Effective: July 01, 2019

Northern California Pipe Trades

H&W Trust Fund 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*.

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Northern California Pipe Trades H and W Trust Fund

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Northern California Pipe Trades H & W Trust Fund
Effective July 1, 2019
PPO Benefit Plan

Summary of Benefits

Northern California Pipe Trades H & W Trust Fund Custom PPO

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

Provider Network: Full PPO Network

This benefit 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 benefit 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: individual
	$1,500: Family	$3,000: Family

No Lifetime Benefit Maximum

Under this benefit Plan there is no dollar limit on the total amount Blue Shield will pay for Covered Services in a Member's lifetime.

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	10%		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, and therapists.				
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	
• Tubal ligation	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
• Vasectomy	10%	✔	Not covered	
• Infertility services	Not covered		Not covered	
Podiatric services	$20/visit		30%	✔
Pregnancy and maternity care				
Physician office visits: prenatal and postnatal	$0	✔	30%	✔
Physician services for pregnancy termination	10%	✔	30%	✔
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% up to $350/day plus 100% of additional charges	✔
Outpatient department of a Hospital: surgery	$35/surgery	✔	30% up to $350/day plus 100% of additional charges	✔
Outpatient department of a Hospital: treatment of illness or injury, radiation therapy, chemotherapy, and necessary supplies	10%	✔	30% up to $350/day plus 100% of additional charges	✔
Inpatient facility services				
Hospital services and stay	$150/admission	✔	30% up to $600/day plus 100% of additional charges	✔

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, such as CT scans, MRIs, MRAs, and PET scans. For the payments for Covered Services that are considered Preventive Health Services, see Preventive Health Services.*				
Laboratory services *Includes diagnostic Papanicolaou (Pap) test.*				
• Laboratory center	$20/visit	✔	30%	✔
• Outpatient department of a Hospital	$20/visit	✔	30% up to $350/day plus 100% of additional charges	✔
X-ray and imaging services *Includes 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% up to $350/day plus 100% of additional charges	✔
Other outpatient diagnostic testing *Testing to diagnose illness or injury such as vestibular function tests, EKG, ECG, 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% up to $350/day plus 100% of additional charges	✔
Radiological and nuclear imaging services				
• Outpatient radiology center	$0	✔	30%	✔
• Outpatient department of a Hospital	$0	✔	30% up to $350/day plus 100% of additional charges	✔
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% up to $350/day plus 100% of additional charges	✔
Speech Therapy services				
Office location	$20/visit	✔	$20/visit	✔
Outpatient department of a Hospital	$20/visit	✔	30% up to $350/day plus 100% of additional charges	✔
Durable medical equipment (DME)				
DME	10%	✔	30%	✔

Benefits[6]	Your payment			
	When using a Participating Provider[3]	CYD[2] applies	When using a Non-Participating Provider[4]	CYD[2] applies
Breast pump	Not covered		Not covered	
Orthotic equipment and devices	10%	✔	30%	✔
Prosthetic equipment and devices	10%	✔	30%	✔
Home health 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, except hemophilia and home infusion nursing visits.				
Home health agency services	10%	✔	Not covered	
Includes home visits by a nurse, Home Health Aide, medical social worker, physical therapist, speech therapist, or occupational therapist.				
Home visits by an infusion nurse	10%	✔	Not covered	
Home health medical supplies	10%	✔	Not covered	
Home infusion agency services	10%	✔	Not covered	
Hemophilia home infusion services	10%	✔	Not covered	
Includes blood factor products.				
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% up to $600/day plus 100% of additional charges	✔
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	

Benefits[6]	Your payment			
	When using a Participating Provider[3]	CYD[2] applies	When using a Non-Participating Provider[4]	CYD[2] applies
Other services and supplies				
Diabetes care services				
• Devices, equipment, and supplies	10%	✔	30%	✔
• Self-management training	$20/visit		30%	✔
Dialysis services	10%	✔	30% up to $300/day plus 100% of additional charges	✔
PKU product formulas and Special Food Products	10%	✔	10%	✔
Allergy serum	10%	✔	30%	✔

