blue of california

Summary of Benefits

Group Plan
PPO Plan

Active Choice® Classic 850 80/60

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.

How Your Active Choice Plan Works

Active Choice is a PPO plan with three categories of Benefits impacting the Deductible:

- Preventive Care Category – Available at no cost to you. These services are not subject to any Deductible.
- Category 1 – Certain routine care services. You can use your First Dollar Services credit towards these services before any Deductible applies.
- Category 2 – All other Covered Services. These services are subject to any Deductible.

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.

		When using a Participating[3] or Non-Participating[4] Provider
Calendar Year medical Deductible	*Individual coverage*	$0
	Family coverage	$0: individual
		$0: Family

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	$3,000	$10,000
Family coverage	$3,000: individual	$10,000: individual
	$6,000: Family	$20,000: 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.

Preventive Care Category	Your payment	
	When using a Participating Provider[3]	**When using a Non-Participating Provider[4]**
Preventive Health Services[6]		
Preventive Health Services	$0	Not covered
California Prenatal Screening Program	$0	$0
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
Durable medical equipment (DME)		
Breast pump	$0	Not covered

Category 1: First Dollar Services – Outpatient Professional and Diagnostic[7]

		When using a Participating[3] or Non-Participating[4] Provider
First Dollar Services credit	*Individual coverage*	$850
	Family coverage	$1,700

Blue Shield credits you with a dollar amount each year to use for certain routine care services. These routine care services are called First Dollar Services.

You do not have to meet any Calendar Year Deductible before Blue Shield provides Benefits for First Dollar Services. When you receive services listed under First Dollar Services, Blue Shield pays 100% of the Allowable Amount for the first $850 per Member or $1,700 per Family, each Calendar Year.

After the first $850 per Member or $1,700 per Family First Dollar Services credit maximum is reached, you pay 100% of the Allowable Amount for any additional First Dollar Services until your Calendar Year Out-of-Pocket Maximum has been reached. Once your Calendar Year Out-of-Pocket Maximum amount has been reached, Blue Shield pays 100% of the Allowable Amount for subsequent services.

The First Dollar Services credit is available for the following outpatient professional and diagnostic services:

- Acupuncture services, up to 20 visits per Member, per Calendar Year
- Allergy serum billed separately from an office visit
- Chiropractic services, up to 12 visits per Member, per Calendar Year
- Diabetes care services
- Durable medical equipment (DME) not listed under the Preventive Care Category
- Outpatient basic diagnostic imaging, pathology, laboratory, and other non-invasive testing services, except emergency and surgery
- Outpatient advanced imaging services, except emergency
- Outpatient rehabilitative and habilitative services, includes Physical Therapy, Occupational Therapy, Respiratory Therapy, and Speech Therapy services
- Primary care and specialty care office visits, except for prenatal and postnatal
- Physician home visit

Category 1: First Dollar Services – Outpatient Professional and Diagnostic[7]

- Other practitioner office visit, includes nurse practitioners, Physician assistants, and therapists
- Orthotic equipment and devices
- Outpatient medical treatment of the teeth, gums, jaw joints, or jaw bones office visit, except surgery
- Podiatric services
- Prosthetic equipment and devices
- Urgent care center services

Note: Only services listed as First Dollar Services are reimbursed as described above. The Preventive Care Category is covered at no charge and is not applied to your First Dollar Services credit. For more about First Dollar Services, see the *Paying for Covered Services* section of the EOC.

Category 2: Outpatient and Inpatient Facility-Based Services[8]	Your payment			
	When using a Participating Provider[3]	**CYD[2] applies**	**When using a Non-Participating Provider[4]**	**CYD[2] applies**
Physician services				
Physician or surgeon services in an Outpatient Facility, except for Category 1 services	20%		40%	
Physician or surgeon services in an inpatient facility	20%		40%	
Other Professional services				
Teladoc consultation	$0		Not covered	
Medical nutrition therapy, not related to diabetes	20%		40%	
Pregnancy and maternity care				
Physician office visits: prenatal and postnatal	20%		40%	
Abortion and abortion-related services	$0		$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.*	$100/visit plus 20%		$100/visit plus 20%	
Emergency room Physician services	20%		20%	
Ambulance services *This payment is for emergency or authorized transport.*	20%		20%	
Outpatient Facility services				
Ambulatory Surgery Center	$250/surgery plus 20%		40% Subject to a Benefit maximum of $350/day	

Category 2: Outpatient and Inpatient Facility-Based Services[8]	Your payment			
	When using a Participating Provider[3]	**CYD[2] applies**	**When using a Non-Participating Provider[4]**	**CYD[2] applies**
Outpatient Department of a Hospital: surgery	$400/surgery plus 20%		40% Subject to a Benefit maximum of $350/day	
Outpatient Department of a Hospital: treatment of illness or injury, radiation therapy, chemotherapy, and necessary supplies	20%		40% Subject to a Benefit maximum of $350/day	
Inpatient facility services				
Hospital services and stay	$500/admission plus 20%		40% Subject to a Benefit maximum of $600/day	
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	$500/admission plus 20%		Not covered	
• Physician inpatient services	20%		Not covered	
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	$500/admission plus 20%		Not covered	
Outpatient Facility services	$400/surgery plus 20%		Not covered	
Physician services	20%		Not covered	

Category 2: Outpatient and Inpatient Facility-Based Services[8]	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.*	20%		Not covered	
Home infusion and home injectable therapy services				
Home infusion agency services *Includes home infusion drugs, medical supplies, and visits by a nurse.*	20%		Not covered	
Hemophilia home infusion services *Includes blood factor products.*	20%		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	20%		20%	
Hospital-based SNF	20%		40% Subject to a Benefit maximum of $600/day	
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				
Dialysis services	20%		40% Subject to a Benefit maximum of $350/day	
PKU product formulas and special food products	20%		20%	
Vasectomy	$0		Not covered	

Category 2: Mental Health and Substance Use Disorder Benefits	Your payment			
Mental health and substance use disorder Benefits are provided through Blue Shield's Mental Health Services 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	$0		40%	
Teladoc mental health	$0		Not covered	
Other Outpatient Mental Health and Substance Use Disorder Services	$0		40%	
Inpatient services				
Physician inpatient services	$0		40%	
Hospital services	$500/admission plus 20%		40% Subject to a Benefit maximum of $600/day	
Residential care	$500/admission plus 20%		40% Subject to a Benefit maximum of $600/day	

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.

Notes

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.

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.

Teladoc. Teladoc mental health and substance use disorder consultations are provided through Teladoc. These services are not administered by Blue Shield's Mental Health Service Administrator (MHSA).

"Allowable Amount" is defined in the EOC. In addition:

- Coinsurance is calculated from the Allowable Amount.

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.

"Allowable Amount" is defined in the EOC. In addition:

- Coinsurance is calculated from the Allowable Amount, which is subject to any stated Benefit maximum.
- Charges above the Allowable Amount 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):

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 and charges above the Allowable Amount.

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 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.

Notes

7 First Dollar Services:

Family coverage has a combined FDS credit maximum. Each Calendar Year when you or one of your Dependents incurs allowed charges for FDS, the amount paid by Blue Shield for those services is deducted from the Family FDS credit amount.

Carryover credit. Any unused portion of the FDS credit may be carried over for use in the next Calendar Year. For more about carryover credit, see the *Paying for Covered Services* section of the EOC.

8 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, if you have outpatient surgery, you may owe separate payments for the facility and the professional surgeon's services.

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

PENDING REGULATORY APPROVAL

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 Care 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 Atención 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)**。