blue of california

Summary of Benefits

Group Plan
PPO Plan

Active Choice® Plus 300 20 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*	$300
	Family coverage	$600

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 $300 per Member or $600 per Family, each Calendar Year.

After the first $300 per Member or $600 per Family First Dollar Services credit maximum is reached, you pay any applicable Deductible, Copayment or Coinsurance, as noted below in the Category 1 First Dollar Services Benefit chart. Once your Calendar Year Out-of-Pocket Maximum amount has been reached, Blue Shield pays 100% of the Allowable Amount for subsequent 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 1: First Dollar Services - Outpatient Professional and Diagnostic[7,8]	Your payment			
The First Dollar Services credit is available for Category 1 First Dollar Services listed in this table. After the First Dollar Services credit is exhausted, you are responsible for the Copayment or Coinsurance, once any Calendar Year Deductible has been met.	**When using a Participating Provider[3]**	**CYD[2] applies**	**When using a Non-Participating Provider[4]**	**CYD[2] applies**
Physician services				
Primary care office visit	$20/visit		40%	
Specialist care office visit	$25/visit		40%	

Category 1: First Dollar Services - Outpatient Professional and Diagnostic[7,8]	**Your payment**			
The First Dollar Services credit is available for Category 1 First Dollar Services listed in this table. After the First Dollar Services credit is exhausted, you are responsible for the Copayment or Coinsurance, once any Calendar Year Deductible has been met.	**When using a Participating Provider[3]**	**CYD[2] applies**	**When using a Non-Participating Provider[4]**	**CYD[2] applies**
Physician home visit	$20/visit		40%	
Other professional services				
Other practitioner office visit *Includes nurse practitioners, Physicians assistants, therapists, and podiatrists.*	$20/visit		40%	
Acupuncture services *Up to 20 visits per Member, per Calendar Year.*	$20/visit		40%	
Chiropractic services *Up to 12 visits per Member, per Calendar Year.*	$20/visit		40%	
Urgent care center services	$20/visit		40%	
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, except emergency and surgery *Includes diagnostic Papanicolaou (Pap) test.*				
• Laboratory center	$20/visit		40%	
• Outpatient Department of a Hospital	$20/visit		40% Subject to a Benefit maximum of $350/day	
Basic imaging services, except emergency and surgery *Includes plain film X-rays, ultrasounds, and diagnostic mammography.*				
• Outpatient radiology center	$20/visit		40%	
• Outpatient Department of a Hospital	$20/visit		40% Subject to a Benefit maximum of $350/day	

Category 1: First Dollar Services - Outpatient Professional and Diagnostic[7,8]	**Your payment**			
The First Dollar Services credit is available for Category 1 First Dollar Services listed in this table. After the First Dollar Services credit is exhausted, you are responsible for the Copayment or Coinsurance, once any Calendar Year Deductible has been met.	**When using a Participating Provider[3]**	**CYD[2] applies**	**When using a Non-Participating Provider[4]**	**CYD[2] applies**
Other outpatient non-invasive diagnostic testing, except emergency and surgery *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		40%	
• Outpatient Department of a Hospital	$20/visit		40% Subject to a Benefit maximum of $350/day	
Advanced imaging services, except emergency *Includes diagnostic radiological and nuclear imaging such as CT scans, MRIs, MRAs, and PET scans.*				
• Outpatient radiology center	20%		40%	
• Outpatient Department of a Hospital	20%		40% Subject to a Benefit maximum of $350/day	
Rehabilitative and habilitative services *Includes Physical Therapy, Occupational Therapy, Respiratory Therapy, and Speech Therapy services.*				
Office location	20%		40%	
Outpatient Department of a Hospital	20%		40% Subject to a Benefit maximum of $350/day	
Durable medical equipment (DME)				
DME not listed under preventive care	20%		40%	
Orthotic equipment and devices	20%		40%	
Prosthetic equipment and devices	20%		40%	
Other services and supplies				
Diabetes care services				
• Devices, equipment, and supplies	20%		40%	
• Self-management training	$20/visit		40%	
• Medical nutrition therapy	$20/visit		40%	

