employer group/union's eligibility requirements, and permanently live in the plan service area. Our service area includes all 50 states and the District of Columbia. Your Medicare-eligible spouse and dependents may also join Blue Shield of California Medicare Rx Plan if they meet these requirements.

If you want to know more about the coverage and costs of Original Medicare, look in your current "**Medicare & You**" handbook. View it online at **www.medicare.gov/medicare-and-you** or get a copy by calling **1-800-MEDICARE (1-800-633-4227)**, 24 hours a day, 7 days a week. TTY users should call **1-877-486-2048.**

Look up pharmacies and covered drugs on our website:

- Pharmacy Directory - **blueshieldca.com/medpharmacy2025**
- Formulary (List of covered drugs) **blueshieldca.com/medformulary2025**

Blue Shield of California's pharmacy network includes limited lower-cost pharmacies with preferred cost sharing. The lower costs advertised in our plan materials for these pharmacies may not be available at the pharmacy you use. For up-to-date information about our network pharmacies, including whether there are any lower-cost pharmacies with preferred cost sharing in your area, please call Customer Service at (888) 239-6469 (TTY: 711), 8 a.m. to 8 p.m. PT, seven days a week or consult the online pharmacy directory at **blueshieldca.com/medpharmacy2025.**

Prescription Drug Coverage Summary of Benefits

Blue Shield of California Medicare Rx Plan (PDP)

Effective July 1, 2025 – June 30, 2026

Monthly plan premium, deductible and limits on how much you pay for covered Part D prescription drugs.

You pay the following:

Blue Shield of California Medicare Rx Plan (PDP)	
Monthly plan premium	Your former employer group/union is responsible for paying premiums beyond your monthly Medicare Part B premium. If you are responsible for any part of the premium, your benefits administrator will tell you the amount you and your former employer group/union contribute to the premium.
Annual Deductible Stage	This stage does not apply because there is no deductible.
Initial Coverage Stage	During this stage, the plan pays its share of your drug costs and you pay your share

You may purchase your drugs at network retail pharmacies and our home delivery service.

What you pay:	**Preferred retail cost-sharing (in-network)^**	
	30-day supply	**100-day supply*[NDS]**
Tier 1: Generic Drugs	$10 copay	$20 copay
Tier 2: Preferred Brand Drugs	$20 copay	$40 copay
Tier 2: Covered Insulins**	$20 copay	$40 copay
Tier 3: Non-Preferred Drugs	$35 copay	$70 copay
Tier 4: Injectable Drugs	30% coinsurance (up to a $150 copay maximum)	30% coinsurance (up to a $450 copay maximum)
Tier 4: Covered Insulins**	$35 copay	$105 copay
Tier 5: Specialty Tier Drugs	30% coinsurance (up to a $150 copay maximum)	Not covered

Covered Insulins are marked with the symbol **INS on the Drug List. This cost-sharing only applies to beneficiaries who do not qualify for a program that helps pay for your drugs ("Extra Help").

*100-day supply cost-sharing also applies to Amazon Pharmacy home delivery service.

[NDS]A long-term (up to a 100-day) supply is not available for select drugs. The drugs that are not available for a long-term supply are marked with the symbol **NDS** in our Drug List.

^If you reside in a long-term care facility, you pay the same as at an in-network standard retail cost-sharing pharmacy for up to a 31-day supply of a covered drug. There are limited situations where you may

be able to get up to a 30-day supply of a covered drug from an out-of-network pharmacy at the same cost as from an in-network standard retail cost-sharing pharmacy.

