blue of california

Summary of Benefits

San Francisco Health Service System
Effective January 1, 2025
PPO Plan

PPO COB

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.

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 any combination of Participating[3] or Non-Participating[4] Providers
Individual coverage	$3,750
Family coverage	$3,750: individual
	$11,250: 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.

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	
California Prenatal Screening Program (available in California only)	$0		$0	
Physician services				
Primary care office visit	$5/visit		$5/visit	
Specialist care office visit	$15/visit		$15/visit	
Physician services provided via telehealth	$0		$0	
Physician home visit	$0		$0	
Physician or surgeon services in an Outpatient Facility	$0		$0	
Physician or surgeon services in an inpatient facility	$0		$0	
Ophthalmologist or optometrist office visit (for diagnosis and treatment of diseases and injuries of the eye)	$5/visit		$5/visit	
Ophthalmologist or optometrist office visit (for diagnosis and treatment of diseases and injuries of the eye)- Specialist	$15/visit		$15/visit	
Other professional services				
Other practitioner office visit *Includes nurse practitioners, physician assistants, therapists, and podiatrists.*	$5/visit		$5/visit	
Acupuncture services *Up to 44 visits per Member, per Calendar Year.*	$15/visit		$15/visit	
Chiropractic services *Up to 44 visits per Member, per Calendar Year.*	$15/visit		$15/visit	
Other professional services provided via telehealth	$0		$0	
Teladoc consultation	$0		Not covered	
Family planning				
• Counseling, consulting, and education	$0		$0	
• Injectable contraceptive, diaphragm fitting, intrauterine device (IUD), implantable contraceptive, and related procedure.	$0		$0	
• Tubal ligation	$0		$0	
• Vasectomy	$0		$0	
Medical nutrition therapy, not related to diabetes	$0		$0	
Pregnancy and maternity care				
Physician office visits: prenatal and postnatal	$0		$0	

Benefits[6]	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.*	$65/visit		$65/visit	
Emergency room Physician services	$0		$0	
Urgent care center services	$20/visit		$20/visit	
Ambulance services *This payment is for emergency or authorized transport.*	$50/transport		$50/transport	
Outpatient Facility services				
Ambulatory Surgery Center	$100/surgery		$100/surgery	
Outpatient Department of a Hospital: surgery	$100/surgery		$100/surgery	
Outpatient Department of a Hospital: treatment of illness or injury, radiation therapy, chemotherapy, and necessary supplies	$0		$0	
Outpatient Department of a Hospital: cardiac rehabilitation	$20/visit		$20/visit	
Outpatient Department of a Hospital: pulmonary rehabilitation	$15/visit		$15/visit	
Inpatient facility services				
Hospital services and stay	$150/admission		$150/admission	
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	$150/admission		Not covered	
• Physician inpatient services	$0		Not covered	

Benefits[6]	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	$150/admission		Not covered	
Outpatient Facility services	$100/surgery		Not covered	
Physician services	$0		Not covered	
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				
Includes diagnostic Papanicolaou (Pap) test.				
• Laboratory center	$0		$0	
• Outpatient Department of a Hospital	$0		$0	
Basic imaging services				
Includes plain film X-rays, ultrasounds, and diagnostic mammography.				
• Outpatient radiology center	$0		$0	
• Outpatient Department of a Hospital	$0		$0	
Other outpatient non-invasive diagnostic testing				
Testing to diagnose illness or injury such as vestibular function tests, EKG, cardiac monitoring, non-invasive vascular studies, sleep medicine testing, muscle and range of motion tests, peripheral artery disease supervised exercise therapy, EEG, and EMG.				
• Office location	$25/visit		$25/visit	
• Outpatient Department of a Hospital	$25/visit		$25/visit	

Benefits[6]	Your payment			
	When using a Participating Provider[3]	CYD[2] applies	When using a Non-Participating Provider[4]	CYD[2] applies
Glaucoma screening	$0		$0	
Diabetic retinopathy screening	$15/visit		$15/visit	
Advanced imaging services *Includes diagnostic radiological and nuclear imaging such as CT scans, MRIs, MRAs, and PET scans.*				
• Outpatient radiology center	$25/visit		$25/visit	
• Outpatient Department of a Hospital	$25/visit		$25/visit	
Rehabilitative and Habilitative Services *Includes physical therapy, occupational therapy, respiratory therapy, and speech therapy services.*				
Office location	$15/visit		$15/visit	
Outpatient Department of a Hospital	$15/visit		$15/visit	
Durable medical equipment (DME)				
DME	$15/item		$15/item	
Breast pump	$0		$0	
Orthotic equipment and devices	$0		$0	
Prosthetic equipment and devices	$0		$0	
Glasses, after cataract surgery	$0		$0	
Home health care services	$0		$0	
Home infusion and home injectable therapy services				
Home infusion agency services *Includes home infusion drugs, medical supplies, and visits by a nurse.*	$0		$0	
Hemophilia home infusion services *Includes blood factor products.*	$0		$0	
Skilled Nursing Facility (SNF) services *Up to 100 days per Member, per benefit period, except when provided as part of a Hospice program. All days count towards the limit, including days during any applicable Deductible period and days in different SNFs during the Calendar Year.*				
Freestanding SNF	$0		$0	
Hospital-based SNF	$0		$0	

Benefits[6]	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		$0	
Other services and supplies				
Diabetes care services				
• Devices, equipment, and supplies	$0		$0	
• Self-management training	$0		$0	
• Medical nutrition therapy	$0		$0	
Dialysis services	$0		$0	
PKU product formulas and special food products	$0		$0	
Allergy serum billed separately from an office visit	$0		$0	
Hearing aid services				
• Hearing aids and equipment *Up to $2,500 maximum per ear, per Member, per 36-month period.*	$0		$0	
Eye examination *One comprehensive eye examination in a consecutive 12-month period provided through the contracted Vision Plan Administrator (VPA).*				
• Ophthalmologic exam	$15/visit		$15/visit	
• Optometric exam	$15/visit		$15/visit	

Mental Health and Substance Use Disorder Benefits	Your payment			
Mental health and substance use disorder Benefits are provided through Blue Shield's Mental Health Service 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	$5/visit		$5/visit	
Mental Health and Substance Use Disorder professional services provided via telehealth	$0		$0	
Teladoc mental health	$0		Not covered	
Other outpatient services, including intensive outpatient care, electroconvulsive therapy, transcranial magnetic stimulation, Behavioral Health Treatment for pervasive developmental disorder or autism in an office setting, home, or other non-institutional facility setting, and office-based opioid treatment	$0		$0	

Mental Health and Substance Use Disorder Benefits	Your payment			
Mental health and substance use disorder Benefits are provided through Blue Shield's Mental Health Service Administrator (MHSA).	**When using a MHSA Participating Provider[3]**	**CYD[2] applies**	**When using a MHSA Non-Participating Provider[4]**	**CYD[2] applies**
Partial Hospitalization Program	$0		$0	
Psychological Testing	$0		$0	
Inpatient services				
Physician inpatient services	$0		$0	
Hospital services	$150/admission		$150/admission	
Residential Care	$150/admission		$150/admission	

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.

Notes

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.

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 combined Participating Provider 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 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.

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.

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

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