

# Trio HMO plan

Summary of Benefits



---

## Find your doctor

Go to [blueshieldca.com/triosfhss](https://blueshieldca.com/triosfhss) and select the type of provider you need. Enter your location, then click Continue.



## Summary of Benefits

San Francisco Health Service System  
Fund (CCSF)  
Effective January 1, 2025  
HMO Plan

### San Francisco Health Service System Custom Trio HMO 25

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).<sup>1</sup> Please read both documents carefully for details.

#### Medical Provider Network:

#### Trio ACO HMO Network

This Plan uses a specific network of Health Care Providers, called the Trio ACO 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)<sup>2</sup>

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

##### When using a Participating Provider<sup>3</sup>

<b>Calendar Year medical Deductible</b>	<i>Individual coverage</i>	\$0
	<i>Family coverage</i>	\$0: individual
		\$0: Family

#### Calendar Year Out-of-Pocket Maximum<sup>4</sup>

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

##### When using a Participating Provider<sup>3</sup>

<i>Individual coverage</i>	\$2,000
<i>Family coverage</i>	\$2,000: individual
	\$4,000: 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.

Blue Shield of California is an independent member of the Blue Shield Association

**Benefits<sup>5</sup>**

**Your payment**

	<b>When using a Participating Provider<sup>3</sup></b>	<b>CYD<sup>2</sup> applies</b>
<b>Preventive Health Services<sup>6</sup></b>		
Preventive Health Services	\$0	
California Prenatal Screening Program	\$0	
<b>Physician services</b>		
Primary care office visit	\$25/visit	
Trio+ specialist care office visit (self-referral)	\$30/visit	
Other specialist care office visit (referred by PCP)	\$25/visit	
Physician home visit	\$25/visit	
Physician or surgeon services in an Outpatient Facility	\$0	
Physician or surgeon services in an inpatient facility	\$0	
<b>Other professional services</b>		
Other practitioner office visit <i>Includes nurse practitioners, physician assistants, therapists, and podiatrists.</i>	\$25/visit	
Teladoc consultation	\$0	
Family planning		
<ul style="list-style-type: none"> <li>• Counseling, consulting, and education</li> <li>• Injectable contraceptive, diaphragm fitting, intrauterine device (IUD), implantable contraceptive, and related procedure.</li> <li>• Tubal ligation</li> <li>• Vasectomy</li> </ul>	\$0	
Medical nutrition therapy, not related to diabetes	\$25/visit	
<b>Pregnancy and maternity care</b>		
Physician office visits: prenatal and postnatal	\$0	
Abortion and abortion-related services	\$0	
<b>Emergency Services</b>		
Emergency room services	\$100/visit	
<i>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.</i>		
Emergency room Physician services	\$0	

**Benefits<sup>5</sup>**

**Your payment**

	<b>When using a Participating Provider<sup>3</sup></b>	<b>CYD<sup>2</sup> applies</b>
<b>Urgent care center services</b>	\$25/visit	
<b>Ambulance services</b> <i>This payment is for emergency or authorized transport.</i>	\$50/transport	
<b>Outpatient Facility services</b>		
Ambulatory Surgery Center	\$100/surgery	
Outpatient Department of a Hospital: surgery	\$100/surgery	
Outpatient Department of a Hospital: treatment of illness or injury, radiation therapy, chemotherapy, and necessary supplies	\$0	
<b>Inpatient facility services</b>		
Hospital services and stay	\$200/admission	
Transplant services <i>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.</i>		
• Special transplant facility inpatient services	\$200/admission	
• Physician inpatient services	\$0	
<b>Diagnostic x-ray, imaging, pathology, and laboratory services</b> <i>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.</i>		
Laboratory and pathology services <i>Includes diagnostic Papanicolaou (Pap) test.</i>		
• Laboratory center	\$0	
• Outpatient Department of a Hospital	\$0	
Basic imaging services <i>Includes plain film X-rays, ultrasounds, and diagnostic mammography.</i>		
• Outpatient radiology center	\$0	
• Outpatient Department of a Hospital	\$0	
Other outpatient Non-invasive diagnostic testing <i>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.</i>		
• Office location	\$0	
• Outpatient Department of a Hospital	\$0	