What you pay:	Standard retail cost-sharing (in-network)^	
	30-day supply	100-day supply*NDS
Tier 1: Generic Drugs	$10 copay	$30 copay[NDS]
Tier 2: Preferred Brand Drugs	$20 copay	$60 copay[NDS]
Tier 2: Covered Insulins**	$20 copay	$60 copay[NDS]
Tier 3: Non-Preferred Drugs	$35 copay	$105 copay[NDS]
Tier 4: Injectable Drugs	30% coinsurance (up to a $150 copay maximum)	30% coinsurance[NDS] (up to a $450 copay maximum)
Tier 4: Covered Insulins**	$35 copay	$105 copay[NDS]
Tier 5: Specialty Tier Drugs	30% coinsurance (up to a $150 copay maximum)	Not covered

Covered Insulins are marked with the symbol **INS on the Drug List. This cost-sharing only applies to beneficiaries who do not qualify for a program that helps pay for your drugs ("Extra Help").
*100-day supply cost-sharing also applies to Amazon Pharmacy home delivery service.
NDS A long-term (up to a 100-day) supply is not available for select drugs. The drugs that are not available for a long-term supply are marked with the symbol **NDS** in our Drug List.
^If you reside in a long-term care facility, you pay the same as at an in-network standard retail cost-sharing pharmacy for up to a 31-day supply of a covered drug. There are limited situations where you may be able to get up to a 30-day supply of a covered drug from an out-of-network pharmacy at the same cost as from an in-network standard retail cost-sharing pharmacy.

What you pay:	Home delivery cost-sharing 100-day supply*[NDS]
Tier 1: Generic Drugs	$20 copay[NDS]
Tier 2: Preferred Brand Drugs	$40 copay[NDS]
Tier 2: Covered Insulins**	$40 copay[NDS]
Tier 3: Non-Preferred Drugs	$70 copay[NDS]
Tier 4: Injectable Drugs	30% coinsurance[NDS] (up to a $450 copay maximum)
Tier 4: Covered Insulins**	$105 copay[NDS]
Tier 5: Specialty Tier Drugs	Not covered

Covered Insulins are marked with the symbol **INS on the Drug List. This cost-sharing only applies to beneficiaries who do not qualify for a program that helps pay for your drugs ("Extra Help").
*100-day supply cost-sharing also applies to Amazon Pharmacy home delivery service.
NDS A long-term (up to a 100-day) supply is not available for select drugs. The drugs that are not available for a long-term supply are marked with the symbol **NDS** in our Drug List.
^If you reside in a long-term care facility, you pay the same as at an in-network standard retail cost-sharing pharmacy for up to a 31-day supply of a covered drug. There are limited situations where you may be able to get up to a 30-day supply of a covered drug from an out-of-network pharmacy at the same cost as from an in-network standard retail cost-sharing pharmacy.

Catastrophic Coverage Stage
After your yearly out-of-pocket costs for covered Part D drugs (including drugs you bought through your retail pharmacy and through home delivery) reach $2,000, the plan pays the full cost for your covered Part D drugs. For excluded drugs covered under our enhanced benefit, you pay the Tier 1: Generic Drugs copayments listed in the tables shown above.

(This stage **protects** you from any additional costs once you have paid your yearly out-of-pocket drug costs.)

Important Message About What You Pay for Vaccines: Our plan covers most adult Part D vaccines at no cost to you. Call Customer Service for more information.

Home Delivery Service
Amazon Pharmacy is our network home delivery pharmacy where you can get a 100-day supply of maintenance drugs. Your order will be delivered with $0 shipping. If you have questions about this, please contact **Amazon Pharmacy at (856) 208-4665, 24 hours a day, 7 days a week. TTY users call 711.** See plan EOC for more information.

Network pharmacies that offer preferred cost-sharing
You may pay less when you visit one of our network pharmacies that offer preferred cost-sharing. Here's just a few:

CVS/pharmacy‡ (including CVS pharmacy at Target)	**(888) 607-4287 [TTY: 711]**
Safeway and Vons pharmacies‡	**(877) 723-3929 [TTY: 711]**
Albertsons/Sav-on/Osco pharmacies‡	**(877) 276-9637 [TTY: 711]**
Costco‡ (You do not have to be a member to use the pharmacy.)	**(800) 955-2292 [TTY: 711]**

Other pharmacies are available in our network.
‡Accepts e-prescribing

We're here to help

Contact Customer Service at **(888) 239-6469** [TTY: **711**] 8 a.m. to 8 p.m. PT, seven days a week.

