blue of california

Group Plan
PPO Plan

Summary of Benefits

Silver Full PPO 1800/55 OffEx

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).[1] 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.

Pharmacy Network: **Rx Ultra**

Drug Formulary: **Standard Formulary**

Calendar Year Deductibles (CYD)[2]

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[3]	When using any combination of Participating[3] and Non-Participating[4] Providers
Calendar Year medical Deductible	*Individual coverage*	$1,800	$3,400
	Family coverage	$1,800: individual $3,600: Family	$3,400: individual $6,800: Family
Calendar Year pharmacy Deductible	*Individual coverage*	$300	not covered
	Family coverage	$300: individual $600: Family	not covered

Calendar Year Out-of-Pocket Maximum[5]

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.

	When using a Participating Provider[3]	When using any combination of Participating[3] or Non-Participating[4] Providers
Individual coverage	$7,800	$13,850
Family coverage	$7,800: individual $15,600: Family	$13,850: individual $27,700: 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.

Benefits[6]	Your payment			
	When using a Participating Provider[3]	CYD[2] applies	When using a Non-Participating Provider[4]	CYD[2] applies
Preventive Health Services[7]				
Preventive Health Services	$0		Not covered	
California Prenatal Screening Program	$0		$0	
Physician services				
Primary care office visit	$55/visit		50%	✔
Specialist care office visit	$80/visit		50%	✔
Physician home visit	$55/visit		50%	✔
Physician or surgeon services in an outpatient facility	35%	✔	50%	✔
Physician or surgeon services in an inpatient facility	35%	✔	50%	✔
Other professional services				
Other practitioner office visit	$55/visit		50%	✔
Includes nurse practitioners, physician assistants, and therapists.				
Acupuncture services	$25/visit	✔	50%	✔
Chiropractic services	$15/visit		50%	✔
Up to 20 visits per Member, per Calendar Year.				
Teladoc consultation	$5/consult		Not covered	
Family planning				
• Counseling, consulting, and education	$0		Not covered	
• Injectable contraceptive; diaphragm fitting, intrauterine device (IUD), implantable contraceptive, and related procedure.	$0		Not covered	
• Tubal ligation	$0		Not covered	
• Vasectomy	35%	✔	Not covered	
Podiatric services	$80/visit		50%	✔
Pregnancy and maternity care[7]				
Physician office visits: prenatal and initial postnatal	$0		50%	✔
Physician services for pregnancy termination	35%	✔	50%	✔
Emergency services				
Emergency room services	$300/visit plus 35%	✔	$300/visit plus 35%	✔
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.				
Emergency room Physician services	35%	✔	35%	✔

Benefits[6]	Your payment			
	When using a Participating Provider[3]	**CYD[2] applies**	**When using a Non-Participating Provider[4]**	**CYD[2] applies**
Urgent care center services	$55/visit		50%	✔
Ambulance services *This payment is for emergency or authorized transport.*	35%	✔	35%	✔
Outpatient facility services				
Ambulatory Surgery Center	35%	✔	50% of up to $350/day plus 100% of additional charges	✔
Outpatient Department of a Hospital: surgery	$250/surgery plus 35%	✔	50% of up to $350/day plus 100% of additional charges	✔
Outpatient Department of a Hospital: treatment of illness or injury, radiation therapy, chemotherapy, and necessary supplies	35%	✔	50% of up to $350/day plus 100% of additional charges	✔
Inpatient facility services				
Hospital services and stay	35%	✔	50% of up to $2,000/day plus 100% of additional charges	✔
Transplant services *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.*				
• Special transplant facility inpatient services	35%	✔	Not covered	
• Physician inpatient services	35%	✔	Not covered	