Category 1: First Dollar Services - Outpatient Professional and Diagnostic[7,8]	Your payment			
The First Dollar Services credit is available for Category 1 First Dollar Services listed in this table. After the First Dollar Services credit is exhausted, you are responsible for the Copayment or Coinsurance, once any Calendar Year Deductible has been met.	**When using a Participating Provider[3]**	**CYD[2] applies**	**When using a Non-Participating Provider[4]**	**CYD[2] applies**
Allergy serum billed separately from an office visit	20%		40%	
Outpatient medical treatment of the teeth, gums, jaw joints, or jaw bones office visit, except surgery	$20/visit		40%	

Category 1: First Dollar Services - Mental Health and Substance Use Disorder Benefits[7]	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%	
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%		40%	
Partial Hospitalization program	20%		40%	
Psychological Testing	20%		40%	

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%	

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**
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	
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	

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**
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	
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	

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**
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				
Teladoc mental health	$0		Not covered	
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.

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.

Notes

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.

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, you may owe an office visit payment in addition to an allergy serum payment when you visit the doctor for an allergy shot after the First Dollar Services credit maximum is exhausted.

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

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Outpatient Prescription Drug Rider

Group Rider
PPO

Enhanced Rx $15/30/45 with $250 Pharmacy Deductible Summary of Benefits

This Summary of Benefits shows the amount you will pay for covered Drugs under this prescription Drug Benefit.

Pharmacy Network:	**Rx Ultra**
Drug Formulary:	**Plus Formulary**

Calendar Year Pharmacy Deductible(CYPD)[1]

A Calendar Year Pharmacy Deductible (CYPD) is the amount a Member pays each Calendar Year before Blue Shield pays for covered Drugs under the outpatient prescription Drug Benefit. Blue Shield pays for some prescription Drugs before the Calendar Year Pharmacy Deductible is met, as noted in the Prescription Drug Benefits chart below.

		When using a Participating[2] or Non-Participating[3] Pharmacy
Calendar Year Pharmacy Deductible	*Per Member*	$250

Prescription Drug Benefits[4,5]

	Your payment			
	When using a Participating Pharmacy[2]	**CYPD[1] applies**	**When using a Non-Participating Pharmacy[3]**	**CYPD[1] applies**
Retail pharmacy prescription Drugs				
Per prescription, up to a 30-day supply.				
Contraceptive Drugs and devices	$0		Applicable Tier 1, Tier 2, or Tier 3 Copayment	
Tier 1 Drugs	$15/prescription		25% plus $15/prescription	
Tier 2 Drugs	$30/prescription	✔	25% plus $30/prescription	✔
Tier 3 Drugs	$45/prescription	✔	25% plus $45/prescription	✔
Tier 4 Drugs	30% up to $250/prescription	✔	30% up to $250/prescription plus 25% of purchase price	✔
Retail pharmacy prescription Drugs				
Per prescription, up to a 90-day supply from a 90-day retail pharmacy.				
Contraceptive Drugs and devices	$0		Not covered	
Tier 1 Drugs	$45/prescription		Not covered	

Prescription Drug Benefits[4,5]	Your payment			
	When using a Participating Pharmacy[2]	CYPD[1] applies	When using a Non-Participating Pharmacy[3]	CYPD[1] applies
Tier 2 Drugs	$90/prescription	✔	Not covered	
Tier 3 Drugs	$135/prescription	✔	Not covered	
Tier 4 Drugs	30% up to $750/prescription	✔	Not covered	
Mail service pharmacy prescription Drugs				
Per prescription, for a 31-90-day supply.				
Contraceptive Drugs and devices	$0		Not covered	
Tier 1 Drugs	$30/prescription		Not covered	
Tier 2 Drugs	$60/prescription	✔	Not covered	
Tier 3 Drugs	$90/prescription	✔	Not covered	
Tier 4 Drugs	30% up to $500/prescription	✔	Not covered	

Notes

1 Calendar Year Pharmacy Deductible (CYPD):

Calendar Year Pharmacy Deductible explained. A Calendar Year Pharmacy Deductible is the amount you pay each Calendar Year before Blue Shield pays for outpatient prescription Drugs under this Benefit.

