


Summary of Benefits and Coverage: What this Plan Covers & What You Pay For Covered Services




Coverage Period: Beginning On or After 1/1/2022

Coverage for: Individual + Family | Plan Type: HMO

CalPERS Trio+ HMO

 The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. **NOTE: Information about the cost of this plan (called the premium) will be provided separately. This is only a summary.** For more information about your coverage, or to get a copy of the complete terms of coverage, visit [www.blueshieldca.com/calpers](http://www.blueshieldca.com/calpers) or call 1-800-334-5847. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms see the Glossary. You can view the Glossary at [healthcare.gov/sbc-glossary](http://healthcare.gov/sbc-glossary) or call 1-866-444-3272 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	\$0.	See the Common Medical Events chart below for your costs for services this plan covers.
Are there services covered before you meet your deductible?	Yes. <u>Preventive care</u> and other services listed in your complete terms of coverage.	This plan covers some items and services even if you haven't yet met the deductible amount. But a <u>copayment</u> or <u>coinsurance</u> may apply. For example, this plan covers certain <u>preventive services</u> without <u>cost-sharing</u> and before you meet your deductible See a list of covered <u>preventive services</u> at <a href="http://healthcare.gov/coverage/preventive-care-benefits/">healthcare.gov/coverage/preventive-care-benefits/</a> .
Are there other deductibles for specific services?	No.	You don't have to meet <u>deductibles</u> for specific services.
What is the <u>out-of-pocket limit</u> for this plan?	<i>Medical: \$1,500 per individual / \$3,000 per family. Pharmacy: \$7,200 per individual / \$14,400 per family. Includes \$1,000 for mail-service formulary prescription drugs per member.</i>	The <u>out-of-pocket limit</u> is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own <u>out-of-pocket limits</u> until the overall family <u>out-of-pocket limit</u> has been met.
What is not included in the <u>out-of-pocket limit</u> ?	<u>Copayments</u> for certain services, <u>premiums</u> , and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u> .
Will you pay less if you use a <u>network provider</u> ?	Yes. See <a href="http://www.blueshieldca.com/calpers">www.blueshieldca.com/calpers</a> or call 1-800-334-5847 for a list of <u>network providers</u> .	This plan uses a <u>provider network</u> . You will pay less if you use a <u>provider</u> in the plan's <u>network</u> . You will pay the most if you use an <u>out-of-network provider</u> , and you might receive a bill from a <u>provider</u> for the difference between the <u>provider's</u> charge and what your plan pays ( <u>balance billing</u> ). Be aware, your <u>network provider</u> might use an <u>out-of-network provider</u> for some services (such as lab work). Check with your <u>provider</u> before you get services.
Do you need a <u>referral</u> to see a <u>specialist</u> ?	Yes.	This plan will pay some or all of the costs to see a <u>specialist</u> for covered services but only if you have a <u>referral</u> before you see the <u>specialist</u> .