**Benefits<sup>5</sup>**

**Your payment**

	<b>When using a Participating Provider<sup>3</sup></b>	<b>CYD<sup>2</sup> applies</b>
<p>Advanced imaging services</p> <p><i>Includes diagnostic radiological and nuclear imaging such as CT scans, MRIs, MRAs, and PET scans.</i></p> <ul style="list-style-type: none"> <li>• Outpatient radiology center \$0</li> <li>• Outpatient Department of a Hospital \$0</li> </ul>		
<p><b>Rehabilitative and Habilitative Services</b></p> <p><i>Includes physical therapy, occupational therapy, respiratory therapy, and speech therapy services.</i></p> <p>Office location \$25/visit</p> <p>Outpatient Department of a Hospital \$25/visit</p>		
<p><b>Durable medical equipment (DME)</b></p> <p>DME \$0</p> <p>Breast pump \$0</p> <p>Orthotic equipment and devices \$0</p> <p>Prosthetic equipment and devices \$0</p>		
<p><b>Home health care services</b></p> <p><i>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.</i></p>	\$25/visit	
<p><b>Home infusion and home injectable therapy services</b></p> <p>Home infusion agency services \$0</p> <p><i>Includes home infusion drugs, medical supplies, and visits by a nurse.</i></p> <p>Hemophilia home infusion services \$0</p> <p><i>Includes blood factor products.</i></p>		
<p><b>Skilled Nursing Facility (SNF) services</b></p> <p><i>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.</i></p> <p>Freestanding SNF \$0</p> <p>Hospital-based SNF \$0</p>		
<p><b>Hospice program services</b></p> <p><i>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.</i></p>	\$0	

**Benefits<sup>5</sup>**

**Your payment**

	<b>When using a Participating Provider<sup>3</sup></b>	<b>CYD<sup>2</sup> applies</b>
<b>Other services and supplies</b>		
Diabetes care services		
<ul style="list-style-type: none"> <li>• Devices, equipment, and supplies</li> <li>• Self-management training</li> <li>• Medical nutrition therapy</li> </ul>	<p>\$0</p> <p>\$25/visit</p> <p>\$25/visit</p>	
Dialysis services	\$0	
PKU product formulas and special food products	\$0	
Allergy serum billed separately from an office visit	50%	
Hearing aid services		
<ul style="list-style-type: none"> <li>• Hearing aids and equipment</li> </ul> <p><i>Up to \$2,500 per ear, per Member, per 36-month period.</i></p>	\$0	

**Mental Health and Substance Use Disorder Benefits**

**Your payment**

<i>Mental health and substance use disorder Benefits are provided through Blue Shield's Mental Health Service Administrator (MHSA).</i>	<b>When using a MHSA Participating Provider<sup>3</sup></b>	<b>CYD<sup>2</sup> applies</b>
<b>Outpatient services</b>		
Office visit, including Physician office visit	\$25/visit	
Teladoc 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	
<b>Inpatient services</b>		
Physician inpatient services	\$0	
Hospital services	\$200/admission	
Residential Care	\$200/admission	

## 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.

---

### 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).

---

### 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 Services in a Calendar Year. Once you reach your Out-of-Pocket Maximum, Blue Shield will pay 100% of the Allowed Charges 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, 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 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.

---

### 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 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. Pb062024:090324

## Outpatient Prescription Drug Benefit

### 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:**

**Plus Formulary**

### Calendar Year Pharmacy Deductible (CYPD)<sup>1</sup>

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<sup>2</sup> Pharmacy

<b>Calendar Year Pharmacy Deductible</b>	Per Member	\$0
--	------------	-----

### Prescription Drug Benefits<sup>3,4</sup>

#### Your payment

	When using a Participating Pharmacy <sup>2</sup>	CYPD <sup>1</sup> applies
<b>Retail pharmacy prescription Drugs<sup>5</sup></b> <i>Per prescription, up to a 30-day supply.</i>		
Contraceptive Drugs and Devices	\$0/prescription	
Formulary Generic Drugs	\$10/prescription	
Formulary Brand Drugs	\$25/prescription	
Non-Formulary Brand Drugs	\$50/prescription	
<b>Mail service pharmacy prescription Drugs</b> <i>Per prescription, for a 31-90-day supply.</i>		
Contraceptive Drugs and Devices	\$0/prescription	
Formulary Generic Drugs	\$20/prescription	
Formulary Brand Drugs	\$50/prescription	
Non-Formulary Brand Drugs	\$100/prescription	
<b>Network Specialty Pharmacy Drugs</b> <i>Per prescription, up to a 30-day supply.</i>		
Specialty Drugs	20% up to \$100/prescription	

