Changes to your Small Business Off Exchange PPO plans

As of January 1, 2027

This notice describes the changes to your Blue Shield health coverage upon your group's renewal. This is only a summary. Updates will be made to the *Evidence of Coverage and Health Service Agreement (EOC)*. Please visit **blueshieldca.com/policies** on or after November 1, 2026 for updated terms and conditions of coverage. If you have any questions about the changes listed below, please contact your Blue Shield representative or call Group Employer Services at **(800) 325-5166.**

All Blue Shield plans are subject to limitations and exclusions. This document is only a summary for informational purposes. It is not a contract. Please refer to the *Evidence of Coverage*, the *Summary of Benefits*, and the group contract for the exact terms and conditions of coverage. Benefits are subject to modification by Blue Shield for subsequently enacted state or federal legislation.

The following changes are being made to your health plan:

Calendar Year Out-of-Pocket Maximum

Due to updated regulatory requirements, the calendar year Out-of-Pocket Maximum for participating providers will increase for the following plans:

	2026	*2027*
Silver Full PPO 1800/65 OffEx **Silver Tandem PPO 1800/65 OffEx**	*When Using a Participating Provider* *$9,500 Individual / $19,000 Family* *When Using a Non-Participating Provider* *$19,000 Individual / $38,000 Family*	*When Using a Participating Provider* *$11,000 Individual / $22,000 Family* *When Using a Non-Participating Provider* *$22,000 Individual / $44,000 Family*
Silver Full PPO 2100/75 OffEx **Silver Tandem PPO 2100/75 OffEx** **Silver Full PPO 2550/75 OffEx** **Silver Tandem PPO 2550/75 OffEx**	*When Using a Participating Provider* *$9,700 Individual / $19,400 Family* *When Using a Non-Participating Provider* *$19,400 Individual / $38,800 Family*	*When Using a Participating Provider* *$11,000 Individual / $22,000 Family* *When Using a Non-Participating Provider* *$22,000 Individual / $44,000 Family*
Bronze Full PPO 4500/65 OffEx **Bronze Tandem PPO 4500/65 OffEx** **Bronze Full PPO 6250/65 OffEx** **Bronze Tandem PPO 6250/65 OffEx** **Bronze Full PPO 6500/70 OffEx** **Bronze Tandem PPO 6500/70 OffEx** **Bronze Full PPO 6850/55 OffEx**	*When Using a Participating Provider* *$9,800 Individual / $19,600 Family*	*When Using a Participating Provider* *$11,000 Individual / $22,000 Family*

Bronze Tandem PPO 6850/55 OffEx **Bronze Full PPO 7500/65 OffEx** **Bronze Tandem PPO 7500/65 OffEx**	*When Using a Non-Participating Provider* *$19,600 Individual / $39,200 Family*	*When Using a Non-Participating Provider* *$22,000 Individual / $44,000 Family*

Specialist care office visit

Due to updated regulatory requirements, the cost share will change for the following plans:

	2026	*2027*
Platinum Full PPO 0/0 OffEx **Platinum Tandem PPO 0/0 OffEx** **Platinum Full PPO 250/15 OffEx** **Platinum Tandem PPO 250/15 OffEx**	*$45/visit*	*$55/visit*
Platinum Full PPO 250/10 OffEx **Platinum Tandem PPO 250/10 OffEx**	*$45/visit*	*$50/visit*

Physician or surgeon services in an Outpatient Facility

Due to updated regulatory requirements, the cost share will change for the following plans:

	2026	*2027*
Platinum Full PPO 250/10 OffEx **Platinum Tandem PPO 250/10 OffEx**	*When Using a Participating Provider* *10% per surgery*	*When Using a Participating Provider* *15% per surgery*
Gold Full PPO 0/35 OffEx **Gold Tandem PPO 0/35 OffEx**	*When Using a Participating Provider* *30% per surgery*	*When Using a Participating Provider* *40% per surgery*
Gold Full PPO 500/30 OffEx **Gold Tandem PPO 500/30 OffEx** **Gold Full PPO 750/35 OffEx** **Gold Tandem PPO 750/35 OffEx** **Gold Full PPO 1000/30 OffEx** **Gold Tandem PPO 1000/30 OffEx**	*When Using a Participating Provider* *20% per surgery, deductible applies*	*When Using a Participating Provider* *30% per surgery, deductible applies*