Mental Health Benefits	Your payment			
Mental health Benefits are provided through Blue Shield's Mental Health Services 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%	✔
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% up to $350/day plus 100% of additional charges	✔
Psychological testing	$0	✔	30%	✔
Inpatient services				
Physician inpatient services	$0	✔	30%	✔
Hospital services	$150/admission	✔	30% up to $600/day plus 100% of additional charges	✔

Mental Health Benefits	Your payment			
Mental health Benefits are provided through Blue Shield's Mental Health Services Administrator (MHSA).	**When using a MHSA Participating Provider[3]**	**CYD[2] applies**	**When using a MHSA Non-Participating Provider[4]**	**CYD[2] applies**
Residential care for mental health condition	$150/admission	✔	30% up to $600/day plus 100% of additional charges	✔

Substance Use Disorder Benefits	Your payment			
Substance use disorder benefits are provided through Blue Shield's mental health services 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%	✔
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% up to $350/day plus 100% of additional charges	✔
Psychological testing	$0	✔	30%	✔
Inpatient services				
Physician inpatient services	$0	✔	30%	✔
Hospital services	$0	✔	30% up to $600/day plus 100% of additional charges	✔
Residential care for substance use disorder condition	$0	✔	30% up to $600/day plus 100% of additional charges	✔

Prior Authorization

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

- Radiological and nuclear imaging services
- Inpatient facility services
- Home health services from Non-Participating Providers
- Mental health services, except outpatient office visits
- 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 benefit 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.

Defined terms are 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 benefit Plan.

If this benefit 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.

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.

Your payment for services from "Other Providers." You will pay the Copayment or Coinsurance applicable to Participating Providers for Covered Services received from Other Providers. However, Other Providers do not have a contract to provide health care services to Members and so are not Participating Providers. Therefore, you will also pay all charges above the Allowable Amount. This out-of-pocket expense can be significant.

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 both:

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

Notes

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

- Any Coinsurance is determined from the Allowable Amount.
- Any charges above the Allowable Amount are not covered, 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.
- Some Benefits from Non-Participating Providers have the Allowable Amount listed in the Benefits chart as a specific dollar ($) amount. You are responsible for any charges above the Allowable Amount, whether or not an amount is listed in the Benefits chart.

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

Your payment after you reach the Calendar Year OOPM. You will continue to pay all charges above a Benefit maximum.

Essential health benefits count towards the OOPM.

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 benefit 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 Copayment in addition to an allergy serum Copayment 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. 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.

Benefit Plans may be modified to ensure compliance with State and Federal requirements.
MS040419:051518;052319;061419_GF

Northern California Pipe Trades H&W Trust Fund
Custom PPO Plan

Outpatient Prescription Drug Coverage
(For groups of 300 and above)

THIS DRUG COVERAGE SUMMARY IS ADDED TO BE COMBINED WITH PPO PLANS UNIFORM HEALTH PLAN BENEFITS AND COVERAGE MATRIX. THE *EVIDENCE OF COVERAGE* AND PLAN CONTRACT SHOULD BE CONSULTED FOR A DETAILED DESCRIPTION OF COVERAGE BENEFITS AND LIMITATIONS.

Blue Shield of California

Highlight: **$0 Calendar Year Pharmacy Deductible**
$10 Formulary Generic/$20 Formulary Brand/$35 Non-Formulary Brand Drug - Retail Pharmacy
$20 Formulary Generic/$40 Formulary Brand/$70 Non-Formulary Brand Drug - Mail Service