Blue Shield of California is an independent member of the Blue Shield Association



### 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.

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 [www.blueshieldca.com/pharmacy](http://www.blueshieldca.com/pharmacy).

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 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 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 of the EOC 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.

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

---

## Notes

---

### **5 Extended day supply of outpatient prescription Drugs at a retail Participating Pharmacy:**

You also have an option to receive up to a 90-day supply of prescription Drugs at any retail network pharmacy, when you take maintenance Drugs for an ongoing condition. If your Physician or Health Care Provider writes a prescription for less than a 90-day supply, the pharmacy will only dispense the amount prescribed. You must pay the applicable retail pharmacy Drug Copayment or Coinsurance for each prescription Drug, for each 30-day supply dispensed. Visit [blueshieldca.com](https://blueshieldca.com) for additional information about how to get a 90-day supply of prescription Drugs from retail pharmacies.

---

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

PENDING REGULATORY APPROVAL

Pb062024;071124;090624

**Acupuncture and Chiropractic Services Rider**

**San Francisco Health Service System Custom Chiro- Acu Access+ and Trio HMO Plans**  
**Summary of Benefits**

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

Benefits	Your Payment	
<i>Covered Services must be determined as Medically Necessary by American Specialty Health Plans of California, Inc. (ASH Plans).</i>		
<i>Up to 30 visits per Member, per Calendar Year for each acupuncture and chiropractic service.</i>	<b>When using an ASH Participating Provider</b>	<b>When using a Non-Participating Provider</b>
<i>Services are not subject to the Calendar Year Deductible and do count towards the Calendar Year Out-of-Pocket Maximum.</i>		
<b>Acupuncture Services</b>		
Office visit	\$15/visit	Not covered
<b>Chiropractic Services</b>		
Office visit	\$15/visit	Not covered
Chiropractic Appliances	All charges above \$50	Not covered

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 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 Services, 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 Services 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 Services 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, nausea and pain.

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.

### **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](http://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

<b>American Specialty Health Plans of California, Inc. (ASH Plans)</b>	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.
<b>ASH Participating Provider</b>	An acupuncturist or a chiropractor under contract with ASH Plans to provide Covered Services to Members.
<b>Musculoskeletal and Related Disorders</b>	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.

**Nausea**

An unpleasant sensation in the abdominal region associated with the desire to vomit that may be appropriately treated by a Participating acupuncturist in accordance with professionally recognized standards of practice and includes adult post-operative Nausea and vomiting, nausea of pregnancy.

---

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

Pb062024

**Assisted Reproductive Technology Rider**

**San Francisco Health Service System Additional Blue Shield Infertility Benefits Summary of Benefits**

This Summary of Benefits shows the amount you will pay for Covered Services under this Assisted Reproductive Technology (ART) Benefit.

Benefits	Your Payment	
	When using a Participating Provider	When using a Non-Participating Provider
<b>Assisted reproductive technology (ART) procedures and associated services</b>	50% of the Allowed Charges	Not covered
<i>Services are not subject to any applicable Deductible and do not count towards the Calendar Year Out-of-Pocket Maximum.</i>		

