



Summary of Benefits

San Francisco Health Service System
Fund (CCSF)
Effective January 1, 2026
PPO Plan

Blue Shield of CA PPO - Out of Area

This Summary of Benefits shows the amount you will pay for Covered Services under this plan. It is only a summary and it is included as part of the Benefit Booklet.¹ Please read both documents carefully for details.

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.

Calendar Year Deductibles (CYD)²

A Calendar Year Deductible (CYD) is the amount a Member pays each Calendar Year before the Claims Administrator pays for Covered Services under the Plan. The Claims Administrator 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 a Non- Participating Provider ⁴ |
|---|---|---|
| Calendar Year medical Deductible | <i>Individual coverage</i> \$250 <i>Family coverage</i> \$250: individual \$750: Family | \$250 \$250: individual \$750: Family |
| | | |

Calendar Year Out-of-Pocket Maximum⁵

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 any combination of Participating ³ or Non- Participating ⁴ Providers | When using any combination of Participating ³ or Non- Participating ⁴ Providers | No Annual or Lifetime Dollar Limit |
|--|---|---|
| <i>Individual coverage</i> \$3,750 | \$3,750 | Under this Plan there is no annual or lifetime dollar limit on the amount Claims Administrator will pay for Covered Services. |
| <i>Family coverage</i> \$3,750: individual \$7,500: Family | \$3,750: per individual | |

Benefits⁶**Your payment**

| | When using a Participating Provider³ | CYD² applies | When using a Non-Participating Provider⁴ | CYD² applies |
|---|--|--------------------------------|--|--------------------------------|
| Preventive Health Services⁷ | | | | |
| Preventive Health Services | \$0 | | \$0 | |
| Preventive immunizations | \$0 | | \$0 | |
| Physician services | | | | |
| Primary care office visit | 15% | ✓ | 15% | ✓ |
| Specialist care office visit | 15% | ✓ | 15% | ✓ |
| Physician home visit | 15% | ✓ | 15% | ✓ |
| Physician or surgeon services in an Outpatient Facility | 15% | ✓ | 15% | ✓ |
| Physician or surgeon services in an inpatient facility | 15% | ✓ | 15% | ✓ |
| Other professional services | | | | |
| Other practitioner office visit | 15% | ✓ | 15% | ✓ |
| <i>Includes nurse practitioners, physician assistants, and therapists.</i> | | | | |
| Acupuncture services | 50% | ✓ | 50% | ✓ |
| <i>Up to \$1,000 maximum per Member, per Calendar Year.</i> | | | | |
| Chiropractic services | 50% | ✓ | 50% | ✓ |
| <i>Up to \$1,000 maximum per Member, per Calendar Year.</i> | | | | |
| Family planning | | | | |
| • Counseling, consulting, and education | \$0 | | \$0 | |
| • Injectable contraceptive | \$0 | | \$0 | |
| • Diaphragm fitting | \$0 | | \$0 | |
| • Intrauterine device (IUD) | \$0 | | \$0 | |
| • Insertion and/or removal of intrauterine device (IUD) | \$0 | | \$0 | |
| • Implantable contraceptive | \$0 | | \$0 | |
| • Tubal ligation | \$0 | | \$0 | |
| • Vasectomy | \$0 | | \$0 | |
| Podiatric services | 15% | ✓ | 15% | ✓ |
| Medical nutrition therapy, not related to diabetes | 15% | ✓ | 15% | ✓ |
| <i>Combined with diabetic medical nutrition therapy, up to 4 visits per Member, per Calendar Year</i> | | | | |
| Diagnosis and Treatment of the Cause of Infertility | 15% | ✓ | 15% | ✓ |