Benefits[6]	Your payment			
	When using a Participating Provider[3]	CYD[2] applies	When using a Non-Participating Provider[4]	CYD[2] applies
Bariatric surgery services, designated California counties				
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.				
Inpatient facility services	35%	✔	Not covered	
Outpatient facility services	$250/surgery plus 35%	✔	Not covered	
Physician services	35%	✔	Not covered	
Diagnostic x-ray, imaging, pathology, and laboratory services				
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.				
Laboratory services				
Includes diagnostic Papanicolaou (Pap) test.				
• Laboratory center	$55/visit		50%	✔
• Outpatient Department of a Hospital	35%	✔	50% of up to $350/day plus 100% of additional charges	✔
X-ray and imaging services				
Includes diagnostic mammography.				
• Outpatient radiology center	$80/visit		50%	✔
• Outpatient Department of a Hospital	$130/visit		50% of up to $350/day plus 100% of additional charges	✔

Benefits[6]	Your payment			
	When using a Participating Provider[3]	CYD[2] applies	When using a Non-Participating Provider[4]	CYD[2] applies
Other outpatient diagnostic testing *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.*				
• Office location	$80/visit		50%	✔
• Outpatient Department of a Hospital	$130/visit		50% of up to $350/day plus 100% of additional charges	✔
Radiological and nuclear imaging services				
• Outpatient radiology center	35%	✔	50%	✔
• Outpatient Department of a Hospital	$150/visit plus 35%	✔	50% of up to $350/day plus 100% of additional charges	✔
Rehabilitative and Habilitative Services *Includes Physical Therapy, Occupational Therapy, Respiratory Therapy, and Speech Therapy services. There is no visit limit for Rehabilitative or Habilitative Services.*				
Office location	35%	✔	50%	✔
Outpatient Department of a Hospital	35%	✔	50% of up to $350/day plus 100% of additional charges	✔
Durable medical equipment (DME)				
DME	50%	✔	Not covered	
Breast pump	$0		Not covered	
Orthotic equipment and devices	35%	✔	Not covered	
Prosthetic equipment and devices	35%	✔	Not covered	

Benefits[6]	Your payment			
	When using a Participating Provider[3]	CYD[2] applies	When using a Non-Participating Provider[4]	CYD[2] applies
Home health care services *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.*	35%	✔	Not covered	
Home infusion and home injectable therapy services				
Home infusion agency services *Includes home infusion drugs and medical supplies.*	35%	✔	Not covered	
Home visits by an infusion nurse	35%	✔	Not covered	
Hemophilia home infusion services *Includes blood factor products.*	35%	✔	Not covered	
Skilled Nursing Facility (SNF) services *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.*				
Freestanding SNF	35%	✔	35%	✔
Hospital-based SNF	35%	✔	50% of up to $2,000/day plus 100% of additional charges	✔
Hospice program services *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.*	$0	✔	Not covered	
Other services and supplies				
Diabetes care services				
• Devices, equipment, and supplies	50%	✔	Not covered	
• Self-management training	$0		50%	✔

Benefits[6]	Your payment			
	When using a Participating Provider[3]	CYD[2] applies	When using a Non-Participating Provider[4]	CYD[2] applies
Dialysis services	35%	✔	50% of up to $350/day plus 100% of additional charges	✔
PKU product formulas and Special Food Products	35%	✔	35%	✔
Allergy serum billed separately from an office visit	35%	✔	50%	✔

Mental Health and Substance Use Disorder Benefits	Your payment			
Mental health and substance use disorder Benefits are provided through Blue Shield's Mental Health Service Administrator (MHSA).	When using a MHSA Participating Provider[3]	CYD[2] applies	When using a MHSA Non-Participating Provider[4]	CYD[2] applies
Outpatient services				
Office visit, including Physician office visit	$55/visit		50%	✔
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	35%	✔	50%	✔
Partial Hospitalization Program	35%	✔	50% of up to $350/day plus 100% of additional charges	✔
Psychological Testing	35%	✔	50%	✔
Inpatient services				
Physician inpatient services	35%	✔	50%	✔
Hospital services	35%	✔	50% of up to $2,000/day plus 100% of additional charges	✔
Residential Care	35%	✔	50% of up to $2,000/day plus 100% of additional charges	✔