 All copayment and coinsurance costs shown in this chart are after your deductible has been met, if a deductible applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Plan Provider (You will pay the least)	Non-Plan Provider (You will pay the most)	
If you visit a health care <u>provider's</u> office or clinic	<u>Primary care</u> visit to treat an injury or illness	\$15/visit	Not Covered	-----None-----
If you visit a health care <u>provider's</u> office or clinic	<u>Specialist</u> visit	<i>Trio+ Specialist: \$30/visit Other Specialist: \$15/visit</i>	Not Covered	Self-referral is available for Trio+ Specialist visits.
If you visit a health care <u>provider's</u> office or clinic	<u>Preventive care/screening</u> /immunization	No Charge	Not Covered	You may have to pay for services that aren't <u>preventive</u> . Ask your <u>provider</u> if the services needed are <u>preventive</u> . Then check what your <u>plan</u> will pay for.
If you have a test	<u>Diagnostic test</u> (x-ray, blood work)	<i>Lab: No Charge X-Ray &amp; Imaging: No Charge Other Diagnostic Examination: No Charge</i>	<i>Lab: Not Covered X-Ray &amp; Imaging: Not Covered Other Diagnostic Examination: Not Covered</i>	<u>Preauthorization</u> is required. Failure to obtain <u>preauthorization</u> may result in non-payment of benefits. The services listed are at a freestanding location.
If you have a test	Imaging (CT/PET scans, MRIs)	<i>Outpatient Radiology Center: No Charge Outpatient Hospital: No Charge</i>	<i>Outpatient Radiology Center: Not Covered Outpatient Hospital: Not Covered</i>	<u>Preauthorization</u> is required. Failure to obtain <u>preauthorization</u> may result in non-payment of benefits.
If you need drugs to treat your illness or condition More information about <u>prescription drug coverage</u> is available at <a href="http://myoptions.blueshieldca.com/calpers/pharmacy">http://myoptions.blueshieldca.com/calpers/pharmacy</a> .	Tier 1	<i>Retail: \$5/prescription Extended Quantity of Maintenance Drugs at Select Retail Pharmacies: \$10/prescription Mail Order: \$10/prescription</i>	<i>Retail: Not Covered Mail Service: Not Covered</i>	<u>Preauthorization</u> is required for select drugs. Failure to obtain <u>preauthorization</u> may result in non-payment of benefits.  <i>Retail: Covers up to a 30-day supply; 50% coinsurance of Blue Shield contracted rate for drugs to treat erectile dysfunction.</i>

\*For more information about limitations and exceptions, see the [plan](#) or policy document at [www.blueshieldca.com/calpers](http://www.blueshieldca.com/calpers).

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Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Plan Provider (You will pay the least)	Non-Plan Provider (You will pay the most)	
<p><b>If you need drugs to treat your illness or condition</b> More information about <b>prescription drug coverage</b> is available at <a href="http://blueshieldca.com/formulary">blueshieldca.com/formulary</a></p>	Tier 2	<p>Retail: \$20/prescription Extended Quantity of Maintenance Drugs at Select Retail Pharmacies: \$40/prescription Mail Order: \$40/prescription</p>	<p>Retail: Not Covered Mail Service: Not Covered</p>	<p>Extended Quantity of Maintenance Drugs at Select Retail Pharmacies: Covers up to a 90-day supply. A list of select retail pharmacies can be obtained by going to the <a href="#">Pharmacy Resources page</a>.</p> <p>Mail Service: Covers up to a 90-day supply.</p>
<p><b>If you need drugs to treat your illness or condition</b> More information about <b>prescription drug coverage</b> is available at <a href="http://blueshieldca.com/formulary">blueshieldca.com/formulary</a></p>	Tier 3	<p>Retail: \$50/prescription Extended Quantity of Maintenance Drugs at Select Retail Pharmacies: \$100/prescription Mail Order: \$100/prescription</p>	<p>Retail: Not Covered Mail Service: Not Covered</p>	
<p><b>If you need drugs to treat your illness or condition</b> More information about <b>prescription drug coverage</b> is available at <a href="http://blueshieldca.com/formulary">blueshieldca.com/formulary</a></p>	Tier 4	<p>Retail: \$30/prescription Extended Quantity of Maintenance Drugs at Select Retail Pharmacies: \$60/prescription Mail Order: \$60/prescription</p>	<p>Retail: Not Covered Mail Service: Not Covered</p>	<p>Specialty Drugs are only available from a Network Specialty Pharmacy, up to a 30-day supply. <u>Preauthorization</u> is required. Failure to obtain <u>preauthorization</u> may result in non-payment of benefits.</p>