Benefits**Your payment**

| | When using a Participating Provider³ | CYD² applies | When using a Non-Participating Provider⁴ | CYD² applies |
|---|--|--------------------------------|--|--------------------------------|
| Infertility Services | | | | |
| Physician or surgeon services in an Outpatient Facility | 15% | ✓ | 15% | ✓ |
| Artificial Inseminations limited to 9 per lifetime | 15% | ✓ | 15% | ✓ |
| Oocyte (egg) retrieval limited to 3 per lifetime | | | | |
| • Ambulatory Surgery Center | 15% | ✓ | 15% | ✓ |
| • Outpatient Department of a Hospital | 15% | ✓ | 15% | ✓ |
| In vitro fertilization (IVF) | 15% | ✓ | 15% | ✓ |
| Gamete Intrafallopian Transfer (GIFT) | | | | |
| • Ambulatory Surgery Center | 15% | ✓ | 15% | ✓ |
| • Outpatient Department of a Hospital | 15% | ✓ | 15% | ✓ |
| Zygote Intrafallopian Transfer (ZIFT) | | | | |
| • Ambulatory Surgery Center | 15% | ✓ | 15% | ✓ |
| • Outpatient Department of a Hospital | 15% | ✓ | 15% | ✓ |
| Embryo transfer | | | | |
| • Ambulatory Surgery Center | 15% | ✓ | 15% | ✓ |
| • Outpatient Department of a Hospital | 15% | ✓ | 15% | ✓ |
| Cryopreservation limited to 1 year of storage per lifetime for each of the following: sperm, reproductive tissue, oocytes (eggs), and embryos | 15% | ✓ | 15% | ✓ |
| Embryo transportation related network disruption ⁸ | 50% | | 50% | |
| <i>Limited to 1 instance and within the 1 year of storage. Up to \$500 maximum.</i> | | | | |
| Pregnancy and maternity care | | | | |
| Physician office visits: prenatal and postnatal | 15% | ✓ | 15% | ✓ |
| Physician services for pregnancy termination | 15% | ✓ | 15% | ✓ |
| Emergency Services | | | | |
| Emergency room services | 15% | ✓ | 15% | ✓ |
| <i>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.</i> | | | | |
| Emergency room services for a non-emergency medical condition ⁵ | 50% | ✓ | 50% | ✓ |
| Emergency room Physician services | 15% | ✓ | 15% | ✓ |

Benefits⁶**Your payment**

| | When using a Participating Provider³ | CYD² applies | When using a Non-Participating Provider⁴ | CYD² applies |
|--|--|--------------------------------|--|--------------------------------|
| Urgent care center services | 15% | ✓ | 15% | ✓ |
| Ambulance services | 15% | ✓ | 15% | ✓ |
| <i>This payment is for emergency or authorized transport.</i> | | | | |
| Outpatient Facility services | | | | |
| Ambulatory Surgery Center | 15% | ✓ | 15% | ✓ |
| Outpatient Department of a Hospital: surgery | 15% | ✓ | 15% | ✓ |
| Outpatient Department of a Hospital: treatment of illness or injury, radiation therapy, chemotherapy, and necessary supplies | 15% | ✓ | 15% | ✓ |
| Inpatient facility services | | | | |
| Hospital services and stay | 15% | ✓ | 15% | ✓ |
| Transplant services | | | | |
| <i>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.</i> | | | | |
| • Special transplant facility inpatient services | 15% | ✓ | Not covered | |
| • Physician inpatient services | 15% | ✓ | Not covered | |
| Bariatric surgery services | | | | |
| <i>Participating Provider benefits for bariatric surgery services are limited to \$60,000 during the entire period you are covered under the Plan.</i> | | | | |
| <i>Non-Participating Provider benefits for bariatric surgery services are limited to \$10,000 during the entire period you are covered under the Plan.</i> | | | | |
| Inpatient facility services | 15% | ✓ | 15% | ✓ |
| Outpatient Facility services | 15% | ✓ | 15% | ✓ |
| Physician services | 15% | ✓ | 15% | ✓ |

