blue of california

Summary of Benefits

San Francisco Health Service System Fund (CCSF)
Effective January 1, 2022
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 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	*Individual coverage*	$250	$250
	Family coverage	$250: individual	$250: individual
		$750: Family	$750: 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 any combination of Participating[3] or Non-Participating[4] Providers	When using any combination of Participating[3] or Non-Participating[4] Providers
Individual coverage	$3,750	$3,750
Family coverage	$3,750: individual	$3,750 per individual
	$7,500: Family	

No Annual or Lifetime Dollar Limit

Under this Plan there is no annual or lifetime dollar limit on the amount Claims Administrator will pay for Covered Services.

Benefits[6]	Your payment			
	When using a Participating Provider[3]	CYD[2] applies	When using a Non-Participating Provider[4]	CYD[2] applies
Preventive Health Services[7]				
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 *Includes nurse practitioners, physician assistants, and therapists.*	15%	✔	15%	✔
Acupuncture services *Up to $1,000 maximum per Member, per Calendar Year.*	50%	✔	50%	✔
Chiropractic services *Up to $1,000 maximum per Member, per Calendar Year.*	50%	✔	50%	✔
Teladoc consultation	15%	✔	Not covered	
Nutritional counseling *Up to 4 visits per Member, per Calendar Year.*	15%	✔	15%	✔
Podiatric services	15%	✔	15%	✔
Family planning				
• Counseling, consulting, and education	$0		15%	✔
• Injectable contraceptive	$0		15%	✔
• Diaphragm fitting	$0		15%	✔
• Intrauterine device (IUD)	$0		15%	✔
• Insertion and/or removal of intrauterine device (IUD)	$0		15%	✔
• Implantable contraceptive	$0		15%	✔
• Tubal ligation	$0		15%	✔
• Vasectomy	15%	✔	15%	✔
• Diagnosis and Treatment of the Cause of Infertility	15%	✔	15%	✔

Benefits[6]	Your payment			
	When using a Participating Provider[3]	CYD[2] applies	When using a Non-Participating Provider[4]	CYD[2] applies
Infertility Services				
• Natural or stimulated artificial inseminations *Limited to 6 procedures per lifetime.*	50%		50%	
• Gamete intrafallopian transfer (GIFT), zygote intrafallopian transfer (ZIFT), or in vitro fertilization (IVF)[8] *Limited to 2 procedures per lifetime.*	50%		50%	
• Intracytoplasmic sperm injection (ICSI)	50%		50%	
• Embryo transportation related network disruption[9] *Limited to 1 instance and within the 1 year of storage. Up to $500 maximum.*	50%		50%	
• Testicular sperm aspiration/microsurgical epididymal sperm aspiration (TESA/MESA) - male factor associated surgical procedures for retrieval of sperm *Limited to 1 procedure per lifetime.*	50%		50%	
• Electroejaculation	50%		50%	
• Embryo biopsy for preimplantation screening (PGS) or diagnosis (PGD)	50%		50%	
• Cryopreservation of sperm, oocytes, ovarian tissue, testicular tissue, embryos *Limited to 1 retrieval and 1 year of storage per lifetime.*	50%		50%	
Pregnancy and maternity care				
Physician office visits: prenatal and postnatal	15%	✔	15%	✔
Physician services for pregnancy termination	15%	✔	15%	✔
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.*	15%	✔	15%	✔
Emergency room services for a non-emergency medical condition[5]	50%	✔	50%	✔
Emergency room Physician services	15%	✔	15%	✔

Benefits[6]	Your payment			
	When using a Participating Provider[3]	CYD[2] applies	When using a Non-Participating Provider[4]	CYD[2] applies
Urgent care center services	15%	✔	15%	✔
Ambulance services *This payment is for emergency or authorized transport.*	15%	✔	15%	✔
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 *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	15%	✔	Not covered	
• Physician inpatient services	15%	✔	Not covered	
Bariatric surgery services *Participating Provider benefits for bariatric surgery services are limited to $60,000 during the entire period you are covered under the Plan.* *Non-Participating Provider benefits for bariatric surgery services are limited to $10,000 during the entire period you are covered under the Plan.*				
Inpatient facility services	15%	✔	15%	✔
Outpatient Facility services	15%	✔	15%	✔
Physician services	15%	✔	15%	✔