Blue Shield of California is a PDP plan with a Medicare contract. Enrollment in Blue Shield of California depends on contract renewal. Blue Shield of California offers individual and employer group retiree plans to Medicare beneficiaries who have Part A and/or Part B. Individual plans are open to all Medicare beneficiaries who reside within a plan's specific service area. Employer group retiree plans are open only to Medicare beneficiaries who are eligible group retirees and who reside within a plan's specific service area. Individual and employer group retiree plans have different service areas and benefits.
Amazon Pharmacy is independent of Blue Shield of California and is contracted with Blue Shield to provide home delivery of prescription medications to Blue Shield members.

The company complies with applicable state laws and federal civil rights laws and does not discriminate, exclude people, or treat them differently on the basis of race, color, national origin, ethnic group identification, medical condition, genetic information, ancestry, religion, sex, marital status, gender, gender identity, sexual orientation, age, mental disability, or physical disability. La compañía cumple con las leyes de derechos civiles federales y estatales aplicables, y no discrimina, ni excluye ni trata de manera diferente a las personas por su raza, color, país de origen, identificación con determinado grupo étnico, condición médica, información genética, ascendencia, religión, sexo, estado civil, género, identidad de género, orientación sexual, edad, ni discapacidad física ni mental. 本公司遵守適用的州法律和聯邦民權法律，並且不會以種族、膚色、原國籍、族群認同、醫療狀況、遺傳資訊、血統、宗教、性別、婚姻狀況、性別認同、性取向、年齡、精神殘疾或身體殘疾而進行歧視、排斥或區別對待他人。

Blue Shield of California is an independent member of the Blue Shield Association
MG00007-Northern California Pipe Trades Trust Fund-GPDP_1024

Blue Shield of California

Notice Informing Individuals about Nondiscrimination and Accessibility Requirements

Discrimination is against the law

Blue Shield of California complies with applicable state laws and federal civil rights laws, and does not discriminate on the basis of race, color, national origin, ancestry, religion, sex, marital status, gender, gender identity, sexual orientation, age, or disability. Blue Shield of California does not exclude people or treat them differently because of race, color, national origin, ancestry, religion, sex, marital status, gender, gender identity, sexual orientation, age, or disability.

Blue Shield of California:

- Provides aids and services at no cost to people with disabilities to communicate effectively with us such as:
  - Qualified sign language interpreters
  - Written information in other formats (including large print, audio, accessible electronic formats, and other formats)
- Provides language services at no cost to people whose primary language is not English such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, contact the Blue Shield of California Civil Rights Coordinator.

If you believe that Blue Shield of California has failed to provide these services or discriminated in another way on the basis of race, color, national origin, ancestry, religion, sex, marital status, gender, gender identity, sexual orientation, age, or disability, you can file a grievance with:

Blue Shield of California
Civil Rights Coordinator
P.O. Box 629007
El Dorado Hills, CA 95762-9007

Phone: (844) 831-4133 (TTY: 711)
Fax: (844) 696-6070
Email: BlueShieldCivilRightsCoordinator@blueshieldca.com

You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, our Civil Rights Coordinator is available to help you. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at **https://ocrportal.hhs.gov/ocr/portal/lobby.jsf**, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue SW.
Room 509F, HHH Building
Washington, DC 20201
(800) 368-1019; TTY: (800) 537-7697

Complaint forms are available at **www.hhs.gov/ocr/office/file/index.html**.

Notice of the Availability of Language Assistance Services
Blue Shield of California

IMPORTANT: Can you read this letter? If not, we can have somebody help you read it. You may also be able to get this letter written in your language. For help at no cost, please call right away at the Member/Customer Service telephone number on the back of your Blue Shield ID card, or (866) 346-7198.