Emergency Services: Emergency Room services

Due to updated regulatory requirements, the cost share will change for the following plans:

	2026	*2027*

Platinum Full PPO 0/0 OffEx **Platinum Tandem PPO 0/0 OffEx**	*When Using a Participating/Non-Participating Provider* *$250/visit + 10%, deductible does not apply*	*When Using a Participating/Non-Participating Provider* *30% per visit, deductible does not apply*
Platinum Full PPO 0/10 OffEx **Platinum Tandem PPO 0/10 OffEx**	*When Using a Participating/Non-Participating Provider* *$150/visit + 10%, deductible does not apply*	*When Using a Participating Provider* *30% per visit, deductible does not apply*
Platinum Full PPO 250/10 OffEx **Platinum Tandem PPO 250/10 OffEx** **Platinum Full PPO 250/15 OffEx** **Platinum Tandem PPO 250/15 OffEx**	*When Using a Participating/Non-Participating Provider* *$150/visit + 10%, deductible applies*	*When Using a Participating Provider* *30% per visit, deductible applies*
Gold Full PPO 0/35 OffEx **Gold Tandem PPO 0/35 OffEx**	*When Using a Participating/Non-Participating Provider* *$250/visit + 30%, deductible does not apply*	*When Using a Participating/Non-Participating Provider* *40% per visit, deductible does not apply*
Gold Full PPO 500/30 OffEx **Gold Tandem PPO 500/30 OffEx** **Gold Full PPO 750/35 OffEx** **Gold Tandem PPO 750/35 OffEx** **Gold Full PPO 1000/30 OffEx** **Gold Tandem PPO 1000/30 OffEx**	*When Using a Participating/Non-Participating Provider* *$250 per visit + 20%, deductible applies*	*When Using a Participating/Non-Participating Provider* *30% per visit, deductible applies*

Silver Full PPO 1800/65 OffEx **Silver Tandem PPO 1800/65 OffEx**	***When Using a Participating/Non-Participating Provider*** *$300/visit + 40%, deductible applies*	***When Using a Participating/Non-Participating Provider*** *50% per visit, deductible applies*
Silver Full PPO 2100/75 OffEx **Silver Tandem PPO 2100/75 OffEx**	***When Using a Participating/Non-Participating Provider*** *$400/visit + 45%, deductible applies*	***When Using a Participating/Non-Participating Provider*** *50% per visit, deductible applies*
Silver Full PPO 2550/75 OffEx **Silver Tandem PPO 2550/75 OffEx**	***When Using a Participating/Non-Participating Provider*** *$350/visit + 45%, deductible applies*	***When Using a Participating/Non-Participating Provider*** *50% per visit, deductible applies*

Outpatient Services : Outpatient Department of a Hospital: surgery | Outpatient Facility services

Due to updated regulatory requirements, the cost share will change for the following plans:

	2026	***2027***
Platinum Full PPO 0/0 OffEx **Platinum Tandem PPO 0/0 OffEx**	*$250/surgery + 10%*	*$250/surgery + 30%*
Platinum Full PPO 0/10 OffEx **Platinum Tandem PPO 0/10 OffEx** **Platinum Full PPO 250/10 OffEx** **Platinum Tandem PPO 250/10 OffEx**	*$250/surgery + 10%*	*30% per surgery*
Gold Full PPO 0/35 OffEx **Gold Tandem PPO 0/35 OffEx**	*$200/surgery + 30%*	*40% per surgery*
Gold Full PPO 500/30 OffEx **Gold Tandem PPO 500/30 OffEx** **Gold Full PPO 750/35 OffEx** **Gold Tandem PPO 750/35 OffEx**	*$200/surgery + 20%, deductible applies*	*30% per surgery, deductible applies*

Gold Full PPO 1000/30 OffEx **Gold Tandem PPO 1000/30 OffEx**	*$250/surgery + 20%, deductible applies*	*30% per surgery, deductible applies*
Silver Full PPO 1800/65 OffEx **Silver Tandem PPO 1800/65 OffEx**	*$250/surgery + 40%, deductible applies*	*50% per surgery, deductible applies*
Silver Full PPO 2100/75 OffEx **Silver Tandem PPO 2100/75 OffEx**	*$400/surgery + 45%, deductible applies*	*50% per surgery, deductible applies*
Bronze Full PPO 6250/65 OffEx **Bronze Tandem PPO 6250/65 OffEx**	*$200/surgery + 40%, deductible applies*	*50% per surgery, deductible applies*

Diagnostic Tests: Outpatient radiology center diagnostic radiological and nuclear imaging such as CT scans, MRIs, MRAs, and PET scans.