Covered Services	Member Copayment	
DEDUCTIBLES (Prescription drug coverage benefits are not subject to the medical plan deductible.)		
Calendar Year Pharmacy Deductible	None	
PRESCRIPTION DRUG COVERAGE[1]	**Participating Pharmacy**	**Non-Participating Pharmacy**[7, 8]
Retail Prescriptions (up to a 30-day supply)		
• Contraceptive Drugs and Devices[2]	$0 per prescription	Applicable Generic, Brand or Non-Formulary Copayment[9]
• Formulary Generic Drugs	$10 per prescription	25% + $10 per prescription
• Formulary Brand Drugs[3, 4]	$20 per prescription	25% + $20 per prescription
• Non-Formulary Brand Drugs[3, 4]	$35 per prescription	25% + $35 per prescription
Mail Service Prescriptions (up to a 90-day supply)		
• Contraceptive Drugs and Devices[2]	$0 per prescription	Not Covered
• Formulary Generic Drugs	$20 per prescription	Not Covered
• Formulary Brand Drugs[3, 4]	$40 per prescription	Not Covered
• Non-Formulary Brand Drugs[3, 4]	$70 per prescription	Not Covered
Specialty Pharmacies (up to a 30-day supply)[5]		
• Specialty Drugs[6]	30% (Up to $150 copayment maximum per prescription)	Not Covered

1 Amounts paid through copayments and any applicable pharamcy deductible do not accrue to the member's medical calendar year out-of-pocket maximum. Please refer to the Evidence of Coverage and Plan Contract for exact terms and conditions of coverage. Please note that if you switch from another plan, your prescription drug deductible credit, if applicable, from the previous plan during the calendar year will not carry forward to your new plan.

2 Contraceptive Drugs and Devices covered under the outpatient prescription drug benefits will not be subject to the applicable calendar year pharmacy deductible when obtained from a participating pharmacy. If a brand contraceptive is requested when a generic equivalent is available, the member will be responsible for paying the difference between the cost to Blue Shield for the brand contraceptive and its generic drug equivalent. In addition, select contraceptives may need prior authorization to be covered without a copayment.

3 Select formulary and non-formulary drugs require prior authorization by Blue Shield for Medical Necessity, or when effective, lower cost alternatives are available.

4 If the member requests a brand drug and a generic drug equivalent is available, the member is responsible for paying the generic drug copayment plus the difference in cost to Blue Shield between the brand drug and its generic drug equivalent.

5 Specialty Drugs are Drugs requiring coordination of care, close monitoring, or extensive patient training for self-administration that generally cannot be met by a retail pharmacy and are available at a Network Specialty Pharmacy. Specialty Drugs may also require special handling or manufacturing processes (such as biotechnology), restriction to certain Physicians or pharmacies, or reporting of certain clinical events to the FDA. Specialty Drugs are generally high cost.

6 Specialty drugs are available from a Network Specialty Pharmacy. A Network Specialty Pharmacy provides specialty drugs by mail or upon member request, at an associated retail store for pickup.

7 To obtain prescription drugs, including contraceptive drugs and devices at a non-participating pharmacy, the member must first pay all charges for the prescription and submit a completed Prescription Drug Claim Form for reimbursement. The member will be reimbursed the price paid for the drug less any applicable deductible, copayment or coinsurance (Generic, Formulary Brand, or Non-Formulary Brand) and any applicable out of network charge.

8 Outpatient prescription drug copayments for covered drugs obtained from non-participating pharmacies will accrue to the participating provider maximum calendar year out-of-pocket maximum.

Note: This plan's prescription drug coverage is on average equivalent to or better than the standard benefit set by the Federal government for Medicare Part D (also called creditable coverage). Because this plan's prescription drug coverage is creditable, you do not have to enroll in a Medicare prescription drug plan while you maintain this coverage. However, you should be aware that if you have a subsequent break in this coverage of 63 days or more anytime after you were first eligible to enroll in a Medicare prescription drug plan, you could be subject to a late enrollment penalty in addition to your Part D premium.

Important Prescription Drug Information

You can find details about your drug coverage three ways:

1. Check your *Evidence of Coverage.*
2. Go to **https://www.blueshieldca.com/bsca/pharmacy/home.sp** and log onto My Health Plan from the home page.
3. Call Member Services at the number listed on your Blue Shield member ID card.

At Blue Shield of California, we're dedicated to providing you with valuable resources for managing your drug coverage. Go online to the *Pharmacy* section of **https://www.blueshieldca.com/bsca/pharmacy/home.sp** and select the *Drug Database and Formulary* to access a variety of useful drug information that can affect your out-of-pocket expenses, such as:

- Look up non-formulary drugs with formulary or generic equivalents;
- Look up drugs that require step therapy or prior authorization;
- Find specifics about your prescription copayments;
- Find local network pharmacies to fill your prescriptions.