IMPORTANTE: ¿Puede leer esta carta? Si no, podemos hacer que alguien le ayude a leerla. También puede recibir esta carta en su idioma. Para ayuda sin cargo, por favor llame inmediatamente al teléfono de Servicios al miembro/cliente que se encuentra al reverso de su tarjeta de identificación de Blue Shield o al (866) 346-7198. (Spanish)

重要通知：您能讀懂這封信嗎？如果不能，我們可以請人幫您閱讀。這封信也可以 用您所講的語言書寫。如需免费幫助，請立即撥打登列在您的Blue Shield ID卡背面上的 會員/客戶服務部的電話，或者撥打電話 (866) 346-7198。(Chinese)

QUAN TRỌNG: Quý vị có thể đọc lá thư này không? Nếu không, chúng tôi có thể nhờ người giúp quý vị đọc thư. Quý vị cũng có thể nhận lá thư này được viết bằng ngôn ngữ của quý vị. Để được hỗ trợ miễn phí, vui lòng gọi ngay đến Ban Dịch vụ Hội viên/Khách hàng theo số ở mặt sau thẻ ID Blue Shield của quý vị hoặc theo số (866) 346-7198. (Vietnamese)

MAHALAGA: Nababasa mo ba ang sulat na ito? Kung hindi, maari kaming kumuha ng isang tao upang matulungan ka upang mabasa ito. Maari ka ring makakuha ng sulat na ito na nakasulat sa iyong wika. Para sa libreng tulong, mangyaring tumawag kaagad sa numerong telepono ng Miyembro/Customer Service sa likod ng iyong Blue Shield ID kard, o (866) 346-7198. (Tagalog)

Baa' ákohwiindzindooígí: Díí naaltsoosísh yíiníłta'go bíiníghah? Doo bíiníghahgóó éí, naaltsoos nich'į' yiidóołtahígíí ła' nihee hóló. Díí naaltsoos ałdó' t'áá Diné k'ehjí ádoolníít nínízingo bíighah. Doo bąąh ílínígó shíká' adoowoł nínízingó nihich'į' béésh bee hodíilnih dóó námboo éí díí Blue Shield bee néího'dílzinígí bine'déé' bikáá' éí doodagó éí (866) 346-7198 jį' hodíílnih. (Navajo)

중요: 이 서신을 읽을 수 있으세요? 읽으실 수 경우, 도움을 드릴 수 있는 사람이 있습니다. 또한 다른 언어로 작성된 이 서신을 받으실 수도 있습니다. 무료로 도움을 받으시려면 Blue Shield ID 카드 뒷면의 회원/고객 서비스 전화번호 또는 (866) 346-7198로 지금 전환하세요. (Korean)

ԿԱՐԵՎՈՐ Է. Կարողանում ե՞ք կարդալ այս նամակը: Եթե ոչ, ապա մենք կօգնենք ձեզ: Դուք պետք է նաև կարողանաք ստանալ այս նամակը ձեր լեզվով: Ծառայությունն անվճար է: Խնդրում ենք անմիջապես զանգահարել Հաճախորդների սպասարկման բաժնի հեռախոսահամարով, որը նշված է ձեր Blue Shield ID քարտի ետևի մասում, կամ (866) 346-7198 համարով: (Armenian)

ВАЖНО: Не можете прочесть данное письмо? Мы поможем вам, если необходимо. Вы также можете получить это письмо написанное на вашем родном языке. Позвоните в Службу клиентской/членской поддержки прямо сейчас по телефону, указанному сзади идентификационной карты Blue Shield, или по телефону (866) 346-7198, и вам помогут совершенно бесплатно. (Russian)

重要：お客様は、この手紙を読むことができますか？ もし読むことができない場合、弊社が、お客様をサポートする人物を手配いたします。 また、お客様の母国語で書かれた手紙をお送りすることも可能です。 無料のサポートを希望される場合は、Blue Shield IDカードの裏面に記載されている会員/お客様サービスの電話番号、または、(866) 346-7198にお電話をおかけください。 (Japanese)

مهم: آیا می‌توانید این نامه را بخوانید؟ اگر پاسختان منفی است، می‌توانیم کسی را برای کمک به شما در اختیارتان قرار دهیم. حتی می‌توانید نسخه مکتوب این نامه را به زبان خودتان دریافت کنید. برای دریافت کمک رایگان، لطفاً بدون فوت وقت از طریق شماره تلفنی که در پشت کارت شناسی Blue Shield تان درج شده است و یا از طریق شماره تلفن 346-7198 (866) با خدمات اعضا/مشتری تماس بگیرید. (Persian)