Due to updated regulatory requirements, the cost share will change for the following plans:

	2026	***2027***
Platinum Full PPO 0/0 OffEx **Platinum Tandem PPO 0/0 OffEx**	*15%*	*10%*
Bronze Full PPO 4500/65 OffEx **Bronze Tandem PPO 4500/65 OffEx**	*40%, deductible applies*	*50%, deductible applies*

Diagnostic Tests: Advanced Imaging: Outpatient department of a Hospital

Due to updated regulatory requirements, the cost share will change for the following plans:

	2026	***2027***
Platinum Full PPO 0/0 OffEx **Platinum Tandem PPO 0/0 OffEx**	*$100/visit + 15%*	*$100/visit + 30%*
Platinum Full PPO 250/10 OffEx **Platinum Tandem PPO 250/10 OffEx**	*$100/visit + 15%*	*$150/visit + 30%*
Gold Full PPO 0/35 OffEx **Gold Tandem PPO 0/35 OffEx**	*$100/visit + 30%*	*40% per visit*
Gold Full PPO 500/30 OffEx **Gold Tandem PPO 500/30 OffEx** **Gold Full PPO 750/35 OffEx** **Gold Tandem PPO 750/35 OffEx** **Gold Full PPO 1000/30 OffEx** **Gold Tandem PPO 1000/30 OffEx**	*$100/visit + 20%, deductible applies*	*30% per visit, deductible applies*
Silver Full PPO 1800/65 OffEx **Silver Tandem PPO 1800/65 OffEx**	*$150/visit + 35%, deductible applies*	*40% per visit, deductible applies*

Silver Full PPO 2550/75 OffEx **Silver Tandem PPO 2550/75 OffEx**	*$150/visit + 40%, deductible applies*	*50% per visit, deductible applies*
Bronze Full PPO 6250/65 OffEx **Bronze Tandem PPO 6250/65 OffEx**	*$100/visit + 40%, deductible applies*	*50% per visit, deductible applies*

Other Services and Supplies: Diabetes Devices, equipment, and supplies

Due to updated regulatory requirements, the cost share will change for the following plans:

	2026	*2027*
Platinum Full PPO 0/0 OffEx **Platinum Tandem PPO 0/0 OffEx** **Platinum Full PPO 0/10 OffEx** **Platinum Tandem PPO 0/10 OffEx** **Gold Full PPO 0/35 OffEx** **Gold Tandem PPO 0/35 OffEx**	*When Using a Non-Participating Provider* *40%; deductible does not apply*	*When Using a Non-Participating Provider* *40%; deductible does apply*

Prescription Drugs-Retail (30-day supply) Retail Tier 2 Drugs

Due to updated regulatory requirements, the cost share will change for the following plans:

	2026	*2027*
Gold Full PPO 0/35 OffEx **Gold Tandem PPO 0/35 OffEx**	*Level A: $50/prescription; deductible does not apply* *Level B: $70/prescription; deductible does not apply*	*Level A: $50/prescription; deductible does apply* *Level B: $70/prescription; deductible does apply*
Silver Full PPO 2100/75 OffEx **Silver Tandem PPO 2100/75 OffEx**	*Level A: $80/prescription; deductible does not apply* *Level B: $105/prescription; deductible does not apply*	*Level A: $80/prescription; deductible does apply* *Level B: $105/prescription; deductible does apply*

Prescription Drugs-Retail (30-day supply) Retail Tier 3 Drugs

Due to updated regulatory requirements, the cost share will change for the following plans:

	2026	*2027*
Gold Full PPO 0/35 OffEx **Gold Tandem PPO 0/35 OffEx**	*Level A: $70/prescription; deductible does not apply* *Level B: $100/prescription; deductible does not apply*	*Level A: $70/prescription; deductible does apply* *Level B: $100/prescription; deductible does apply*

Prescription Drugs-Retail (30-day supply) Retail Tier 4 Drugs

Due to updated regulatory requirements, the cost share will change for the following plans:

