blue california

Summary of Benefits

CAPE
Effective January 1, 2027
POS Plan

California Association of Professional Employees Custom POS Lite Option

This Summary of Benefits shows the amount you will pay for Covered Benefits 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: POS Added Advantage Network

This Plan uses a specific network of Health Care Providers, called the POS Added Advantage provider network. This Plan provides benefits at three different levels:

- **Level I (HMO Participating Providers):** Services must be provided or prior authorized by your primary care Physician or medical group/IPA, with some exceptions. Please review your EOC for details about how to access care under this level.
- **Level II (PPO Participating Providers):** Services are provided by Participating Providers. Any Copayment or Coinsurance is calculated from the Allowable Amount.
- **Level III (Non-Participating Providers):** Services are provided by Non-Participating Providers.

You are responsible for any Copayment or Coinsurance and any charges over the Allowable Amount. You pay less for Covered Benefits when you use a Level I or Level II provider than when you use a Level III provider. 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 Benefits under the Plan. Blue Shield pays for some Covered Benefits before the Calendar Year Deductible is met, as noted in the Benefits chart below.

		Level I[3]	Level II[3]	Level III[4]
Calendar Year medical Deductible	*Individual coverage*	$0	$400	
	Family coverage	$0: individual $0: Family	$400: individual $800: Family	

Calendar Year Out-of-Pocket Maximum[5]

An Out-of-Pocket Maximum is the most a Member will pay for Covered Benefits each Calendar Year. Any exceptions are listed in the Notes section at the end of this Summary of Benefits.

	Level I[3]	Level II[3]	Level III[4]
Individual coverage	$1,500	$4,000	$6,000
Family coverage	$1,500: individual $3,000: Family	$4,000: individual $8,000: Family	$6,000: individual $12,000: 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 Benefits.

Blue Shield of California is an independent member of the Blue Shield Association

Benefits[6]	Your payment					
	Level I[3]	CYD[2] applies	Level II[3]	CYD[2] applies	Level III[4]	CYD[2] applies
Preventive Health Services[7]						
Preventive Health Services	$0		$0		$0	
California Prenatal Screening Program	$0		$0		$0	
Physician services						
Primary care office visit	$10/visit		$25/visit		30%	✔
Specialist care office visit	$10/visit		$25/visit		30%	✔
Office visit for allergy serum injection	$10/visit		$25/visit		30%	✔
Physician home visit	$25/visit		20%	✔	30%	✔
Physician or surgeon services in an Outpatient Facility	$0		20%	✔	30%	✔
Physician or surgeon services in an inpatient facility	$0		20%	✔	30%	✔
Other professional services						
Other practitioner office visit *Includes nurse practitioners, physician assistants, therapists, and podiatrists.*	$10/visit		$25/visit		30%	✔
Teladoc Health consultation	$0		$0		Not covered	
Family planning						
• Counseling, consulting, and education	$0		$25/visit		30%	✔
• Injectable contraceptive, intrauterine device (IUD), implantable contraceptive, and related procedure.	$0		$25/visit		30%	✔
• Diaphragm fitting procedure	$0		$0		$0	
• Tubal ligation	$0		50%	✔	50%	✔
• Vasectomy	$75/surgery		50%	✔	50%	✔
Medical nutrition therapy, not related to diabetes	$0		20%	✔	30%	✔
Infertility Services						
Physician or surgeon services in an Outpatient Facility	$0		20%	✔	30%	✔
Artificial Inseminations limited to 6 per lifetime	$0		20%	✔	30%	✔