ਮਹੱਤਵਪੂਰਨ: ਕੀ ਤੁਸੀਂ ਇਸ ਪੱਤਰ ਨੂੰ ਪੜ੍ਹ ਸਕਦੇ ਹੋ? ਜੇ ਨਹੀਂ ਤਾਂ ਇਸ ਨੂੰ ਪੜ੍ਹਨ ਵਿਚ ਮਦਦ ਲਈ ਅਸੀਂ ਕਿਸੇ ਵਿਅਕਤੀ ਦਾ ਪ੍ਰਬੰਧ ਕਰ ਸਕਦੇ ਹਾਂ। ਤੁਸੀਂ ਇਹ ਪੱਤਰ ਆਪਣੀ ਭਾਸ਼ਾ ਵਿਚ ਲਿਖਿਆ ਹੋਇਆ ਵੀ ਪ੍ਰਾਪਤ ਕਰ ਸਕਦੇ ਹੋ। ਮੁਫ਼ਤ ਵਿਚ ਮਦਦ ਪ੍ਰਾਪਤ ਕਰਨ ਲਈ ਤੁਹਾਡੇ Blue Shield ID ਕਾਰਡ ਦੇ ਪਿੱਛੇ ਦਿੱਤੇ ਮੈਂਬਰ/ਕਸਟਮਰ ਸਰਵਿਸ ਟੈਲੀਫ਼ੋਨ ਨੰਬਰ ਤੇ, ਜਾਂ (866) 346-7198 ਤੇ ਕਾੱਲ ਕਰੋ। (Punjabi)

ប្រការសំខាន់ៈ តើអ្នកអាចលិខិតនេះ បានដែរឬទេ? បើមិនអាចទេ យើងអាចឲ្យគេជួយអ្នកក្នុងការអានលិខិតនេះ។ អ្នកក៏អាចទទួលបានលិខិតនេះជាភាសារបស់អ្នកផងដែរ។ សម្រាប់ជំនួយដោយឥតគិតថ្លៃ សូមហៅទូរស័ព្ទភ្លាមៗទៅកាន់លេខទូរស័ព្ទសេវាសមាជិក/អតិថិជនដែលមាននៅលើខ្នងប័ណ្ណសម្គាល់ Blue Shield របស់អ្នក ឬតាមរយៈលេខ (866) 346-7198។ (Khmer)

المهم :هل تستطيع قراءة هذا الخطاب؟ أن لم تستطع قراءته، يمكننا إحضار شخص ما ليساعدك في قراءته. قد تحتاج أيضاً إلى الحصول على هذا الخطاب مكتوباً بلغتك. للحصول على المساعدة بدون تكلفة، يرجى الاتصال الآن على رقم هاتف خدمة العملاء/أحد الأعضاء المدون على الجانب الخلفي من بطاقة الهوية Blue Shield أو على الرقم 346-7198 (866).(Arabic)

TSEEM CEEB: Koj pos tuaj yeem nyeem tau tsab ntawv no? Yog hais tias nyeem tsis tau, peb tuaj yeem nrhiav ib tug neeg los pab nyeem nws rau koj. Tej zaum koj kuj yuav tau txais muab tsab ntawv no sau ua koj hom lus. Rau kev pab txhais dawb, thov hu kiag rau tus xov tooj Kev Pab Cuam Tub Koom Xeeb/Tub Lag Luam uas nyob rau sab nraum nrob qaum ntawm koj daim npav Blue Shield ID, los yog hu rau tus xov tooj (866) 346-7198. (Hmong)

สำคัญ: คุณอ่านจดหมายฉบับนี้ได้หรือไม่ หากไม่ได้ โปรดขอความช่วยจากผู้อ่านได้ คุณอาจได้รับจดหมายฉบับนี้เป็นภาษาของคุณ หากต้องการความช่วยเหลือโดยไม่มีค่าใช้จ่าย โปรดติดต่อฝ่ายบริการลูกค้า/สมาชิกทางเบอร์โทรศัพท์ในบัตรประจำตัว Blue Shield ของคุณ หรือโทร (866) 346-7198 (Thai)