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Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Plan Provider (You will pay the least)	Non-Plan Provider (You will pay the most)	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	<i>Ambulatory Surgery Center:</i> No Charge <i>Outpatient Hospital:</i> No Charge	<i>Ambulatory Surgery Center:</i> Not Covered <i>Outpatient Hospital:</i> Not Covered	-----None-----
If you have outpatient surgery	Physician/surgeon fees	No Charge	Not Covered	-----None-----
If you need immediate medical attention	<u>Emergency room care</u>	<i>Facility Fee:</i> \$50/visit <i>Physician Fees:</i> No Charge	<i>Facility Fee:</i> \$50/visit <i>Physician Fees:</i> No Charge	Emergency services copayment does not apply if Member is admitted directly to hospital as an inpatient from emergency room or kept for observation and hospital bills for an emergency room observation visit.
If you need immediate medical attention	<u>Emergency medical transportation</u>	No Charge	No Charge	This payment is for emergency or authorized transport.
If you need immediate medical attention	<u>Urgent care</u>	\$15/visit	<i>Within <u>Plan</u> Service Area:</i> Not Covered <i>Outside <u>Plan</u> Service Area:</i> \$15/visit	-----None-----
If you have a hospital stay	Facility fee (e.g., hospital room)	No Charge	Not Covered	<u>Preauthorization</u> is required. Failure to obtain <u>preauthorization</u> may result in non-payment of benefits.
If you have a hospital stay	Physician/surgeon fees	No Charge	Not Covered	-----None-----
If you need mental health, behavioral health, or substance abuse services	Outpatient services	<i>Office Visit:</i> \$15/visit <i>Outpatient Services:</i> No Charge <i>Partial Hospitalization:</i> No Charge <i>Psychological Testing:</i> No Charge	<i>Office Visit:</i> Not Covered <i>Outpatient Services:</i> Not Covered <i>Partial Hospitalization:</i> Not Covered <i>Psychological Testing:</i> Not Covered	<u>Preauthorization</u> is required except for office visits. Failure to obtain <u>preauthorization</u> may result in non-payment of benefits.

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Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Plan Provider (You will pay the least)	Non-Plan Provider (You will pay the most)	
If you need mental health, behavioral health, or substance abuse services	Inpatient services	Physician Inpatient Services: No Charge Hospital Services: No Charge Residential Care: No Charge	Physician Inpatient Services: Not Covered Hospital Services: Not Covered Residential Care: Not Covered	<u>Preauthorization</u> is required. Failure to obtain <u>preauthorization</u> may result in reduction or non-payment of benefits.
If you are pregnant	Office visits	No Charge	Not Covered	-----None-----
If you are pregnant	Childbirth/delivery professional services	No Charge	Not Covered	-----None-----
If you are pregnant	Childbirth/delivery facility services	No Charge	Not Covered	-----None-----
If you need help recovering or have other special health needs	<u>Home health care</u>	No Charge	Not Covered	<u>Preauthorization</u> is required. Failure to obtain <u>preauthorization</u> may result in non-payment of benefits.
If you need help recovering or have other special health needs	<u>Rehabilitation services</u>	Office Visit: \$15/visit Outpatient Hospital: \$15/visit	Office Visit: Not Covered Outpatient Hospital: Not Covered	-----None-----
If you need help recovering or have other special health needs	<u>Habilitation services</u>	Office Visit: \$15/visit Outpatient Hospital: \$15/visit	Office Visit: Not Covered Outpatient Hospital: Not Covered	-----None-----
If you need help recovering or have other special health needs	<u>Skilled nursing care</u>	Freestanding Skilled Nursing Facility (SNF): No Charge Hospital-based Skilled Nursing Facility (SNF): No Charge	Freestanding Skilled Nursing Facility (SNF): Not Covered Hospital-based Skilled Nursing Facility (SNF): Not Covered	<u>Preauthorization</u> is required. Failure to obtain <u>preauthorization</u> may result in non-payment of benefits. Coverage limited to 100 days per member per benefit period.