**Assisted Reproductive Technology (ART) Procedures and Associated Services**

**Benefit Maximums**

<b>Natural artificial inseminations</b> <i>Without ovum [oocyte or ovarian tissue (egg)] stimulation</i>	6 procedures per lifetime
<b>Stimulated artificial inseminations</b> <i>With ovum [oocyte or ovarian tissue] stimulation</i>	3 procedures per lifetime
<b>Gamete intrafallopian transfer (GIFT), Zygote intrafallopian transfer (ZIFT), or In-vitro fertilization (IVF)</b>	2 procedures per lifetime
<b>Intracytoplasmic sperm injection (ICSI)</b>	No benefit maximum
<b>Assisted embryo hatching</b>	No benefit maximum
<b>Elective single embryo transfer, including preparation of embryo for transfer</b>	No benefit maximum
<b>Embryo biopsy for preimplantation screening (PGS) or diagnosis (PGD)</b>	No benefit maximum
<b>Cryopreservation of embryos, oocytes, ovarian tissue, sperm</b> <i>Retrieved from a Subscriber, spouse or Domestic Partner. Includes one retrieval and one year of storage per person</i>	1 egg retrieval and 1 year of storage in a lifetime

Blue Shield of California is an independent member of the Blue Shield Association

## Lifetime Benefit Maximum

---

Lifetime Benefit maximums for the above described procedures apply to all services related to or performed in conjunction with such procedures, such that once the maximums for the above procedures have been reached, no services related to or performed in conjunction with the procedures will be covered.

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

Pb062024



## Introduction

---

Only the Subscriber, spouse or Domestic Partner is entitled to Benefits under this Assisted Reproductive Technology (ART) Benefit. Covered Services for Infertility include all professional, Hospital, Ambulatory Surgery Center, ancillary services and injectable drugs when authorized by the Primary Care Physician to a Subscriber, spouse or Domestic Partner for the inducement of fertilization as described herein.

For the purposes of this Benefit, Infertility is:

- a demonstrated condition recognized by a licensed physician and surgeon as a cause for infertility; or
- the inability to conceive a pregnancy or to carry a pregnancy to a live birth.

## Benefits

---

Benefits are provided for a Subscriber, spouse or Domestic Partner who meets the definition of Infertility for a medically appropriate diagnostic work-up and ART procedures.

The Subscriber, spouse or Domestic Partner is responsible for the Copayment or Coinsurance listed for all professional and Hospital services, Ambulatory Surgery Center and ancillary services used in connection with any procedure covered under this Benefit, and injectable drugs administered by the provider to induce fertilization. If your Employer selected the Outpatient Prescription Drug Rider as an optional Benefit, self-administered Drugs prescribed to induce fertilization are covered at the applicable Drug tier Copayment or Coinsurance. Procedures must be consistent with established medical practice for the treatment of Infertility and authorized by the Primary Care Physician.

The Calendar Year Medical Deductible does not apply to these Covered Services, and Cost Share for these Covered Services does not apply towards the Out-of-Pocket Maximum responsibility.

## Exclusions

---

No Benefits are provided for:

- Services received from Non-Participating Providers;
- Outpatient Prescription Drugs prescribed for self-administration, if your Employer did not select the Outpatient Prescription Drug Rider;
- Services for or incident to sexual dysfunction and sexual inadequacies, except as provided for treatment of organically based conditions, for which Covered Services are provided only under the medical Benefits portion of the Evidence of Coverage (EOC);
- Services incident to or resulting from procedures for a surrogate mother. However, if the surrogate mother is enrolled in a Blue Shield of California health Plan, Covered Services for pregnancy and maternity care for the surrogate mother will be covered under that health Plan;
- Services for collection, purchase or storage of embryos, oocytes, ovarian tissue, or sperm from donors other than the Subscriber, spouse or Domestic Partner entitled to Benefits under this Assisted Reproductive Technology (ART) Benefit;
- Cryopreservation of embryos, oocytes, ovarian tissue, or sperm from donors other than the Subscriber, spouse or Domestic Partner entitled to Benefits under this Assisted Reproductive Technology (ART) Benefit;
- Home ovulation prediction testing kits or home pregnancy tests;

- Microsurgical epididymal sperm aspiration (MESA), percutaneous epididymal sperm aspiration (PESA), and testicular sperm aspiration (TESA) if the Subscriber, spouse or Domestic Partner had a previous vasectomy;
- Reversal of surgical sterilization and associated services;
- Any services not specifically listed as a Covered Service, above; or
- Covered Services in excess of the lifetime Benefit maximums.

Benefits are limited to a Subscriber, spouse or Domestic Partner who meets the definition of Infertility as defined at the time services are provided.