Benefits[6]	Your payment					
	Level I[3]	CYD[2] applies	Level II[3]	CYD[2] applies	Level III[4]	CYD[2] applies
Oocyte (egg) retrieval limited to 3 per lifetime						
• Ambulatory Surgery Center	$75/surgery		20%	✔	30% Subject to a Benefit maximum of $600/day	✔
• Outpatient Department of a Hospital	$75/surgery		20%	✔	30% Subject to a Benefit maximum of $600/day	✔
In vitro fertilization (IVF)	$0		20%	✔	30%	✔
Gamete Intrafallopian Transfer (GIFT) limited to 3 per lifetime						
• GIFT Ambulatory Surgery Center	$75/surgery		20%	✔	30% Subject to a Benefit maximum of $600/day	✔
• Outpatient Department of a Hospital	$75/surgery		20%	✔	30% Subject to a Benefit maximum of $600/day	✔
Zygote Intrafallopian Transfer (ZIFT) limited to 3 per lifetime						
• Ambulatory Surgery Center	$75/surgery		20%	✔	30% Subject to a Benefit maximum of $600/day	✔
• Outpatient Department of a Hospital	$75/surgery		20%	✔	30% Subject to a Benefit maximum of $600/day	✔
Embryo transfer						
• Ambulatory Surgery Center	$75/surgery		20%	✔	30% Subject to a Benefit maximum of $600/day	✔

Benefits[6]	Your payment					
	Level I[3]	**CYD[2] applies**	**Level II[3]**	**CYD[2] applies**	**Level III[4]**	**CYD[2] applies**
• Outpatient Department of a Hospital	$75/surgery		20%	✔	30% Subject to a Benefit maximum of $600/day	✔
Cryopreservation limited to 1 year of storage per lifetime for each of the following: sperm, reproductive tissue, oocytes (eggs), and embryos	$0		20%	✔	30%	✔
Pregnancy and maternity care						
Physician office visits: prenatal and postnatal	$0		$25/visit		30%	✔
Abortion and abortion-related services	$0		$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 Level I member payment under Inpatient facility services/ Hospital services and stay.*	$50/visit		$50/visit		$50/visit	
Emergency room Physician services	$0		$0		$0	
Urgent care center services	$10/visit		$25/visit		30%	✔
Ambulance services *This payment is for emergency or authorized transport.*	$50/transport		20%	✔	20%	✔
Outpatient Facility services						
Ambulatory Surgery Center	$75/surgery		20%	✔	30% Subject to a Benefit maximum of $600/day	✔
Outpatient Department of a Hospital: surgery	$75/surgery		20%	✔	30% Subject to a Benefit maximum of $600/day	✔

Benefits[6]	Your payment					
	Level I[3]	CYD[2] applies	Level II[3]	CYD[2] applies	Level III[4]	CYD[2] applies
Outpatient Department of a Hospital: treatment of illness or injury, radiation therapy, chemotherapy, and necessary supplies	$0		20%	✔	30% Subject to a Benefit maximum of $600/day	✔
Inpatient facility services						
Hospital services and stay	$0		20%	✔	30% 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	$0		Not covered		Not covered	
• Physician inpatient services	$0		Not covered		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	$0		20%	✔	Not covered	
Outpatient Facility services	$75/surgery		20%	✔	Not covered	
Physician services	$0		20%	✔	Not covered	

Benefits[6]	Your payment					
	Level I[3]	CYD[2] applies	Level II[3]	CYD[2] applies	Level III[4]	CYD[2] applies
Diagnostic x-ray, imaging, pathology, and laboratory services						
This payment is for Covered Benefits that are diagnostic, non-Preventive Health Services, and diagnostic radiological procedures. For the payments for Covered Benefits that are considered Preventive Health Services, see Preventive Health Services.						
Laboratory and pathology services						
Includes diagnostic Papanicolaou (Pap) test.						
• Laboratory center	$0		20%	✔	30%	✔
• Outpatient Department of a Hospital	$0		20%	✔	30% Subject to a Benefit maximum of $600/day	✔
Basic imaging services						
Includes plain film X-rays, ultrasounds, and diagnostic mammography.						
• Outpatient radiology center	$0		20%	✔	30%	✔
• Outpatient Department of a Hospital	$0		20%	✔	30% Subject to a Benefit maximum of $600/day	✔
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	$0		20%	✔	30%	✔
• Outpatient Department of a Hospital	$0		20%	✔	30% Subject to a Benefit maximum of $600/day	✔