महत्वपूर्ण: क्या आप इस पत्र को पढ़ सकते हैं? यदि नहीं, तो हम इसे पढ़ने में आपकी मदद के लिए किसी व्यक्ति का प्रबंध कर सकते हैं। आप इस पत्र को अपनी भाषा में भी प्राप्त कर सकते हैं। नि:शुल्क मदद प्राप्त करने के लिए अपने Blue Shield ID कार्ड के पीछे दिए गये मेंबर/कस्टमर सर्विस टेलीफोन नंबर, या (866) 346-7198 पर कॉल करें। (Hindi)

ສິ່ງສຳຄັນ: ທ່ານສາມາດອ່ານຈົດໝາຍນີ້ໄດ້ບໍ? ຖ້າອ່ານບໍ່ໄດ້, ພວກເຮົາສາມາດໃຫ້ບາງຄົນຊ່ວຍອ່ານໃຫ້ທ່ານຟັງໄດ້. ທ່ານຍັງສາມາດຂໍໃຫ້ແປຈົດໝາຍນີ້ເປັນພາສາຂອງທ່ານໄດ້.ສຳລັບຄວາມຊ່ວຍເຫຼືອແບບບໍ່ເສຍຄ່າ, ກະລຸນາ ໂທຫາເບີໂທຂອງຝ່າຍບໍລິການສະມາຊິກ/ລູກຄ້າໃນທັນທີເບີໂທລະສັບຢູ່ດ້ານຫຼັງບັດສະມາຊິກ Blue Shield ຂອງທ່ານ, ຫຼືໂທໄປຫາເບີ(866) 346-7198. (Laotian)

How to choose the health plan that's right for you

Questions to consider

Answering the questions below can help you choose the right plan for you and your family.

Plan names →	Plan A	Plan B
Which doctors can you see?		
Are the doctors and other providers you use in the health plan's network?		
Does the plan allow you to see doctors outside the network?		
Does the plan require a referral from a PCP to see a specialist?		
Does the plan cover the following?		
The prescription medication(s) you use		
Special services or programs for chronic conditions such as cancer, asthma, or diabetes		
The costs for delivering a baby		
Mental health and/or substance abuse services		
Alternative medical therapies such as chiropractic and acupuncture services		
Any specific services or treatments you need		
Care away from home if you or your family members live outside of California (for college or work)		

Compare health plan costs

Enter the deductible, copayment, or coinsurance amounts for the plans you want to compare. List the amounts for the benefits you'll use the most.

Also, check the plan's website to make sure the prescriptions you take are in the plan's formulary. If the plan offers a mail service pharmacy, you may be able to save money on maintenance medications.

Plan names →	Plan A	Plan B
Type of plan (HMO, PPO, POS, etc.)		
Premiums (the amount that comes out of your paycheck biweekly/monthly, etc.)		
Medical benefits		
Annual out-of-pocket maximum or copayment maximum		
Annual deductible		
Physician office visits		
Specialist office visits		
Outpatient X-ray, pathology, lab work		
Emergency room services		
Outpatient surgery performed by an ambulatory surgery center		
Outpatient surgery performed in a hospital		
Inpatient non-emergency facility services		
Pregnancy and maternity care benefits		
Family planning and infertility benefits		
Chiropractic and/or acupuncture services		
Rehabilitation benefits (physical, occupational and respiratory therapy)		
Mental health services		
Other:		
Pharmacy benefits		
Enter the prescriptions you regularly refill and compare the costs from the plan's summary of benefits.		
Annual deductible		
Drug #1:		
Drug #2:		
Drug #3:		

Glossary

Not sure what it means?

Use this glossary as a handy reference for some common health benefit terms.

Below are definitions related to Blue Shield health plan terms. Some terms may not apply to your plan. See your *Evidence of Coverage* or *Benefit Booklet* for details.

Allowable amount – The total dollar amount Blue Shield has established for the benefits the member has received. Physicians who have contracted with Blue Shield must accept this amount as payment in full. If a member chooses to go outside of our networks, he or she may be responsible for a much larger payment.