Benefits[6]	Your payment			
	When using a Participating Provider[3]	CYD[2] applies	When using a Non-Participating Provider[4]	CYD[2] applies
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, such as CT scans, MRIs, MRAs, and PET scans. For the payments for Covered Services that are considered Preventive Health Services, see Preventive Health Services.				
Laboratory services				
Includes diagnostic Papanicolaou (Pap) test.				
• Laboratory center	15%	✔	15%	✔
• Outpatient Department of a Hospital	15%	✔	15%	✔
X-ray and imaging services				
Includes diagnostic mammography.				
• Outpatient radiology center	15%	✔	15%	✔
• Outpatient Department of a Hospital	15%	✔	15%	✔
Other outpatient diagnostic testing				
Testing to diagnose illness or injury such as vestibular function tests, EKG, ECG, cardiac monitoring, non-invasive vascular studies, sleep medicine testing, muscle and range of motion tests, EEG, and EMG.				
• Office location	15%	✔	15%	✔
• Outpatient Department of a Hospital	15%	✔	15%	✔
Radiological and nuclear imaging services				
• Outpatient radiology center	15%	✔	15%	✔
• Outpatient Department of a Hospital	15%	✔	15%	✔
Rehabilitative and Habilitative Services				
Includes physical therapy, occupational therapy, and respiratory therapy.				
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%	✔
Durable medical equipment (DME)				
DME	15%	✔	15%	✔

Benefits[6]	Your payment			
	When using a Participating Provider[3]	CYD[2] applies	When using a Non-Participating Provider[4]	CYD[2] applies
Breast pump	$0		15%	✔
Orthotic equipment and devices	15%	✔	15%	✔
Prosthetic equipment and devices	15%	✔	15%	✔
Home health care services *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.*	15%	✔	15%	✔
Home infusion and home injectable therapy services				
Home infusion agency services *Includes home infusion drugs and medical supplies.*	15%	✔	15%	✔
Home visits by an infusion nurse	15%	✔	15%	✔
Hemophilia home infusion services *Includes blood factor products.*	15%	✔	15%	✔
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%	✔

Benefits[6]	Your payment			
	When using a Participating Provider[3]	CYD[2] applies	When using a Non-Participating Provider[4]	CYD[2] 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	15%	✔	15%	✔
• Devices, equipment, and supplies				
• Self-management training	15%	✔	15%	✔
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 *Up to $2,500 maximum per ear, per Member, per 36 months.*	15%		15%	
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 Provider[3]	CYD[2] applies	When using a Non-Participating Provider[4]	CYD[2] 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%	✔
Behavioral Health Treatment in home or other non-institutional setting	15%	✔	15%	✔
Office-based opioid treatment	15%	✔	15%	✔
Partial Hospitalization Program	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
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:

- Radiological and nuclear imaging services
- Outpatient mental health services, except office visits
- 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.

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.

Notes

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 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 medical Calendar Year Deductible or Calendar Year Pharmacy 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 Fresh or Frozen Transfer Cycles:

Embryo, gamete or zygote fresh or frozen transfer cycles must be received in conjunction with any of the following Covered Services: in-vitro fertilization (IVF), gamete intrafallopian transfer (GIFT), or zygote intrafallopian transfer (ZIFT).

9 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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Outpatient Prescription Drug Benefit

San Francisco Health Service System Fund (CCSF) - ASO PPO
Effective January 1, 2022
PPO

Enhanced Rx $10/25/50 with $0 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 the Claims Administrator pays for covered Drugs under the outpatient prescription Drug Benefit. The Claims Administrator 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*	$0

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 (mostly preferred Generic Drugs and some Brand Drugs)	$10/prescription		50% plus $10/prescription	
Tier 2 Drugs (mostly preferred Brand Drugs and some Generic Drugs)	$25/prescription		50% plus $25/prescription	
Tier 3 Drugs (non-preferred Generic and non-preferred Brand Drugs)	$50/prescription		50% plus $50/prescription	
Tier 4 Drugs (Speciality and high-cost Drugs)	$50/prescription		50% plus $50/prescription	
Mail service pharmacy prescription Drugs				
Per prescription, up to a 90-day supply.				
Contraceptive Drugs and devices	$0		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 1 Drugs (mostly preferred Generic Drugs and some Brand Drugs)	$20/prescription		Not covered	
Tier 2 Drugs (mostly preferred Brand Drugs and some Generic Drugs)	$50/prescription		Not covered	
Tier 3 Drugs (non-preferred Generic and non-preferred Brand Drugs)	$100/prescription		Not covered	
Tier 4 Drugs (high-cost Drugs)	$100/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 the Claims Administrator 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 the Claims Administrator 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.

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

Notes

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 the Claims Administrator 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.

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.

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

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