Benefits⁶**Your payment**

| | When using a Participating Provider³ | CYD² applies | When using a Non-Participating Provider⁴ | CYD² applies |
|--|--|--------------------------------|--|--------------------------------|
| Diagnostic x-ray, imaging, pathology, and laboratory services | | | | |
| <i>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.</i> | | | | |
| Laboratory and pathology services | | | | |
| <i>Includes diagnostic Papanicolaou (Pap) test.</i> | | | | |
| • Laboratory center | 15% | ✓ | 15% | ✓ |
| • Outpatient Department of a Hospital | 15% | ✓ | 15% | ✓ |
| Basic imaging services | | | | |
| <i>Includes plain film X-rays, ultrasounds, and diagnostic mammography.</i> | | | | |
| • Outpatient radiology center | 15% | ✓ | 15% | ✓ |
| • Outpatient Department of a Hospital | 15% | ✓ | 15% | ✓ |
| Other outpatient non-invasive diagnostic testing | | | | |
| <i>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.</i> | | | | |
| • Office location | 15% | ✓ | 15% | ✓ |
| • Outpatient Department of a Hospital | 15% | ✓ | 15% | ✓ |
| Advanced imaging services | | | | |
| <i>Includes diagnostic radiological and nuclear imaging such as CT scans, MRIs, MRAs, and PET scans.</i> | | | | |
| • Outpatient radiology center | 15% | ✓ | 15% | ✓ |
| • Outpatient Department of a Hospital | 15% | ✓ | 15% | ✓ |
| Rehabilitative and Habilitative Services | | | | |
| <i>Includes physical therapy, occupational therapy, and respiratory therapy.</i> | | | | |
| Office location | 15% | ✓ | 15% | ✓ |
| Outpatient Department of a Hospital | 15% | ✓ | 15% | ✓ |
| Speech Therapy services | | | | |
| Office location | 15% | ✓ | 15% | ✓ |
| Outpatient Department of a Hospital | 15% | ✓ | 15% | ✓ |

Benefits⁶**Your payment**

| | When using a Participating Provider³ | CYD² applies | When using a Non-Participating Provider⁴ | CYD² applies |
|--|--|--------------------------------|--|--------------------------------|
| Durable medical equipment (DME) | | | | |
| DME | 15% | ✓ | 15% | ✓ |
| Breast pump | \$0 | | 15% | ✓ |
| Orthotic equipment and devices | 15% | ✓ | 15% | ✓ |
| Prosthetic equipment and devices | 15% | ✓ | 15% | ✓ |
| Home health care services | 15% | ✓ | 15% | ✓ |
| Up to 120 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. | | | | |
| Home infusion and home injectable therapy services | | | | |
| Home infusion agency services | 15% | ✓ | 15% | ✓ |
| Includes home infusion drugs, medical supplies, and visits by a nurse. | | | | |
| Hemophilia home infusion services | 15% | ✓ | 15% | ✓ |
| Includes blood factor products. | | | | |
| Skilled Nursing Facility (SNF) services | | | | |
| Up to 120 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 | 15% | ✓ | 15% | ✓ |
| Hospital-based SNF | 15% | ✓ | 15% | ✓ |
| Hospice program services | | | | |
| Pre-Hospice consultation | 15% | ✓ | 15% | ✓ |
| Routine home care | 15% | ✓ | 15% | ✓ |
| 24-hour continuous home care | 15% | ✓ | 15% | ✓ |
| Short-term inpatient care for pain and symptom management | 15% | ✓ | 15% | ✓ |
| Inpatient respite care | 15% | ✓ | 15% | ✓ |

