

Mental Health or Substance Use Disorder Benefits

Your payment

	When using a Participating Provider ³	CYD ² applies	When using a Non-Participating Provider ⁴	CYD ² applies
Outpatient services				
Office visit, including Physician office visit	20%	✓	40%	✓
Teladoc Health mental health	\$0		Not covered	
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	20%	✓	40%	✓
Partial Hospitalization Program	20%	✓	40% Subject to a Benefit maximum of \$350/day	✓
Psychological Testing	20%	✓	40%	✓
Inpatient services				
Physician inpatient services	\$0	✓	40%	✓
Hospital services	20%	✓	40% Subject to a Benefit maximum of \$600/day	✓
Residential Care	20%	✓	40% Subject to a Benefit maximum of \$600/day	✓

Prescription Drug Benefits^{8,9}

Your payment

	When using a Participating Pharmacy ³	CYD ² applies	When using a Non-Participating Pharmacy ⁴	CYD ² applies
Retail pharmacy prescription Drugs				
<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	\$25/prescription	✓	25% plus \$25/prescription	✓
Tier 3 Drugs	\$40/prescription	✓	25% plus \$40/prescription	✓

Prescription Drug Benefits^{8,9}

Your payment

	When using a Participating Pharmacy ³	CYD ² applies	When using a Non-Participating Pharmacy ⁴	CYD ² applies
Tier 4 Drugs	30% up to \$250/prescription	✓	30% up to \$250/prescription plus 25% of purchase price	✓
Retail pharmacy prescription Drugs				
<i>Per prescription, for a 90-day supply.</i>				
Contraceptive Drugs and devices	\$0		Not covered	
Tier 1 Drugs	\$30/prescription	✓	Not covered	
Tier 2 Drugs	\$75/prescription	✓	Not covered	
Tier 3 Drugs	\$120/prescription	✓	Not covered	
Tier 4 Drugs	30% up to \$750/prescription	✓	Not covered	
Mail service pharmacy prescription Drugs				
<i>Per prescription, for a 31-90-day supply.</i>				
Contraceptive Drugs and devices	\$0		Not covered	
Tier 1 Drugs	\$20/prescription	✓	Not covered	
Tier 2 Drugs	\$50/prescription	✓	Not covered	
Tier 3 Drugs	\$80/prescription	✓	Not covered	
Tier 4 Drugs	30% up to \$500/prescription	✓	Not covered	

Prior Authorization

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

- Advanced imaging services
- Outpatient mental health services, except office visits and office-based opioid treatment
- Inpatient facility services
- Hospice program services
- Some prescription Drugs (see blueshieldca.com/pharmacy)

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):