

## Summary of Benefits

### PPO Needles Plan

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:

#### 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)<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. 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 Provider <sup>3</sup>	When using a Non-Participating Provider <sup>4</sup>
Calendar Year medical Deductible	<i>Individual coverage</i>	\$0	\$250
	<i>Family coverage</i>	\$0: individual	\$250: individual
		\$0: Family	\$750: Family

#### Calendar Year Out-of-Pocket Maximum<sup>5</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 Notes section at the end of this Summary of Benefits.

#### 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.

	When using a Participating Provider <sup>3</sup>	When using any combination of Participating <sup>3</sup> or Non-Participating <sup>4</sup> Providers
<i>Individual coverage</i>	\$1,500	\$2,250
<i>Family coverage</i>	\$1,500: individual	\$2,250: individual
	\$3,000: Family	\$4,750: Family

Benefits<sup>6</sup>

## Your payment

	When using a Participating Provider <sup>3</sup>	CYD <sup>2</sup> applies	When using a Non-Participating Provider <sup>4</sup>	CYD <sup>2</sup> applies
<b>Preventive Health Services<sup>7</sup></b>				
Preventive Health Services	\$0		30%	✓
California Prenatal Screening Program	\$0		\$0	
<b>Physician services</b>				
Primary care office visit	\$10/visit		30%	✓
Specialist care office visit	\$10/visit		30%	✓
Physician home visit	\$10/visit		30%	✓
Physician or surgeon services in an outpatient facility	\$0		30%	✓
Physician or surgeon services in an inpatient facility	\$0		30%	✓
<b>Other professional services</b>				
Other practitioner office visit <i>Includes nurse practitioners, physician assistants, and therapists.</i>	\$10/visit		30%	✓
Acupuncture services <i>Up to 20 visits per Member, per Calendar Year.</i>	\$0		30%	✓
Chiropractic services <i>Up to 30 visits per Member, per Calendar Year.</i>	\$10/visit		30%	✓
Teladoc consultation	\$0		Not covered	
Family planning				
• Counseling, consulting, and education	\$0		30%	✓
• Injectable contraceptive; diaphragm fitting, intrauterine device (IUD), implantable contraceptive, and related procedure.	\$0		30%	✓
• Tubal ligation	\$0		30%	✓
• Vasectomy	\$75/surgery		30%	✓
Podiatric services	\$10/visit		30%	✓
<b>Pregnancy and maternity care<sup>7</sup></b>				
Physician office visits: prenatal and postnatal	\$10/visit		30%	✓
Physician services for pregnancy termination	\$150/surgery		30%	✓

	When using a Participating Provider <sup>3</sup>	CYD <sup>2</sup> applies	When using a Non-Participating Provider <sup>4</sup>	CYD <sup>2</sup> applies
<b>Emergency services</b>				
Emergency room services	\$50/visit		\$50/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		\$0	
<b>Urgent care center services</b>	\$10/visit		30%	✓
<b>Ambulance services</b>				
<i>This payment is for emergency or authorized transport.</i>				
<b>Outpatient facility services</b>				
Ambulatory Surgery Center	\$0		30%	✓
Outpatient Department of a Hospital: surgery	\$0		30%	✓
Outpatient Department of a Hospital: treatment of illness or injury, radiation therapy, chemotherapy, and necessary supplies	\$0		30%	✓
<b>Inpatient facility services</b>				
Hospital services and stay	\$0		30%	✓
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	\$0		Not covered	
• Physician inpatient services	\$0		Not covered	
<b>Bariatric surgery services, designated California counties</b>				
<i>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.</i>				
Inpatient facility services	\$0		Not covered	
Outpatient facility services	\$0		Not covered	

Benefits<sup>6</sup>

Your payment

	When using a Participating Provider <sup>3</sup>	CYD <sup>2</sup> applies	When using a Non-Participating Provider <sup>4</sup>	CYD <sup>2</sup> applies
Physician services	\$0		Not covered	
<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, 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.</i>				
Laboratory services				
<i>Includes diagnostic Papanicolaou (Pap) test.</i>				
• Laboratory center	\$0		30%	✓
• Outpatient Department of a Hospital	\$0		30%	✓
X-ray and imaging services				
<i>Includes diagnostic mammography.</i>				
• Outpatient radiology center	\$0		30%	✓
• Outpatient Department of a Hospital	\$0		30%	✓
Other outpatient diagnostic testing				
<i>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.</i>				
• Office location	\$0		30%	✓
• Outpatient Department of a Hospital	\$0		30%	✓
Radiological and nuclear imaging services				
• Outpatient radiology center	\$0		30%	✓
• Outpatient Department of a Hospital	\$0		30%	✓
<b>Rehabilitative and Habilitative Services</b>				
<i>Includes Physical Therapy, Occupational Therapy, Respiratory Therapy, and Speech Therapy services.</i>				
Office location	\$10/visit		30%	✓
Outpatient Department of a Hospital	\$10/visit		30%	✓
<b>Durable medical equipment (DME)</b>				
DME	\$0		30%	✓
Breast pump	\$0		Not covered	
Orthotic equipment and devices	\$0		30%	✓
Prosthetic equipment and devices	\$0		30%	✓

