blue of california

Summary of Benefits

Group Plan
EPO Plan

Full EPO 20-500 80%

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. This is an Exclusive Provider Organization (EPO) plan. You must receive all Covered Services from a Participating Provider, but there are some exceptions. Please review your Evidence of Coverage for details about how to access care under this Plan. You can find Participating Providers in this network at blueshieldca.com.

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]
Calendar Year medical Deductible	*Individual coverage*	$500
	Family coverage	$500: individual
		$1,500: Family

Calendar Year Out-of-Pocket Maximum[4]

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]
Individual coverage	$3,000
Family coverage	$3,000: individual
	$6,000: 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[5]	Your payment	
	When using a Participating Provider[3]	**CYD[2] applies**
Preventive Health Services[6]		
Preventive Health Services	$0	
California Prenatal Screening Program	$0	
Physician services		
Primary care office visit	$20/visit	
Specialist care office visit	$25/visit	
Physician home visit	$20/visit	
Physician or surgeon services in an Outpatient Facility	20%	✔
Physician or surgeon services in an inpatient facility	20%	✔
Other professional services		
Other practitioner office visit *Includes nurse practitioners, physician assistants, therapists, and podiatrists.*	$20/visit	
Acupuncture services *Up to 20 visits per Member, per Calendar Year.*	$20/visit	
Chiropractic services *Up to 20 visits per Member, per Calendar Year.*	$20/visit	
Teladoc Health consultation	$0	
Family planning		
• Counseling, consulting, and education	$0	
• Injectable contraceptive, diaphragm fitting, intrauterine device (IUD), implantable contraceptive, and related procedure.	$0	
• Tubal ligation	$0	
• Vasectomy	$0	
Medical nutrition therapy, not related to diabetes	20%	✔
Infertility Services		
Physician or surgeon services in an Outpatient Facility	20%	✔
Artificial Inseminations limited to 6 per lifetime	20%	✔
Oocyte (egg) retrieval limited to 3 per lifetime		
• Ambulatory Surgery Center	10%	✔
• Outpatient Department of a Hospital	25%	✔
In vitro fertilization (IVF)	20%	✔
Embryo transfer		
• Ambulatory Surgery Center	10%	✔
• Outpatient Department of a Hospital	25%	✔

Benefits[5]	Your payment	
	When using a Participating Provider[3]	**CYD[2] applies**
Cryopreservation limited to 1 year of storage per lifetime for each of the following: sperm, reproductive tissue, oocytes (eggs), and embryos	20%	✔
Pregnancy and maternity care		
Physician office visits: prenatal and postnatal	20%	✔
Abortion and abortion-related services	$0	
Emergency Services		
Emergency room services *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.*	$150/visit plus 20%	
Emergency room Physician services	20%	
Urgent care center services	$20/visit	
Ambulance services *This payment is for emergency or authorized transport.*	20%	✔
Outpatient Facility services		
Ambulatory Surgery Center	10%	✔
Outpatient Department of a Hospital: surgery	25%	✔
Outpatient Department of a Hospital: treatment of illness or injury, radiation therapy, chemotherapy, and necessary supplies	20%	✔
Inpatient facility services		
Hospital services and stay	20%	✔
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	20%	✔
• Physician inpatient services	20%	✔
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	20%	✔

Benefits[5]	Your payment	
	When using a Participating Provider[3]	**CYD[2] applies**
Outpatient Facility services	25%	✔
Physician services	20%	✔
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. For the payments for Covered Services that are considered Preventive Health Services, see Preventive Health Services.		
Laboratory and pathology services		
Includes diagnostic Papanicolaou (Pap) test.		
• Laboratory center	$20/visit	✔
• Outpatient Department of a Hospital	$45/visit	✔
Basic imaging services		
Includes plain film X-rays, ultrasounds, and diagnostic mammography.		
• Outpatient radiology center	$20/visit	✔
• Outpatient Department of a Hospital	$45/visit	✔
Other outpatient non-invasive diagnostic testing		
Testing to diagnose illness or injury such as vestibular function tests, EKG, cardiac monitoring, non-invasive vascular studies, sleep medicine testing, muscle and range of motion tests, EEG, and EMG.		
• Office location	$20/visit	✔
• Outpatient Department of a Hospital	$45/visit	✔
Advanced imaging services		
Includes diagnostic radiological and nuclear imaging such as CT scans, MRIs, MRAs, and PET scans.		
• Outpatient radiology center	20%	✔
• Outpatient Department of a Hospital	30%	✔
Rehabilitative and Habilitative Services		
Includes physical therapy, occupational therapy, respiratory therapy, and speech therapy services.		
Office location	$20/visit	✔
Outpatient Department of a Hospital	$20/visit	✔
Durable medical equipment (DME)		
DME	20%	✔
Breast pump	$0	
Orthotic equipment and devices	20%	✔
Prosthetic equipment and devices	20%	✔

Benefits[5]	Your payment	
	When using a Participating Provider[3]	**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.*	20%	✔
Home infusion and home injectable therapy services		
Home infusion agency services *Includes home infusion drugs, medical supplies, and visits by a nurse.*	$45/visit	✔
Hemophilia home infusion services *Includes blood factor products.*	$45/visit	✔
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	20%	✔
Hospital-based SNF	20%	✔
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	
Other services and supplies		
Diabetes care services		
• Devices, equipment, and supplies	20%	✔
• Self-management training	$20/visit	
• Medical nutrition therapy	$20/visit	
Dialysis services	20%	✔
PKU product formulas and special food products	20%	✔
Allergy serum billed separately from an office visit	20%	✔

Mental Health and Substance Use Disorder Benefits	Your payment	
	When using a Participating Provider[3]	**CYD[2] applies**
Outpatient services		
Office visit, including Physician office visit	$20/visit	
Teladoc Health mental health	$0	

Mental Health and Substance Use Disorder Benefits	Your payment	
	When using a Participating Provider[3]	**CYD[2] applies**
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%	✔
Partial Hospitalization Program	20%	✔
Psychological Testing	20%	✔
Inpatient services		
Physician inpatient services	20%	✔
Hospital services	20%	✔
Residential Care	20%	✔

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

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 Calendar Year 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.

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.

Notes

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

Calendar Year Out-of-Pocket Maximum explained. The Out-of-Pocket Maximum is the most you are required to pay for Covered Services in a Calendar Year. Once you reach your Out-of-Pocket Maximum, Blue Shield will pay 100% of the Allowable Amount for Covered Services for the rest of the Calendar Year.

Your payment after you reach the Calendar Year OOPM. You will continue to pay all charges for services that are not covered, charges above the Allowable Amount, and charges for services above any Benefit maximum.

Any Deductibles count towards the OOPM. Any amounts you pay that count towards the Calendar Year medical Deductible also count towards the Calendar Year Out-of-Pocket Maximum.

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.

5 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 payment in addition to an allergy serum payment when you visit the doctor for an allergy shot.

6 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.

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

PENDING REGULATORY APPROVAL