	2026	*2027*

Platinum Full PPO 250/10 OffEx **Platinum Tandem PPO 250/10 OffEx**	*20% up to $250/prescription*	*30% up to $250/prescription*
Silver Full PPO 1800/65 OffEx **Silver Tandem PPO 1800/65 OffEx**	*30% up to $250/prescription, deductible does apply*	*40% up to $250/prescription, deductible does apply*

Prescription Drugs-Retail (90-day supply) Retail Tier 2 Drugs

Due to updated regulatory requirements, the cost share will change for the following plans:

	2026	***2027***
Gold Full PPO 0/35 OffEx **Gold Tandem PPO 0/35 OffEx**	*Level A: $150/prescription; deductible does not apply* *Level B: $210/prescription; deductible does not apply*	*Level A: $150/prescription; deductible does apply* *Level B: $210/prescription; deductible does apply*
Silver Full PPO 2100/75 OffEx **Silver Tandem PPO 2100/75 OffEx**	*Level A: $240/prescription; deductible does not apply* *Level B: $315/prescription; deductible does not apply*	*Level A: $240/prescription; deductible does apply* *Level B: $315/prescription; deductible does apply*

Prescription Drugs-Retail (90-day supply) Retail Tier 3 Drugs

Due to updated regulatory requirements, the cost share will change for the following plans:

	2026	***2027***
Gold Full PPO 0/35 OffEx **Gold Tandem PPO 0/35 OffEx**	*Level A: $140/prescription; deductible does not apply* *Level B: $300/prescription; deductible does not apply*	*Level A: $140/prescription; deductible does apply* *Level B: $300/prescription; deductible does apply*

Prescription Drugs-Retail (90-day supply) Retail Tier 4 Drugs

Due to updated regulatory requirements, the cost share will change for the following plans:

	2026	***2027***
Platinum Full PPO 250/10 OffEx **Platinum Tandem PPO 250/10 OffEx**	*20% up to $750/prescription*	*30% up to $750/prescription*

Silver Full PPO 1800/65 OffEx **Silver Tandem PPO 1800/65 OffEx**	*30% up to $750/prescription, deductible applies*	*40% up to $750/prescription, deductible applies*

Prescription Drugs-Mail Order (31-90-day supply) Home Delivery Tier 2 Drugs

Due to updated regulatory requirements, the cost share will change for the following plans:

	2026	***2027***
Gold Full PPO 0/35 OffEx **Gold Tandem PPO 0/35 OffEx**	*$100/prescription; deductible does not apply*	*$100/prescription; deductible does apply*

Prescription Drugs-Mail Order (31-90-day supply) Home Delivery Tier 3 Drugs

Due to updated regulatory requirements, the cost share will change for the following plans:

	2026	***2027***
Gold Full PPO 0/35 OffEx **Gold Tandem PPO 0/35 OffEx**	*$140/prescription; deductible does not apply*	*$140/prescription; deductible does apply*

Prescription Drugs-Mail Order (31-90-day supply) Home Delivery Tier 4 Drugs

Due to updated regulatory requirements, the cost share will change for the following plans:

	2026	***2027***
Platinum Full PPO 250/10 OffEx **Platinum Tandem PPO 250/10 OffEx**	*20% up to $500/prescription*	*30% up to $500/prescription*
Silver Full PPO 1800/65 OffEx **Silver Tandem PPO 1800/65 OffEx**	*30% up to $500/prescription, deductible applies*	*40% up to $500/prescription, deductible applies*
Silver Full PPO 2100/75 OffEx **Silver Tandem PPO 2100/75 OffEx**	*$160/prescription; deductible does not apply*	*$160/prescription; deductible does apply*

The following changes have been made to your benefits:

Care outside of California/ Out of area Service

The *Care outside of California and Out of area Service* sections in the EOC has been revised to clarify the language to align with BCBSA Brand Book updates.

Revised language and replaced BlueCard® Program with Inter-Plan Program, BlueCard® Service Area with Domestic Service Area, and Inter-Plan Arrangement with Inter-Plan Program.

Definitions: Domestic Service Area

The *Domestic Service Area* has been revised in the Definitions section of your EOC to rename BlueCard® Service Area to Domestic Service Area to clarify the Inter-Plan Program language to align with BCBSA Brand Book updates.