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		Plan Provider (You will pay the least)	Non-Plan Provider (You will pay the most)	
If you need help recovering or have other special health needs	<u>Durable medical equipment</u>	No Charge	Not Covered	<u>Preauthorization</u> is required. Failure to obtain <u>preauthorization</u> may result in non-payment of benefits.
If you need help recovering or have other special health needs	<u>Hospice services</u>	No Charge	Not Covered	<u>Preauthorization</u> is required except for pre-hospice consultation. Failure to obtain <u>preauthorization</u> may result in non-payment of benefits.
If your child needs dental or eye care	Children's eye exam	No Charge	Not Covered	-----None-----
If your child needs dental or eye care	Children's glasses	Not Covered	Not Covered	
If your child needs dental or eye care	Children's dental check-up	Not Covered	Not Covered	

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## Excluded Services & Other Covered Services:

Services Your <u>Plan</u> Generally Does NOT Cover (Check your policy or <u>plan</u> document for more information and a list of any other <u>excluded services</u> .)		
<ul style="list-style-type: none"><li>• Cosmetic surgery</li><li>• Dental care (Adult)</li><li>• Long-term care</li></ul>	<ul style="list-style-type: none"><li>• Non-emergency care when traveling outside the U.S.</li><li>• Private-duty nursing</li></ul>	<ul style="list-style-type: none"><li>• Routine eye care (Adult)</li><li>• Routine foot care</li><li>• Weight loss programs</li></ul>
Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your <u>plan</u> document.)		
<ul style="list-style-type: none"><li>• Acupuncture</li><li>• Bariatric surgery</li></ul>	<ul style="list-style-type: none"><li>• Chiropractic care</li><li>• Hearing aids</li></ul>	<ul style="list-style-type: none"><li>• Infertility treatment</li></ul>

**Your Rights to Continue Coverage:** There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, at 1-877-267-2323 x61565 or [cciio.cms.gov](http://cciio.cms.gov). Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit [HealthCare.gov](http://HealthCare.gov) or call 1-800-318-2596.

**Your Grievance and Appeals Rights:** There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact: 1-800-334-5847 or the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or [dol.gov/ebsa/healthreform](http://dol.gov/ebsa/healthreform).

### Does this plan provide Minimum Essential Coverage? **Yes**

Minimum Essential Coverage generally includes plans, health insurance available through the Marketplace or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of Minimum Essential Coverage, you may not be eligible for the premium tax credit.

### Does this plan meet the Minimum Value Standards? **Yes**

If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

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## Language Access Services:

English: For assistance in English at no cost, call 1-866-346-7198.

Spanish (Español): Para obtener asistencia en Español sin cargo, llame al 1-866-346-7198.

Tagalog (Tagalog): Kung kailanganninyo ang libreng tulong sa Tagalog tumawag sa 1-866-346-7198.

Chinese (中文): 如果需要中文的免费帮助, 请拨打这个号码1-866-346-7198.

Navajo (Dine): Diné k'ehjí doo baah ílínígó shika' at'ooowól nínízingo, kwijí' hodíílnih 1-866-346-7198.

Vietnamese (Tiếng Việt): Để được hỗ trợ miễn phí tiếng Việt, vui lòng gọi đến số 1-866-346-7198.

Korean (한국어): 한국어도움이 필요하시면, 1-866-346-7198 무료전화 로전화하십시오.

Armenian (Հայերեն): Հայերեն լեզվով անվճար օգնություն ստանալու համար խնդրում ենք զանգահարել 1-866-346-7198.

Russian (Русский): если нужна бесплатная помощь на русском языке, то позвоните 1-866-346-7198.

Japanese (日本語): 日本語支援が必要な場合1-866-346-7198に電話をかけてください。無料で提供します。

Persian (فارسی): برای دریافت کمک رایگان زبان فارسی، لطفاً با شماره تلفن 1-866-346-7198 تماس بگیرید.