Benefits (covered services) – The medically necessary services and supplies covered by the health plan.

Copayment/coinsurance – The predetermined amount (copayment) or a percentage of the cost (coinsurance) for which you are responsible for paying, based on your plan benefits.

Deductible – The dollar amount you must pay for covered services each calendar year before Blue Shield starts paying benefits under your plan. You are responsible for this amount. Specific services, such as preventive care, are covered before you reach the calendar-year deductible.

You may have two kinds of deductibles: medical and pharmacy. Your medical deductible applies to covered services such as physician office visits. Your pharmacy deductible applies to outpatient prescription drugs obtained from a participating provider.

Evidence of Coverage* or *Benefit Booklet – The official Blue Shield documents that describe member benefits, copayments or coinsurance, exclusions and limitations.

Network providers/participating providers/provider network – A provider (includes doctors, hospitals, urgent care centers, etc.) that has agreed to contract with Blue Shield to provide covered services to members of a given health plan. A participating provider has agreed to accept Blue Shield's contracted rate for covered services.

Out-of-pocket maximum – Your maximum copayment or coinsurance responsibility each calendar year for covered services. Copayments or coinsurance for a small number of covered services do not apply to the annual out-of-pocket maximum. You will continue to be responsible for copayments or coinsurance for these services even after you reach the out-of-pocket maximum.

Prescription drug formulary – The list of preferred medications maintained by Blue Shield for its prescription drug benefits. This list includes both generic and brand-name drugs approved by the Food and Drug Administration (FDA).

Prescription drug tiers – Prescription drugs in a formulary are typically grouped into tiers based on defined categories, such as generic drugs, preferred brand-name drugs, non-preferred brand-name drugs, and specialty drugs. The tier that your medication is in determines your portion of the drug cost. A typical drug benefit includes three or four tiers. You can find information about what you pay by drug tier in your health plan documents.

Prior authorization – Some services require prior authorization before treatment, in addition to your doctor's referral. A referral and a prior authorization are two different things. For example, when your primary care physician cannot give you the treatment you need, he or she refers you to a specialist. However, if you require a hospital stay or certain surgical procedures, radiological treatments, etc., Blue Shield of California must authorize these medical services before you can receive them. Before receiving such services, call the Member Services or Shield Concierge number on the back of your Blue Shield member ID card to obtain a prior authorization.

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Have questions? Get answers.

If you have any questions about the health plans described in this brochure, call Member Services at **(855) 256-9404**, 7 a.m. to 7 p.m. PT, Monday through Friday.

Take us with you anywhere

Log in to our mobile app and keep your health plan at your fingertips. Our mobile app is available on the App Store℠ and Google Play™.

GET IT ON Google Play

Download on the App Store

Find us on social media

Follow us on Facebook at facebook.com/BlueShieldCA, Twitter @BlueShieldCA and Instagram @BlueShieldofCA for healthy tips, daily inspiration, member info and support. It's an easy way to stay connected.

Member confidentiality

Blue Shield protects the confidentiality and privacy of your personal and health information, including medical information and individually identifiable information such as your name, address, telephone number and Social Security number. To ensure this, Blue Shield requires a signed authorization form for you to access health information for your spouse or dependents over the age of 18.

To request an authorization form, call Blue Shield Member Services. Or, you can also download the form by going to blueshieldca.com. Just log in, select *Family Members* under "Who's Covered" and then choose *Manage Family*. Scroll to the bottom of the page to download the Authorization for Release of PHI form.

If you don't have access to the Internet, or you have questions about how Blue Shield protects your privacy and confidentiality, please call our Privacy Office directly at (888) 266-8080.

Blue Shield of California complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability or sex.

Blue Shield of California cumple con las leyes federales de derechos civiles aplicables y no discrimina por motivos de raza, color, nacionalidad, edad, discapacidad o sexo.

Blue Shield of California 遵守適用的聯邦民權法律規定，不因種族、膚色、民族血統、年齡、殘障或性別而歧視任何人。

Blue Shield of California is an independent member of the Blue Shield Association A17234-NCPT (8/17)