Benefits⁶**Your payment**

| | When using a Participating Provider³ | CYD² applies | When using a Non-Participating Provider⁴ | CYD² applies |
|--|--|--------------------------------|--|--------------------------------|
| Reconstructive surgery services | | | | |
| Outpatient Facility services | 15% | ✓ | 15% | ✓ |
| Inpatient facility services | 15% | ✓ | 15% | ✓ |
| Physician services | 15% | ✓ | 15% | ✓ |
| Medical treatment of the teeth, gums, jaw joints, and jaw bones | | | | |
| Outpatient Facility services | 15% | ✓ | 15% | ✓ |
| Inpatient facility services | 15% | ✓ | 15% | ✓ |
| Physician services | 15% | ✓ | 15% | ✓ |
| Other services and supplies | | | | |
| Diabetes care services | | | | |
| • Devices, equipment, and supplies | 15% | ✓ | 15% | ✓ |
| • Self-management training | 15% | ✓ | 15% | ✓ |
| • Medical nutrition therapy | 15% | ✓ | 15% | ✓ |
| <i>Combined with medical nutrition therapy, not related to diabetes, up to 4 visits per Member, per Calendar Year.</i> | | | | |
| Dialysis services | 15% | ✓ | 15% | ✓ |
| PKU product formulas and special food products | 15% | ✓ | 15% | ✓ |
| Allergy serum billed separately from an office visit | 15% | ✓ | 15% | ✓ |
| Hearing aid services | | | | |
| • Hearing aids and equipment | 15% | | 15% | |
| <i>Up to \$2,500 maximum per ear, per Member, per 36-month period.</i> | | | | |
| Clinical trials for treatment of cancer or life-threatening diseases or conditions | Regular medical services for Members enrolled in clinical trials will be covered at the same Cost Shares as any other services (office visit, inpatient, outpatient, etc.) | | | |

Mental Health and Substance Use Disorder Benefits**Your payment**

| | When using a Participating Provider³ | CYD² applies | When using a Non-Participating Provider⁴ | CYD² applies |
|--|--|--------------------------------|--|--------------------------------|
| Outpatient services | | | | |
| Office visit, including Physician office visit | 15% | ✓ | 15% | ✓ |
| Intensive outpatient care | 15% | ✓ | 15% | ✓ |
| Behavioral Health Treatment in an office setting | 15% | ✓ | 15% | ✓ |

Mental Health and Substance Use Disorder Benefits

Your payment

| | When using a Participating Provider ³ | CYD ² applies | When using a Non-Participating Provider ⁴ | CYD ² applies |
|--|--|--------------------------|--|--------------------------|
| Behavioral Health Treatment in home or other non-institutional setting | 15% | ✓ | 15% | ✓ |
| Office-based opioid treatment | 15% | ✓ | 15% | ✓ |
| Partial Hospitalization Program | 15% | ✓ | 15% | ✓ |
| Psychological Testing | 15% | ✓ | 15% | ✓ |
| Inpatient services | | | | |
| Physician inpatient services | 15% | ✓ | 15% | ✓ |
| Hospital services | 15% | ✓ | 15% | ✓ |
| Residential Care | 15% | ✓ | 15% | ✓ |

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 Benefit Booklet for more about Benefits that require prior authorization.

Notes

1 Benefit Booklet:

The Benefit Booklet describes the Benefits, limitations, and exclusions that apply to coverage under this Plan. Please review the Benefit Booklet for more details of coverage outlined in this Summary of Benefits. You can request a copy of the Benefit Booklet at any time.

Capitalized terms are defined in the Benefit Booklet. Refer to the Benefit Booklet 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 the Claims Administrator 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 the Claims Administrator 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 Participating Provider Deductible and Non-Participating Provider Deductible.

Notes

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 Benefit Booklet. 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 Benefit Booklet. 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 Deductible or 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, the Claims Administrator will pay 100% of the Allowable Amount for Covered Services for the rest of the Calendar Year. Charges for Services which are specifically excluded from accumulating to the OOPM, contained within the Benefit Booklet, do not count towards the OOPM.

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.

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.

This Plan cross accumulates Participating Provider and Non-Participating Provider OOPM. This means that any amounts you pay towards your Participating Provider OOPM also count towards your Non-Participating Provider OOPM. Also, any amounts you pay towards your Non-Participating Provider OOPM counts towards your 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 payment in addition to an allergy serum payment when you visit the doctor for an allergy shot.

Notes

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 Embryo Transportation:

Network Disruption is defined as when a facility closes and/or the Member moves during the covered year of storage, the Member will be reimbursed up to the limit of \$500.

Plans may be modified to ensure compliance with Federal requirements.

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