TIPS!

Using the convenient mail service pharmacy can save you time and money. If you take a consistent dose of a covered maintenance drug for a chronic condition, such as diabetes or high blood pressure, you can receive up to a 90-day supply through the mail service pharmacy with a reduced copayment. Call the mail service pharmacy at (866) 346-7200. Members using TTY equipment can call TTY/TDD 866-346-7197.

Plan designs may be modified to ensure compliance with State and Federal requirements.
A16154-c (01/19) MS040519;061419_GF

Northern California Pipe Trades H & W Trust Fund Additional Hearing Aid and Ancillary Equipment Benefit

Attachment to Benefit Summary (Uniform Benefits and Coverage Matrix)

Additional coverage for PPO plans

How the Plan Works

In addition to the benefits set forth in the Benefit Summary (Uniform Benefits and Coverage Matrix), your group has added hearing aid benefits to your benefit plan. Coverage includes hearing aid services, subject to the conditions and limitations listed below. This rider provides a $2,000 allowance every 24 months towards the purchase of hearing aids and ancillary equipment. The calendar year deductible does not apply to the services provided in this hearing aid services benefit and hearing aid expenses in excess of the maximum allowance are not included in the calendar year out-of-pocket maximum amount.

Coverage Details

The hearing aid allowance includes:

- A hearing aid instrument, monaural or binaural, including ear mold(s) and the initial battery and cords
- Hearing aid examination (for evaluation and/or fitting, counseling, and adjustments)
- Hearing aid device checks
- Electroacoustic evaluations for hearing aids

Benefit Plan Design

Plan Options	Benefit Allowance
PPO Plans	$2,000 allowance every 24 months

The following services are not covered:

- Purchase of batteries or other ancillary equipment, except those covered under the terms of the initial hearing aid purchase
- Charges for a hearing aid which exceed specifications prescribed for correction of a hearing loss
- Replacement parts for hearing aids, repair of hearing aid after the covered warranty period and replacement of a hearing aid more than once in any period of 24 months
- Surgically implanted hearing devices

All benefits are subject to the general provisions, limitations and exclusions listed in your *Evidence of Coverage*.

Northern California Pipe Trades H & W Trust Fund Additional Blue Shield Infertility Benefits

How the Plan Works

Your health plan includes infertility benefits in addition to those listed in the Benefit Summary (Uniform Benefits and Coverage Matrix[1]). Coverage includes authorized professional, hospital, ambulatory surgery center, and ancillary services, as well as injectable drugs. Benefits are provided for a medically appropriate diagnostic work-up and ART (Assisted Reproductive Technology) procedures[2].

Coverage Details

The following ART procedures and associated services are limited, per lifetime as shown.

- Six (6) natural (without ovum/egg [oocyte or ovarian tissue] stimulation) artificial inseminations and;
- Three (3) stimulated (with ovum/egg [oocyte or ovarian tissue] stimulation) artificial inseminations and;
- One (1) gamete intrafallopian transfer (GIFT)[3]
- Cryopreservation of sperm/ oocytes/ embryos when retrieved from a covered subscriber, spouse or domestic partner. Benefits include cryopreservation services for a condition which the treating physician anticipates will cause infertility in the future (except when the infertile condition is caused by elective chemical or surgical sterilization procedures). Benefits are limited to one retrieval and one year of storage per person per lifetime

EXCLUDED: in-vitro fertilization (IVF), intracytoplasmic sperm injection (ICSI), and zygote intrafallopian transfer (ZIFT).

All benefits are subject to a lifetime benefit maximum[4] and copayment.

Health Plans	Copayment
HMO plans**	50% of the allowable amount
PPO Plans**	50% of the allowable amount

1 If you are an HMO member, services that diagnose and treat the cause of infertility are included in your basic plan benefits. For PPO, members, diagnosis and treatment for the cause of infertility are only covered when the group adds "Additional Blue Shield Infertility Benefits" to the Plan.