Benefits[6]	Your payment					
	Level I[3]	CYD[2] applies	Level II[3]	CYD[2] applies	Level III[4]	CYD[2] applies
Advanced imaging services *Includes diagnostic radiological and nuclear imaging such as CT scans, MRIs, MRAs, and PET scans.*						
• Outpatient radiology center	$0		20%	✔	30%	✔
• Outpatient Department of a Hospital	$0		20%	✔	30% Subject to a Benefit maximum of $600/day	✔
Rehabilitative and Habilitative Services *Includes physical therapy, occupational therapy, respiratory therapy, and speech therapy services.*						
Office location	$10/visit		20%	✔	30%	✔
Outpatient Department of a Hospital	$10/visit		20%	✔	30% Subject to a Benefit maximum of $600/day	✔
Durable medical equipment (DME)						
DME	$0		$0		$0	
Breast pump	$0		$0		$0	
Orthotic equipment and devices	$0		$0		$0	
Prosthetic equipment and devices	$0		$0		$0	
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.*	$10/visit		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.*	$0		20%	✔	Not covered	

Benefits[6]	Your payment					
	Level I[3]	CYD[2] applies	Level II[3]	CYD[2] applies	Level III[4]	CYD[2] applies
Hemophilia home infusion services *Includes blood factor products.*	$0		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	$0		20%	✔	20%	✔
Hospital-based SNF	$0		20%	✔	30% 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		Not covered	
Other services and supplies						
Diabetes care services						
• Devices, equipment, and supplies	$0		$0		$0	
• Self-management training	$10/visit		$25/visit		30%	✔
• Medical nutrition therapy	$10/visit		$25/visit		30%	✔
Dialysis services	$0		20%	✔	30% Subject to a Benefit maximum of $300/day	✔
PKU product formulas and special food products	$0		20%	✔	20%	✔
Allergy serum billed separately from an office visit	50%		50%	✔	50%	✔

Mental Health or Substance Use Disorder Benefits	Your payment					
	Level I[3] Care authorized by Blue Shield or provided by Participating Providers	**CYD[2] applies**	**Level II[3]** There are no separate benefit payments under Level II	**CYD[2] applies**	**Level III[4]** When using Non-Participating Providers	**CYD[2] applies**
Outpatient services						
Office visit, including Physician office visit	$10/visit				30%	✔
Teladoc Health mental health	$0				Not covered	
Other outpatient services, including intensive outpatient care, electroconvulsive therapy, transcranial magnetic stimulation						
• Office location, clinic, home, or other non-institutional facility setting	$0				30%	✔
• Outpatient Department of a Hospital	$0				30% Subject to a Benefit maximum of $600/day	✔
Office-based opioid treatment	$0				30%	✔
Partial Hospitalization Program	$0				30% Subject to a Benefit maximum of $600/day	✔
Neuropsychological and Psychological Testing	$0				30%	✔
Inpatient services						
Physician inpatient services	$0				30%	✔
Hospital services	$0				30% Subject to a Benefit maximum of $600/day	✔
Residential Care	$0				30% 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.

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 Benefits under the Plan.

If this Plan has any Calendar Year Deductible(s), Covered Benefits subject to that Deductible are identified with a check mark (✔) in the Benefits chart above.

Covered Benefits not subject to the Calendar Year medical Deductible. Some Covered Benefits received from Participating Providers are paid by Blue Shield before you meet any Calendar Year medical Deductible. These Covered Benefits do not have a check mark (✔) next to them in the "CYD applies" column in the Benefits chart above.

This Plan has a combined Participating Provider 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. Once the individual Deductible or Family Deductible is reached, cost sharing applies until the Out-of-Pocket Maximum is reached.

3 Using Level I and Level II Participating Providers:

Level I and Level II Participating Providers have a contract to provide health care services to Members. When you receive Covered Benefits from a Level I or Level II 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.

4 Using Level III Non-Participating Providers:

Level III Non-Participating Providers do not have a contract to provide health care services to Members. When you receive Covered Benefits from a Level III 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 Benefits in a Calendar Year. Once you reach your Out-of-Pocket Maximum, Blue Shield will pay 100% of the Allowable Amount for Covered Benefits 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 separate Participating Provider OOPM 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 Benefits are Received:

Each time you receive multiple Covered Benefits, 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.

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 Benefits 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
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