Punjabi (ਪੰਜਾਬੀ): ਪੰਜਾਬੀ ਵਿਚ ਸਹਾਇਤਾ ਲਈ ਵਿਰਾਮ ਵਰਕੇ 1-866-346-7198 'ਤੇ ਕਾਲ ਕਰੋ।

Khmer (ភាសាខ្មែរ): សូមជំនួយភាសាអង់គ្លេសដោយឥតគិតថ្លៃ សូមទាក់ទងមកលេខ 1-866-346-7198។

Arabic (العربية): للحصول على المساعدة في اللغة العربية مجاناً، تفضل باتصال على هذا الرقم: 1-866-346-7198.

Hmong (Hnoob): Xav tau kev pab dawb lub Hmoob, thov hu rau 1-866-346-7198.

Hindi (हिन्दी): हिन्दी में बिना खर्च के सहायता के लिए, 1-866-346-7198 पर कॉल करें।

Thai (ไทย): สำหรับความช่วยเหลือเป็นภาษาไทยโดยไม่มีค่าใช้จ่ายโปรดโทร 1-866-346-7198

Laotian (ພາສາລາວ): ສໍາລັບການຊ່ວຍເຫຼືອເປັນພາສາລາວແບບບໍ່ເສຍຄ່າ, ກະລຸນາໂທ1-866-346-7198.

————— *To see examples of how this [plan](#) might cover costs for a sample medical situation, see the next section.* —————

### **PRA Disclosure Statement**

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is **0938-1146**. The time required to complete this information collection is estimated to average **0.08** hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

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About these Coverage Examples:



**This is not a cost estimator.** Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

**Peg is Having a Baby**

(9 months of participating pre-natal care and a hospital delivery)

- The plan's overall deductible \$0
- Specialist copayment \$15
- Hospital (facility) copayment \$0
- Other copayment \$0

**This EXAMPLE event includes services like:**

Specialist office visits (*prenatal care*)  
 Childbirth/Delivery Professional Services  
 Childbirth/Delivery Facility Services  
 Diagnostic tests (*ultrasounds and blood work*)  
 Specialist visit (*anesthesia*)

<b>Total Example Cost</b>	<b>\$12,700</b>
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**In this example, Peg would pay:**

<i>Cost Sharing</i>	
Deductibles	\$0
Copayments	\$20
Coinsurance	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$60
<b>The total Peg would pay is</b>	<b>\$80</b>

**Managing Joe's Type 2 Diabetes**

(a year of routine participating care of a well-controlled condition)

- The plan's overall deductible \$0
- Specialist copayment \$15
- Hospital (facility) copayment \$0
- Other copayment \$0

**This EXAMPLE event includes services like:**

Primary care physician office visits (*including disease education*)  
 Diagnostic tests (*blood work*)  
 Prescription drugs  
 Durable medical equipment (*glucose meter*)

<b>Total Example Cost</b>	<b>\$5,600</b>
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**In this example, Joe would pay:**

<i>Cost Sharing</i>	
Deductibles	\$0
Copayments	\$550
Coinsurance	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$60
<b>The total Joe would pay is</b>	<b>\$610</b>

**Mia's Simple Fracture**

(participating emergency room visit and follow up care)

- The plan's overall deductible \$0
- Specialist copayment \$15
- Hospital (facility) copayment \$0
- Other copayment \$0

**This EXAMPLE event includes services like:**

Emergency room care (*including medical supplies*)  
 Diagnostic test (*x-ray*)  
 Durable medical equipment (*crutches*)  
 Rehabilitation services (*physical therapy*)

<b>Total Example Cost</b>	<b>\$2,800</b>
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**In this example, Mia would pay:**

<i>Cost Sharing</i>	
Deductibles	\$0
Copayments	\$80
Coinsurance	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$0
<b>The total Mia would pay is</b>	<b>\$80</b>

The plan would be responsible for the other costs of these EXAMPLE covered services.

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