2 These services are covered only when authorized by Blue Shield and provided by a Participating Provider (Shield Spectrum PPO Savings Plus Plans and Active Choice Plans). Procedures must be consistent with established medical practice in treatment of infertility and induced fertilization.

3 This procedure is covered only when performed on a subscriber or covered spouse/ domestic partner.

4 The lifetime benefit maximums for the above described procedures apply to all services related to or performed in conjunction with such procedures.

** Services provided under this benefit are not subject to any applicable calendar year medical deductible and do not accrue to the calendar year out-of-pocket maximum. Services continue to be the member's responsibility after the calendar year out-of-pocket maximum is reached.

This is only a summary for informational purposes. It is not a contract. Please refer to the *plan contract* and *Evidence of Coverage* for a detailed description of covered benefits and limitations.

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 ádoolníił nínízingo bíighah. Doo bąąh íliníigó 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' hodíilnih. (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)

ប្រការសំខាន់៖ 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)

術語表

不確定其含義?

請將此術語表用作部分普通健康福利術語的簡易參考。

以下是有關 Blue Shield 健康計劃術語的定義。部分術語可能不適用於您的計劃。請參閱您的《*承保範圍說明書*》或《*福利手冊*》瞭解詳情。

《承保範圍說明書》或《福利手冊》 – Blue Shield 提供的正式保險文件, 其中說明了會員福利、共付額或共同保險、不承保的項目和限制。

處方藥層級 – 在《處方藥承保摘要》中, 處方藥按以下層級進行分類:

- 第 1 層級 – Blue Shield 標準藥品處方集中的多數學名藥和低價的品牌藥。
- 第 2 層級 – Blue Shield 標準藥品處方集中的首選品牌藥和非首選學名藥。
- 第 3 層級 – Blue Shield 標準藥品處方集中的非首選品牌藥和非首選學名藥。
- 第 4 層級 – 專科用藥或費用高於 $600 的藥物。

處方藥物處方集 – 由 Blue Shield 維護的處方藥福利首選藥物列表。該列表包括美國食品和藥物管理局 (FDA) 批准的學名藥和品牌藥。

福利 (承保服務) – 由健康計劃所承保的具醫療必要性的服務及用品。

共付額/共同保險 – 據您的計劃福利而定, 這是由您負責支付的預定金額 (共付額) 或服務費用的百分比 (共同保險) 。

事先授權 – 某些服務在治療前, 除了醫生轉介之外, 還必須取得事先授權。轉介和事先授權是兩件不同的事。例如, 如果您的主治醫生無法為您提供所需治療時, 其可將您轉介至專科醫生。但是, 如果您需要住院或某些手術程序、放射治療等, 您必須在獲得該等醫療服務前獲得 Blue Shield of California 的授權。接受該等服務前, 您可以撥打 Blue Shield 會員 ID 卡背面的電話號碼聯絡會員服務部或 Shield Concierge, 以獲取事先授權。

網絡內醫療服務提供者/合約醫療服務提供者/醫療服務提供者網絡 – 醫療服務提供者 (包括醫師、醫院、緊急護理中心等) 經與 Blue Shield 簽約為特定健康計劃的會員提供承保服務。合約醫療服務提供者同意接受 Blue Shield 的合約費率, 以此作為承保服務的付款。

允許額 – Blue Shield 為會員所接受之福利而設定的美金總額。Blue Shield 的合約醫生必須接受此一數額為全額付款。如果會員選擇網絡外的醫生, 則其可能必須支付更高的金額。

自付額 – 每日曆年, 在 Blue Shield 開始就計劃項下的福利付款前, 您必須為承保服務支付的金額。這是您必須支付的費用。在您達到日曆年自付額前, 特定服務可獲得承保, 如預防性護理。

您可能有兩種自付額: 醫療服務和藥房。您的醫療服務自付額適用於承保服務, 例如醫生診所診療。您的藥房自付額適用於合約醫療服務提供者所提供給門診患者的處方藥。

最高付現額 – 您每日曆年須就承保服務承擔的最高共付額或共同保險限額。少部分承保服務的共付額或共同保險不計入年度最高付現額。達到最高付現額後, 您將繼續負責支付該等服務的共付額或共同保險。

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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. PST, 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)