If this Benefit has a Calendar Year Pharmacy Deductible, outpatient prescription Drugs subject to the Deductible are identified with a check mark (✔) in the Benefits chart above.

Any applicable Copayment, Coinsurance and CYPD you pay counts towards the Calendar Year Out-of-Pocket Maximum.

Outpatient prescription Drugs not subject to the Calendar Year Pharmacy Deductible. Some outpatient prescription Drugs received from Participating Pharmacies are paid by Blue Shield before you meet any Calendar Year Pharmacy Deductible. These outpatient prescription Drugs do not have a check mark (✔) next to them in the "CYPD applies" column in the Prescription Drug Benefits chart above.

2 Using Participating Pharmacies:

Participating Pharmacies have a contract to provide outpatient prescription Drugs to Members. When you obtain covered prescription Drugs from a Participating Pharmacy, you are only responsible for the Copayment or Coinsurance, once any Calendar Year Pharmacy Deductible has been met.

Participating Pharmacies and Drug Formulary. You can find a Participating Pharmacy and the Drug Formulary by visiting www.blueshieldca.com/pharmacy.

3 Using Non-Participating Pharmacies:

Non-Participating Pharmacies do not have a contract to provide outpatient prescription Drugs to Members. When you obtain prescription Drugs from a Non-Participating Pharmacy, you must pay all charges for the prescription, then submit a completed claim form for reimbursement. You will be reimbursed based on the price you paid for the Drug.

Notes

4 Outpatient Prescription Drug Coverage:

Medicare Part D-creditable coverage-

This prescription Drug coverage is on average equivalent to or better than the standard benefit set by the federal government for Medicare Part D (also called creditable coverage). Because this prescription Drug coverage is creditable, you do not have to enroll in Medicare Part D while you maintain this coverage; however, you should be aware that if you do not enroll in Medicare Part D within 63 days following termination of this coverage, you could be subject to Medicare Part D premium penalties.

5 Outpatient Prescription Drug Coverage:

Brand Drug coverage when a Generic Drug is available. If you select a Brand Drug when a Generic Drug equivalent is available, you are responsible for the difference between the cost to Blue Shield for the Brand Drug and its Generic Drug equivalent plus the Tier 1 Copayment or Coinsurance. This difference in cost will not count towards any Calendar Year Pharmacy Deductible, medical Deductible, or the Calendar Year Out-of-Pocket Maximum. If your Physician or Health Care Provider prescribes a Brand Drug and indicates that a Generic Drug equivalent should not be substituted, you pay your applicable tier Copayment or Coinsurance. If your Physician or Health Care Provider does not indicate that a Generic Drug equivalent should not be substituted, you may request a Medical Necessity Review. If approved, the Brand Drug will be covered at the applicable Drug tier Copayment or Coinsurance.

See the Obtaining outpatient prescription Drugs at a Participating Pharmacy section of the EOC for more information about how a brand contraceptive may be covered without a Copayment or Coinsurance.

Short-Cycle Specialty Drug program. This program allows initial prescriptions for select Specialty Drugs to be filled for a 15-day supply with your approval. When this occurs, the Copayment or Coinsurance will be pro-rated.

Specialty Drugs. Specialty Drugs are only available from a Network Specialty Pharmacy, up to a 30-day supply.

Oral Anticancer Drugs. You pay up to $250 for oral Anticancer Drugs from a Participating Pharmacy, up to a 30-day supply. Oral Anticancer Drugs from a Participating Pharmacy are not subject to any Deductible.

Mail service Drugs. You pay the applicable 30-day retail pharmacy Copayment or Coinsurance for a 30-day supply or less from the mail service pharmacy.

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