blue california

# Summary of Benefits

**Group Plan**
**HMO Plan**

## Bronze Access+ HMO® 7000/65 OffEx

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.

**Pharmacy Network:** **Rx Spectrum**

**Drug Formulary:** **Standard Formulary**

### 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.

| | | When using a Participating Provider[3] |
|---|---|---|
| **Calendar Year medical and pharmacy Deductible** | *Individual coverage* | $7,000 |
| *This Plan combines medical and pharmacy Deductibles into one Calendar Year Deductible* | *Family coverage* | $7,000: individual<br>$14,000: 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* | $11,650 |
| *Family coverage* | $11,650: individual<br>$23,300: 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.

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| 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 | $65/visit | |
| Access+ specialist care office visit (self-referral) | $85/visit | |
| Other specialist care office visit (referred by PCP) | $85/visit | |
| Physician home visit | $65/visit | |
| Physician or surgeon services in an Outpatient Facility | $150/visit | |
| Physician or surgeon services in an inpatient facility | 50% | |
| **Other professional services** | | |
| Other practitioner office visit<br>*Includes nurse practitioners, physician assistants, therapists, and podiatrists.* | $65/visit | |
| Acupuncture services | $15/visit | |
| Chiropractic services<br>*Up to 20 visits per Member, per Calendar Year.* | $15/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 | $150/visit | |
| **Pregnancy and maternity care** | | |
| Physician office visits: prenatal and initial postnatal | $0 | |
| Abortion and abortion-related services | $0 | |

| Benefits[5] | Your payment | |
|---|---|---|
| | **When using a Participating Provider[3]** | **CYD[2] applies** |
| **Emergency Services** | | |
| Emergency room services | 50% | ✔ |
| *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.* | | |
| Emergency room Physician services | 50% | ✔ |
| **Urgent care center services** | $65/visit | |
| **Ambulance services** | 50% | ✔ |
| *This payment is for emergency or authorized transport.* | | |
| **Outpatient Facility services** | | |
| Ambulatory Surgery Center | 50% | ✔ |
| Outpatient Department of a Hospital: surgery | 50% | ✔ |
| Outpatient Department of a Hospital: treatment of illness or injury, radiation therapy, chemotherapy, and necessary supplies | 50% | ✔ |
| **Inpatient facility services** | | |
| Hospital services and stay | 50% | ✔ |
| 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 | 50% | ✔ |
| • Physician inpatient services | 50% | |
| **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 | $65/visit | |
| • Outpatient Department of a Hospital | $65/visit | |
| Basic imaging services | | |
| *Includes plain film X-rays, ultrasounds, and diagnostic mammography.* | | |
| • Outpatient radiology center | $115/visit | ✔ |

| Benefits[5] | Your payment | |
|---|---|---|
| | **When using a Participating Provider[3]** | **CYD[2] applies** |
| • Outpatient Department of a Hospital | $115/visit | ✔ |
| Other outpatient non-invasive diagnostic testing<br>*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 | $115/visit | ✔ |
| • Outpatient Department of a Hospital | $115/visit | ✔ |
| Advanced imaging services<br>*Includes diagnostic radiological and nuclear imaging such as CT scans, MRIs, MRAs, and PET scans.* | | |
| • Outpatient radiology center | $400/visit | |
| • Outpatient Department of a Hospital | $400/visit | ✔ |
| **Rehabilitative and Habilitative Services**<br>*Includes Physical Therapy, Occupational Therapy, Respiratory Therapy, and Speech Therapy services. There is no visit limit for Rehabilitative or Habilitative Services.* | | |
| Office location | $70/visit | |
| Outpatient Department of a Hospital | $70/visit | |
| **Durable medical equipment (DME)** | | |
| DME | 50% | |
| Breast pump | $0 | |
| Orthotic equipment and devices | 50% | |
| Prosthetic equipment and devices | 50% | |
| **Home health care services**<br>*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.* | 50% | |
| **Home infusion and home injectable therapy services** | | |
| Home infusion agency services<br>*Includes home infusion drugs, medical supplies, and visits by a nurse.* | 50% | |
| Hemophilia home infusion services<br>*Includes blood factor products.* | 50% | |

| Benefits[5] | Your payment | |
|---|---|---|
| | When using a Participating Provider[3] | CYD[2] applies |
| **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 | 50% | ✔ |
| Hospital-based SNF | 50% | ✔ |
| **Hospice program services** | $0 | |
| *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.* | | |
| **Other services and supplies** | | |
| Diabetes care services | | |
| • Devices, equipment, and supplies | 50% | |
| • Self-management training | $0 | |
| • Medical nutrition therapy | $0 | |
| Dialysis services | 50% | |
| 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 | $65/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 | | |
| • Office location, clinic, home, or other non-institutional facility setting | $115/visit | |
| • Outpatient Department of a Hospital | $115/visit | |
| Office-based opioid treatment | $115/visit | |
| Partial Hospitalization Program | $115/visit | |
| Neuropsychological and Psychological Testing | $115/visit | |