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.

# 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](mailto: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](http://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。如需免費幫助，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 lib्रेng 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 naaltsoosish yíiniłta'go bíniǵhah? Doo bíniǵhahgóó éí, naaltsoos nich'í' yiidóoltaǵíí ła' nihee hółó. Díí naaltsoos aldó' t'áá Diné k'ehjí ádoolníł nínízingó bíǵhah. Doo ɓaąh ílinígó shíká' adoowoł nínízingó nihich'í' béesh bee hodiłnih dóó námboo éí díí Blue Shield bee néiho'díłzinígí bine'dée' bikáá' éí doodagó éí (866) 346-7198 jí' hodiłnih. (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)

**ԿԱՐՆՎՈՐ Է.** Կարողանում ե՞ք կարդալ այս նամակը: Եթե ոչ, ապա մենք կօգնենք ձեզ: Դուք պետք է նաև կարողանաք ստանալ այս նամակը ձեր լեզվով: Օտոայությունն 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 (866) 346-7198 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। ਮੁਫਤ ਵਿਚ ਮਦਦ ਪ੍ਰਾਪਤ ਕਰਨ ਲਈ ਤੁਹਾਡੇ Blue Shield ID ਕਾਰਡ ਦੇ ਪਿੱਛੇ ਦਿੱਤੇ ਮੈਂਬਰ/ਕਸਟਮਰ ਸਰਵਿਸ ਟੈਲੀਫੋਨ ਨੰਬਰ ਤੇ, ਜਾਂ (866) 346-7198 ਤੇ ਕਾਲ 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 (866) 346-7198. (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 โปรดขอความช่วยเหลือจากผู้อ่านได้ 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। निःशुल्क मदद प्राप्त करने के लिए अपने Blue Shield ID कार्ड के पीछे दिए गये मंबर/कस्टमर सर्विस टेलीफोन नंबर, या (866) 346-7198 पर कॉल करें। (Hindi)

**ສິ່ງສຳຄັນ:** ທ່ານສາມາດອ່ານຈົດໝາຍນີ້ໄດ້ບໍ່? ຖ້າອ່ານບໍ່ໄດ້, ພວກເຮົາສາມາດໃຫ້ບາງຄົນຊ່ວຍອ່ານໃຫ້ທ່ານພັງໄດ້. ທ່ານຍັງສາມາດຂໍໃຫ້ແບ່ງຈົດໝາຍນີ້ເປັນພາສາຂອງທ່ານໄດ້. ສຳລັບຄວາມຊ່ວຍເຫຼືອແບບບໍ່ເສຍຄ່າ, ກະລຸນາ ໂທຫາເບີໂທຂອງຝ່າຍບໍລິການສະມາຊິກ/ລູກຄ້າໃນທັນທີເບີໂທລະສັບຢູ່ດ້ານຫຼັງບັດສະມາຊິກ Blue Shield ຂອງທ່ານ, ຫຼືໂທໂທເບີ(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 A	Plan B
Plan names →		
<b>Which doctors can you see?</b>		
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?		
<b>Does the plan cover the following?</b>		
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 A	Plan B
Plan names →		
Type of plan (HMO, PPO, POS, etc.)		
Premiums (the amount that comes out of your paycheck biweekly/monthly, etc.)		
<b>Medical benefits</b>		
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:		
<b>Pharmacy benefits</b>		
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:		



## Have questions? Get answers.

If you have any questions about the health plans described in this brochure, call Shield Concierge at **(855) 747-5800**, 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<sup>SM</sup> and Google Play<sup>TM</sup>.



### Find us on social media

Follow us on Facebook at [facebook.com/BlueShieldCA](https://facebook.com/BlueShieldCA), Twitter [@BlueShieldCA](https://twitter.com/BlueShieldCA) and Instagram [@BlueShieldofCA](https://instagram.com/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](https://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.

Apple and the Apple logo are trademarks of Apple Inc. App Store is a service mark of Apple Inc.

Google Play is a trademark of Google Inc.

Blue Shield and the Shield symbol are registered trademarks of the BlueCross BlueShield Association, an association of independent Blue Cross and Blue Shield plans .

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。