Prescription Drug Benefits[8,9]	Your payment			
A separate Calendar Year pharmacy Deductible applies.	**When using a Participating Pharmacy[3]**	**CYD[2] applies**	**When using a Non-Participating Pharmacy[4]**	**CYD[2] applies**
Retail pharmacy prescription Drugs				
Per prescription, up to a 30-day supply.				
Contraceptive Drugs and devices	$0		Not covered	
Tier 1 Drugs	$20/prescription		Not covered	
Tier 2 Drugs	$75/prescription	✔	Not covered	
Tier 3 Drugs	$115/prescription	✔	Not covered	
Tier 4 Drugs (excluding Specialty Drugs)	30% up to $250/prescription	✔	Not covered	
Mail service pharmacy prescription Drugs				
Per prescription, up to a 90-day supply.				
Contraceptive Drugs and devices	$0		Not covered	
Tier 1 Drugs	$40/prescription		Not covered	
Tier 2 Drugs	$150/prescription	✔	Not covered	
Tier 3 Drugs	$230/prescription	✔	Not covered	
Tier 4 Drugs (excluding Specialty Drugs)	30% up to $500/prescription	✔	Not covered	
Network Specialty Pharmacy Drugs				
Per prescription, up to a 30-day supply.				
Tier 4 Specialty Drugs	30% up to $250/prescription	✔	Not covered	
Oral Anticancer Drugs	30% up to $250/prescription		Not covered	
Per prescription, up to a 30-day supply.				

Pediatric Benefits	Your payment			
Pediatric Benefits are available through the end of the month in which the Member turns 19.	**When using a Participating Dentist[3]**	**CYD[2] applies**	**When using a Non-Participating Dentist[4]**	**CYD[2] applies**
Pediatric dental[10]				
Diagnostic and preventive services				
• Oral exam	$0		20%	

Pediatric Benefits	Your payment			
Pediatric Benefits are available through the end of the month in which the Member turns 19.	**When using a Participating Dentist[3]**	**CYD[2] applies**	**When using a Non-Participating Dentist[4]**	**CYD[2] applies**
• Preventive – cleaning	$0		20%	
• Preventive – x-ray	$0		20%	
• Sealants per tooth	$0		20%	
• Topical fluoride application	$0		20%	
• Space maintainers - fixed	$0		20%	
Basic services				
• Restorative procedures	20%		30%	
• Periodontal maintenance	20%		30%	
Major services				
• Oral surgery	50%		50%	
• Endodontics	50%		50%	
• Periodontics (other than maintenance)	50%		50%	
• Crowns and casts	50%		50%	
• Prosthodontics	50%		50%	
Orthodontics (Medically Necessary)	50%		50%	

Pediatric Benefits	Your payment			
Pediatric Benefits are available through the end of the month in which the Member turns 19.	**When using a Participating Provider[3]**	**CYD[2] applies**	**When using a Non-Participating Provider[4]**	**CYD[2] applies**
Pediatric vision[11]				
Comprehensive eye examination				
One exam per Calendar Year.				
• Ophthalmologic visit	$0		All charges above $30	
• Optometric visit	$0		All charges above $30	
Eyewear/materials				
One eyeglass frame and eyeglass lenses, or contact lenses instead of eyeglasses, up to the Benefit per Calendar Year. Any exceptions are noted below.				
• Contact lenses				
Non-elective (Medically Necessary) - hard or soft	$0		All charges above $225	
Up to two pairs per eye per Calendar Year.				
Elective (cosmetic/convenience)				