| Mental Health or Substance Use Disorder Benefits | Your payment | |
|---|---|---|
| | When using a Participating Provider[3] | CYD[2] applies |
| **Inpatient services** | | |
| Physician inpatient services | 50% | |
| Hospital services | 50% | ✔ |
| Residential Care | 50% | ✔ |

| Prescription Drug Benefits[7,8] | Your payment | | |
|---|---|---|---|
| | When using a Participating Pharmacy[3] | | CYD[2] applies |
| | Level A | Level B | |
| **Retail pharmacy prescription Drugs** | | | |
| *Per prescription, up to a 30-day supply.* | | | |
| Contraceptive Drugs and devices | $0 | $0 | |
| Tier 1 Drugs | $25/prescription | $30/prescription | |
| Tier 2 Drugs | $115/prescription | $145/prescription | ✔ |
| Tier 3 Drugs | $160/prescription | $210/prescription | ✔ |
| Tier 4 Drugs | 50% up to $500/prescription | 50% up to $500/prescription | ✔ |
| **Retail pharmacy prescription Drugs** | | | |
| *Per prescription, for a 90-day supply.* | | | |
| Contraceptive Drugs and devices | $0 | $0 | |
| Tier 1 Drugs | $75/prescription | $90/prescription | |
| Tier 2 Drugs | $345/prescription | $435/prescription | ✔ |
| Tier 3 Drugs | $480/prescription | $630/prescription | ✔ |
| Tier 4 Drugs | 50% up to $1,500/prescription | 50% up to $1,500/prescription | ✔ |
| **Home delivery pharmacy prescription Drugs** | | | |
| *Per prescription, for a 31-90-day supply.* | | | |
| Contraceptive Drugs and devices | $0 | | |
| Tier 1 Drugs | $50/prescription | | |
| Tier 2 Drugs | $230/prescription | | ✔ |
| Tier 3 Drugs | $320/prescription | | ✔ |
| Tier 4 Drugs | 50% up to $1,000/prescription | | ✔ |

| Pediatric Benefits | Your payment | |
|---|---|---|
| *Pediatric Benefits are available through the end of the month in which the Member turns 19.* | **When using a Participating Dentist[3]** | **CYD[2] applies** |
| **Pediatric dental[9]** | | |
| Diagnostic and preventive services | | |
| • Oral exam | $0 | |
| • Preventive – cleaning | $0 | |
| • Preventive – x-ray | $0 | |
| • Sealants per tooth | $0 | |
| • Topical fluoride application | $0 | |
| • Space maintainers - fixed | $0 | |
| Basic services | | |
| • Restorative procedures | 20% | |
| • Periodontal maintenance | 20% | |
| • Adjunctive general services | 20% | |
| Major services | | |
| • Oral surgery | 50% | |
| • Endodontics | 50% | |
| • Periodontics (other than maintenance) | 50% | |
| • Crowns and casts | 50% | |
| • Prosthodontics | 50% | |
| Orthodontics (Medically Necessary) | 50% | |

| Pediatric Benefits | Your payment | |
|---|---|---|
| *Pediatric Benefits are available through the end of the month in which the Member turns 19.* | **When using a Participating Provider[3]** | **CYD[2] applies** |
| **Pediatric vision[10]** | | |
| Comprehensive eye examination | | |
| *One exam per Calendar Year.* | | |
| • Ophthalmologic visit | $0 | |
| • Optometric visit | $0 | |
| Contact lens fitting and evaluation | | |
| *When you choose contact lenses instead of eyeglasses, one per Member every 12 months by a Participating Provider if administered at the same time as the comprehensive exam. There is a maximum of two follow up visits.* | | |
| • Standard lenses | $0 | |
| • Non-standard lenses | All charges above $60 | |