Definitions: Intensive Outpatient Program

The *Intensive Outpatient Program* has been revised in the Definitions section of your EOC to clarify the number of hours per week for an outpatient treatment program for mental health or substance use disorders that provide structure, monitoring, and medical/psychological intervention as follows:

An outpatient treatment program for mental health or substance use disorders that provides structure, monitoring, and medical/psychological intervention for nine to nineteen hours a week.

Definitions: Inter-Plan Programs
The *Inter-Plan Programs* has been revised in the Definitions section of the EOC to rename the Inter-Plan Arrangements to Inter-Plan Programs clarify the language to align with BCBSA Brand Book updates.

Definitions: Neuropsychological and Psychological Testing
The *Neuropsychological and Psychological* Testing has been revised in the Definitions section of the EOC from Psychological Testing to Neuropsychological and Psychological to include testing to assess the health of certain brain functions as follows:

Testing to diagnose a mental health condition and/or to assess the health of certain brain functions when referred by a provider providing Mental Health and Substance Use Disorder Benefits.

Definitions: Other Outpatient Mental Health and Substance Use Disorder Services
The definition of *Other Outpatient Mental Health and Substance Use Disorder Services* has been revised in the EOC to add Neurophysiological testing to the list of Outpatient Facility and professional services for the diagnosis and treatment of Mental Health and Substance Use Disorders as follows:
Neuropsychological and Psychological Testing.

Mental Health and Substance Use Disorder Benefits
The *Mental Health and Substance Use Disorder* section in the EOC and SOB has been revised to clarify Blue Shield Mental Health and Substance Use Disorder services administration and management of the behavioral health benefits for members.

Other Outpatient Mental Health and Substance Use Disorder Services
The Other Outpatient Mental Health and Substance Use Disorder Services sub-category section has been revised to clarify treatment not supported by current Generally Accepted Standards of Mental Health and Substance Use Disorder Care.

Outpatient Prescription Drug Coverage
The note *Outpatient Prescription Drug Coverage* in the Notes section of the SOB has added language for Insulin cost sharing limit.

Insulin. You will not pay more than $35 for a 30-day supply of Formulary insulin Prescription Drugs from a Participating Pharmacy.

Prescription Drug Benefits:
Obtaining outpatient prescription Drugs from the Home delivery Participating Pharmacy
The *Prescription Drug Benefit* section in the EOC and SOB has been revised to clarify the new pharmacy home delivery vendor.

Revised language and "Mail order pharmacy" or "Mail service pharmacy" have been renamed to "Home delivery pharmacy".

Sub-category Obtaining outpatient prescription Drugs from the mail service Participating Pharmacy renamed to Obtaining outpatient prescription Drugs from the home delivery Participating Pharmacy.

EOC and Optional Rider change: Infertility
Defined terms have been changed to align with the mandate.

NOTICES AVAILABLE ONLINE

Nondiscrimination and Language Assistance Services

Blue Shield complies with applicable state and federal civil rights laws. We also offer language assistance services at no additional cost.

View our nondiscrimination notice and language assistance notice: **blueshieldca.com/notices**. You can also call for language assistance services: **(866) 346-7198 (TTY: 711)**.

If you are unable to access the website above and would like to receive a copy of the nondiscrimination notice and language assistance notice, please call Customer Service at **(888) 256-3650 (TTY: 711)**.

Servicios de asistencia en idiomas y avisos de no discriminación

Blue Shield cumple con las leyes de derechos civiles federales y estatales aplicables. También, ofrecemos servicios de asistencia en idiomas sin costo adicional.

Vea nuestro aviso de no discriminación y nuestro aviso de asistencia en idiomas en **blueshieldca.com/notices**. Para obtener servicios de asistencia en idiomas, también puede llamar al **(866) 346-7198 (TTY: 711)**.

Si no puede acceder al sitio web que aparece arriba y desea recibir una copia del aviso de no discriminación y del aviso de asistencia en idiomas, llame a Servicio al Cliente al **(888) 256-3650 (TTY: 711)**.

非歧視通知和語言協助服務

Blue Shield 遵守適用的州及聯邦政府的民權法。同時，我們免費提供語言協助服務。

如需檢視我司的非歧視通知和語言幫助通知，請造訪 **blueshieldca.com/notices**。您還可致電尋求語言協助服務：**(866) 346-7198 (TTY: 711)**。

如果您無法造訪上述網站，且希望收到一份非歧視通知和語言幫助通知的副本，請致電客戶服務部，電話：**(888) 256-3650 (TTY: 711)**。