Pediatric Benefits	Your payment			
Pediatric Benefits are available through the end of the month in which the Member turns 19.	**When using a Participating Provider[3]**	**CYD[2] applies**	**When using a Non-Participating Provider[4]**	**CYD[2] applies**
Standard and non-standard, hard *Up to a 3 month supply for each eye per Calendar Year based on lenses selected.*	$0		All charges above $75	
Standard and non-standard, soft *Up to a 6 month supply for each eye per Calendar Year based on lenses selected.*	$0		All charges above $75	
• Eyeglass frames				
Collection frames	$0		All charges above $40	
Non-collection frames	All charges above $150		All charges above $40	
• Eyeglass lenses *Lenses include choice of glass or plastic lenses, all lens powers (single vision, bifocal, trifocal, lenticular), fashion or gradient tint, scratch coating, oversized, and glass-grey #3 prescription sunglasses.*				
Single vision	$0		All charges above $25	
Lined bifocal	$0		All charges above $35	
Lined trifocal	$0		All charges above $45	
Lenticular	$0		All charges above $45	
Optional eyeglass lenses and treatments				
• Ultraviolet protective coating (standard only)	$0		Not covered	
• Polycarbonate lenses	$0		Not covered	
• Standard progressive lenses	$55		Not covered	
• Premium progressive lenses	$95		Not covered	
• Anti-reflective lens coating (standard only)	$35		Not covered	
• Photochromic - glass lenses	$25		Not covered	
• Photochromic - plastic lenses	$25		Not covered	
• High index lenses	$30		Not covered	
• Polarized lenses	$45		Not covered	

Pediatric Benefits

Pediatric Benefits are available through the end of the month in which the Member turns 19.	**Your payment** When using a Participating Provider[3]	CYD[2] applies	When using a Non-Participating Provider[4]	CYD[2] applies
Low vision testing and equipment				
• Comprehensive low vision exam *Once every 5 Calendar Years.*	35%		Not covered	
• Low vision devices *One aid per Calendar Year.*	35%		Not covered	
Diabetes management referral	$0		Not covered	

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
- Pediatric vision non-elective contact lenses and low vision testing and equipment
- 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):

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 medical Deductible and pharmacy Deductible.

This Plan has a has a Participating Provider Calendar Year Deductible as well as a combined Participating Provider and Non-Participating Provider Calendar Year Deductible. This means that any amounts you pay towards your

Participating Provider Calendar Year Deductible also count towards your combined Participating and Non-Participating Provider Calendar Year 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.

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.

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.

5 Calendar Year Out-of-Pocket Maximum (OOPM):

Your payment after you reach the Calendar Year OOPM. You will continue to pay all charges for the following Covered Services after the Calendar Year Out-of-Pocket Maximum is met:

- dialysis center Benefits: dialysis services from a Non-Participating Provider
- Benefit maximum: charges for services after any Benefit limit is reached

Essential health benefits count towards the OOPM.

Any Deductibles count towards the OOPM. Any amounts you pay that count towards the medical or pharmacy 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.

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.

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.

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. 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.

8 Outpatient Prescription Drug Coverage:

Medicare Part D-creditable coverage-

This Plan's 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 plan's 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.

9 Outpatient Prescription Drug Coverage:

Brand Drug coverage when a Generic Drug is available. If you, the Physician, or Health Care Provider, 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.

Request for Medical Necessity Review. 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.

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.

10 Pediatric Dental Coverage:

Pediatric dental benefits are provided through Blue Shield's Dental Plan Administrator (DPA).

Orthodontic Covered Services. The Copayment or Coinsurance for Medically Necessary orthodontic Covered Services applies to a course of treatment even if it extends beyond a Calendar Year. This applies as long as the Member remains enrolled in the Plan.

11 Pediatric Vision Coverage:

Pediatric vision benefits are provided through Blue Shield's Vision Plan Administrator (VPA).

Covered Services from Non-Participating Providers. There is no Copayment or Coinsurance up to the listed Allowable Amount. You pay all charges above the Allowable Amount.

Coverage for frames. If frames are selected that are more expensive than the Allowable Amount established for frames under this Benefit, you pay the difference between the Allowable Amount and the provider's charge.

"Collection frames" are covered with no Member payment from Participating Providers. Retail chain Participating Providers do not usually display the frames as "collection," but a comparable selection of frames is maintained.

"Non-collection frames" are covered up to an Allowable Amount of $150; however, if the Participating Provider uses:

- wholesale pricing, then the Allowable Amount will be up to $99.06.

Notes

- warehouse pricing, then the Allowable Amount will be up to $103.64.

Participating Providers using wholesale pricing are identified in the provider directory.

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

PENDING REGULATORY APPROVAL