| Pediatric Benefits | Your payment | |
|---|---|---|
| *Pediatric Benefits are available through the end of the month in which the Member turns 19.* | **When using a Participating Provider[3]** | **CYD[2] applies** |
| Eyewear/materials | | |
| *One eyeglass frame and eyeglass lenses, or contact lenses instead of eyeglasses, up to the Benefit per Calendar Year. Any exceptions are noted below.* | | |
| • Contact lenses | | |
| Non-elective (Medically Necessary) - hard or soft | $0 | |
| *Up to two pairs per eye per Calendar Year.* | | |
| Elective (cosmetic/convenience) | | |
| Standard and non-standard, hard | $0 | |
| *Up to a 3 month supply for each eye per Calendar Year based on lenses selected.* | | |
| Standard and non-standard, soft | $0 | |
| *Up to a 6 month supply for each eye per Calendar Year based on lenses selected.* | | |
| • Eyeglass frames | | |
| Collection frames | $0 | |
| Non-collection frames | All charges above $150 | |
| • Eyeglass lenses | | |
| *Lenses include choice of glass or plastic lenses, all lens powers (single vision, bifocal, trifocal, lenticular), fashion or gradient tint, scratch coating, oversized, and glass-grey #3 prescription sunglasses.* | | |
| Single vision | $0 | |
| Lined bifocal | $0 | |
| Lined trifocal | $0 | |
| Lenticular | $0 | |
| Optional eyeglass lenses and treatments | | |
| • Ultraviolet protective coating (standard only) | $0 | |
| • Polycarbonate lenses | $0 | |
| • Standard progressive lenses | $55 | |
| • Premium progressive lenses | $95 | |
| • Anti-reflective lens coating (standard only) | $35 | |
| • Photochromic - glass lenses | $25 | |
| • Photochromic - plastic lenses | $25 | |
| • High index lenses | $30 | |
| • Polarized lenses | $45 | |
| Low vision testing and equipment | | |
| • Comprehensive low vision exam | 35% | |
| *Once every 5 Calendar Years.* | | |

| Pediatric Benefits | Your payment | |
|---|---|---|
| *Pediatric Benefits are available through the end of the month in which the Member turns 19.* | **When using a Participating Provider[3]** | **CYD[2] applies** |
| • Low vision devices<br>*One aid per Calendar Year.* | 35% | |

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

*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. Any amount you have paid toward the individual Deductible will be applied to both the individual Deductible and the Family Deductible.

**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.

*Any Deductibles count towards the OOPM.* Any amounts you pay that count towards the Calendar Year combined medical and pharmacy Deductible also count towards the Calendar Year Out-of-Pocket 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. Any amount you have paid toward the individual OOPM will be applied to both the individual OOPM and the Family OOPM.

**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.

**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.

**7 Outpatient Prescription Drug Coverage:**

**Medicare Part D-creditable coverage-**

This Plan's 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 plan's 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.

**8 Outpatient Prescription Drug Coverage:**

*Brand Drug coverage when a Generic or Biosimilar Drug is available.* If you, the Physician, or Health Care Provider, select a Brand Drug when a Generic Drug equivalent or Biosimilar Drug is available, you are responsible for the difference between the cost to Blue Shield for the Brand Drug and its Generic Drug equivalent or Biosimilar Drug plus the applicable tier Copayment or Coinsurance of the Brand Drug. This difference in cost will not count towards any Calendar Year pharmacy Deductible, medical Deductible, or the Calendar Year Out-of-Pocket Maximum.

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.

*Request for Medical Necessity Review.* If you or your Physician believes a Brand Drug is Medically Necessary, either person may request a Medical Necessity Review. If approved, the Brand Drug will be covered at the applicable Drug tier 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.

*Retail pharmacy.* You may receive up to a 90-day supply for maintenance Drugs at a Participating Pharmacy when you pay the applicable Copayment or Coinsurance for each 30-day supply.

*Participating Pharmacies*. Blue Shield has two participation levels for retail pharmacies; Level A and Level B. You can go to any Level A or Level B pharmacy to obtain covered Drugs.

*Home delivery.* You pay the applicable 30-day retail pharmacy Copayment or Coinsurance for a 30-day supply or less from the home delivery pharmacy.

*Insulin.* You will not pay more than $35 for a 30-day supply of Formulary insulin Prescription Drugs from a Participating Pharmacy.

## Notes

**9 Pediatric Dental Coverage:**

*Pediatric dental Benefits are provided through Blue Shield's Dental Plan Administrator (DPA).*

*Orthodontic Covered Benefits.* The Copayment or Coinsurance for Medically Necessary orthodontic Covered Benefits applies to a course of treatment even if it extends beyond a Calendar Year. This applies as long as the Member remains enrolled in the Plan.

*This plan is compliant with requirements of the pediatric dental EHB benchmark plan, including coverage of services in circumstances of Medical Necessity as defined in the Early Periodic Screening, Diagnosis and Treatment (EPSDT) benefit.*

**10 Pediatric Vision Coverage:**

*Pediatric vision Benefits are provided through Blue Shield's Vision Plan Administrator (VPA).*

*Coverage for frames.* If frames are selected that are more expensive than the Allowable Amount established for frames under this Benefit, you pay the difference between the Allowable Amount and the provider's charge.

"Collection frames" are covered with no Member payment from Participating Providers. Retail chain Participating Providers do not usually display the frames as "collection," but a comparable selection of frames is maintained.

"Non-collection frames" are covered up to an Allowable Amount of $150; however, if the Participating Provider uses:

- wholesale pricing, then the Allowable Amount will be up to $103.64.

Participating Providers using wholesale pricing are identified in the provider directory.

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