	When using a Participating Provider <sup>3</sup>	CYD <sup>2</sup> applies	When using a Non-Participating Provider <sup>4</sup>	CYD <sup>2</sup> applies
<b>Home health care services</b> <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>	\$0		Not covered	
<b>Home infusion and home injectable therapy services</b> Home infusion agency services <i>Includes home infusion drugs and medical supplies.</i>	\$0		Not covered	
Home visits by an infusion nurse	\$0		Not covered	
Hemophilia home infusion services <i>Includes blood factor products.</i>	\$0		Not covered	
<b>Skilled Nursing Facility (SNF) services</b> <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>				
Freestanding SNF	\$0		\$0	
Hospital-based SNF	\$0		30%	✓
<b>Hospice program services</b> <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>	\$0		Not covered	
<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> </ul> Dialysis services PKU product formulas and Special Food Products Allergy serum billed separately from an office visit	\$0 \$10/visit \$0 \$0 \$0		30% 30% 30% \$0 30%	✓ ✓ ✓ ✓ ✓

## 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>	When using a MHSA Participating Provider <sup>3</sup>	CYD <sup>2</sup> applies	When using a MHSA Non-Participating Provider <sup>4</sup>	CYD <sup>2</sup> applies
<b>Outpatient services</b>				
Office visit, including Physician office visit	\$10/visit		30%	✓
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		30%	✓
Partial Hospitalization Program	\$0		30%	✓
Psychological Testing	\$0		30%	✓
<b>Inpatient services</b>				
Physician inpatient services	\$0		30%	✓
Hospital services	\$0		30%	✓
Residential Care	\$0		30%	✓

## Prior Authorization

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

- Radiological and nuclear imaging services
- Outpatient mental health services, except office visits
- 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 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 separate Participating Provider Deductible and Non-Participating Provider 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.

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### 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.

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

- Coinsurance is calculated from the Allowable Amount or Benefit maximum, whichever is less.

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### 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, or
- any charges above the stated dollar amount, which is the Benefit maximum.

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

- Coinsurance is calculated from the Allowable Amount or Benefit maximum, whichever is less.
- Charges above the Allowable Amount or Benefit maximum 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.

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### 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 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.

## Notes

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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.

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### **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.

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### **7 Preventive Health Services:**

If you only receive Preventive Health Services during a Physician office visit, there is no Copayment or Coinsurance 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.

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





Teamsters Local 1932 Health and  
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Effective July 18, 2020  
PPO

## Outpatient Prescription Drug Rider

### PPO Needles Enhanced Rx \$10/15/15 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> or Non-Participating<sup>3</sup> Pharmacy**

**Calendar Year Pharmacy Deductible** *Per Member* \$0

#### Prescription Drug Benefits<sup>4,5</sup>

#### Your payment

	When using a Participating Pharmacy <sup>2</sup>	CYPD <sup>1</sup> applies	When using a Non-Participating Pharmacy <sup>3</sup>	CYPD <sup>1</sup> applies
<b>Retail pharmacy prescription Drugs</b>				
<i>Per prescription, up to a 30-day supply.</i>				
Contraceptive Drugs and devices	\$0		Applicable Tier 1, Tier 2, or Tier 3 Copayment	
Tier 1 Drugs	\$10/prescription		25% plus \$10/prescription	
Tier 2 Drugs	\$15/prescription		25% plus \$15/prescription	
Tier 3 Drugs	\$15/prescription		25% plus \$15/prescription	
Tier 4 Drugs (excluding Specialty Drugs)	\$10/prescription		25% plus \$10/prescription	
<b>Mail service pharmacy prescription Drugs</b>				
<i>Per prescription, up to a 90-day supply.</i>				
Contraceptive Drugs and devices	\$0		Not covered	

## Prescription Drug Benefits<sup>4,5</sup>

## Your payment

	When using a Participating Pharmacy <sup>2</sup>	CYPD <sup>1</sup> applies	When using a Non-Participating Pharmacy <sup>3</sup>	CYPD <sup>1</sup> applies
Tier 1 Drugs	\$10/prescription		Not covered	
Tier 2 Drugs	\$15/prescription		Not covered	
Tier 3 Drugs	\$15/prescription		Not covered	
Tier 4 Drugs (excluding Specialty Drugs)	\$10/prescription		Not covered	
<b>Network Specialty Pharmacy Drugs</b>				
<i>Per prescription, up to a 30-day supply.</i>				
Tier 4 Specialty Drugs	\$10/prescription		Not covered	
<b>Oral anticancer Drugs</b>				
<i>Per prescription, up to a 30-day supply.</i>				

## Notes

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

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

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

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/wellness/drugs/formulary#heading2](http://www.blueshieldca.com/wellness/drugs/formulary#heading2).

### 3 Using Non-Participating Pharmacies:

Non-Participating Pharmacies do not have a contract to provide outpatient prescription Drugs to Members. When you obtain prescription Drugs from a Non-Participating Pharmacy, you must pay all charges for the prescription, then submit a completed claim form for reimbursement. You will be reimbursed based on the price you paid for the Drug.

### 4 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.

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### 5 Outpatient Prescription Drug Coverage:

Brand Drug coverage when a Generic Drug is available. If you select a Brand Drug when a Generic Drug equivalent is available, you are responsible for the difference between the cost to Blue Shield for the Brand Drug and its Generic Drug equivalent plus the Tier 1 Copayment or Coinsurance. This difference in cost will not count towards any Calendar Year Pharmacy Deductible, medical Deductible, or the Calendar Year Out-of-Pocket Maximum. If your Physician or Health Care Provider prescribes a Brand Drug and indicates that a Generic Drug equivalent should not be substituted, you pay your applicable tier Copayment or Coinsurance. If your Physician or Health Care Provider does not indicate that a Generic Drug equivalent should not be substituted, you may request a Medical Necessity Review. If approved, the Brand Drug will be covered at the applicable Drug tier 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.

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