blue california

Summary of Benefits

California Small Manufacturing Trust
dba CSMT
Effective June 1, 2026
HMO Plan

Custom Access+ HMO® Facility Coinsurance 30-30%

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: Access+ HMO Network

This Plan uses a specific network of Health Care Providers, called the Access+ HMO provider network. Medical Groups, Independent Practice Associations (IPAs), and Physicians in this network are called Participating Providers. You must select a Primary Care Physician from this network to provide your primary care and help you access services, 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 Benefits under the Plan.

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

Calendar Year Out-of-Pocket Maximum[4]

An Out-of-Pocket Maximum is the most a Member will pay for Covered Benefits each Calendar Year. Any exceptions are listed in the EOC.

	When using a Participating Provider[3]
Individual coverage	$3,500
Family coverage	$3,500: individual
	$7,000: 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[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	$30/visit	
Access+ specialist care office visit (self-referral)	$50/visit	
Other specialist care office visit (referred by PCP)	$30/visit	
Physician home visit	$30/visit	
Physician or surgeon services in an Outpatient Facility	$0	
Physician or surgeon services in an inpatient facility	$0	
Other professional services		
Other practitioner office visit *Includes nurse practitioners, physician assistants, therapists, and podiatrists.*	$30/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	$0	
Infertility Services		
Physician or surgeon services in an Outpatient Facility	$0	
Artificial Inseminations limited to 6 per lifetime	$0	
Oocyte (egg) retrieval limited to 3 per lifetime		
• Ambulatory Surgery Center	20%	
• Outpatient Department of a Hospital	20%	
In vitro fertilization (IVF)	$0	
Embryo transfer		
• Ambulatory Surgery Center	20%	
• Outpatient Department of a Hospital	20%	
Cryopreservation limited to 1 year of storage per lifetime for each of the following: sperm, reproductive tissue, oocytes (eggs), and embryos	$0	

Benefits[5]	Your payment	
	When using a Participating Provider[3]	**CYD[2] applies**
Pregnancy and maternity care		
Physician office visits: prenatal and postnatal	$0	
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	
Emergency room Physician services	$0	
Urgent care center services	$30/visit	
Ambulance services *This payment is for emergency or authorized transport.*	$150/transport	
Outpatient Facility services		
Ambulatory Surgery Center	20%	
Outpatient Department of a Hospital: surgery	20%	
Outpatient Department of a Hospital: treatment of illness or injury, radiation therapy, chemotherapy, and necessary supplies	$0	
Inpatient facility services		
Hospital services and stay	30%	
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	30%	
• Physician inpatient services	$0	
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	$15/visit	
• Outpatient Department of a Hospital	$15/visit	

Benefits[5]	Your payment	
	When using a Participating Provider[3]	**CYD[2] applies**
Basic imaging services *Includes plain film X-rays, ultrasounds, and diagnostic mammography.*		
• Outpatient radiology center	$15/visit	
• Outpatient Department of a Hospital	$15/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	$15/visit	
• Outpatient Department of a Hospital	$15/visit	
Advanced imaging services *Includes diagnostic radiological and nuclear imaging such as CT scans, MRIs, MRAs, and PET scans.*		
• Outpatient radiology center	$100/visit	
• Outpatient Department of a Hospital	$100/visit	
Rehabilitative and Habilitative Services *Includes physical therapy, occupational therapy, respiratory therapy, and speech therapy services.*		
Office location	$30/visit	
Outpatient Department of a Hospital	$30/visit	
Durable medical equipment (DME)		
DME	$0	
Breast pump	$0	
Orthotic equipment and devices	$0	
Prosthetic equipment and devices	$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.*	$30/visit	
Home infusion and home injectable therapy services		
Home infusion agency services *Includes home infusion drugs, medical supplies, and visits by a nurse.*	$0	

Benefits[5]	Your payment	
	When using a Participating Provider[3]	CYD[2] applies
Hemophilia home infusion services *Includes blood factor products.*	$0	
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	$25/admission	
Hospital-based SNF	$25/admission	
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	$0	
• Self-management training	$30/visit	
• Medical nutrition therapy	$30/visit	
Dialysis services	$0	
PKU product formulas and special food products	$0	
Allergy serum billed separately from an office visit	50%	

Mental Health or Substance Use Disorder Benefits	Your payment	
	When using a Participating Provider[3]	CYD[2] applies
Outpatient services		
Office visit, including Physician office visit	$30/visit	
Teladoc Health mental health	$0	
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	$0	
Partial Hospitalization Program	$0	
Psychological Testing	$0	
Inpatient services		
Physician inpatient services	$0	

Mental Health or Substance Use Disorder Benefits	Your payment	
	When using a Participating Provider[3]	CYD[2] applies
Hospital services	30%	
Residential Care	30%	

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.

3 Using Participating Providers:

Participating Providers have a contract to provide health care services to Members. When you receive Covered Benefits from a Participating Provider, you are only responsible for the Copayment or Coinsurance, once any Calendar Year Deductible has been met.

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 Benefits in a Calendar Year. Once you reach your Out-of-Pocket Maximum, Blue Shield will pay 100% of the Allowed Charges 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, charges above the Allowed Charges, and charges for services above any Benefit 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 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.

Notes

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 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.