blue of california

EIA/City of Redding
Effective January 1, 2020
PPO Plan

Summary of Benefits

Base PPO 3500

This Summary of Benefits shows the amount you will pay for Covered Services under this Claims Administrator benefit plan. It is only a summary and it is included as part of the Benefit Booklet.[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 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[3] or Non-Participating[4] Provider
Calendar Year medical Deductible	*Individual coverage*	$500
	Family coverage	$500: individual
		$1,000: 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 a Non-Participating Provider[4]
Individual coverage	$3,500	$ None
Family coverage	$3,500: individual	$ None: individual
	$7,000: Family	$ None: 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		40%	✔
Physician services				
Primary care office visit	$20/visit		40%	✔
Specialist care office visit	$20/visit		40%	✔
Physician home visit	20%	✔	40%	✔
Physician or surgeon services in an outpatient facility	20%	✔	40%	✔
Physician or surgeon services in an inpatient facility	20%	✔	40%	✔
Other professional services				
Other practitioner office visit	$20/visit		40%	✔
Includes nurse practitioners, physician assistants, and therapists.				
Acupuncture services	20%	✔	20%	✔
Combined with Chiropractic services, up to 15 visits per Member, per Calendar Year.				
Chiropractic services	20%	✔	40%	✔
Combined with Acupuncture services, up to 15 visits per Member, per Calendar Year.				
Teladoc consultation	$20/consult		Not covered	
Family planning				
• Counseling, consulting, and education	$0		40%	✔
• Injectable contraceptive	$0		40%	✔
• Diaphragm fitting	$0		40%	✔
• Intrauterine device (IUD)	$0		40%	✔
• Insertion and/or removal of intrauterine device (IUD)	$0		40%	✔
• Implantable contraceptive	$0		40%	✔
• Tubal ligation	$0		40%	✔
• Vasectomy	20%	✔	40%	✔
Podiatric services	$20/visit		40%	✔
Pregnancy and maternity care[7]				
Physician office visits: prenatal and postnatal	20%	✔	40%	✔
Physician services for pregnancy termination	20%	✔	40%	✔

Benefits[6]	Your payment			
	When using a Participating Provider[3]	CYD[2] applies	When using a Non-Participating Provider[4]	CYD[2] applies
Emergency services				
Emergency room services	$50/visit plus 20%		$50/visit plus 20%	
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	20%	✔	20%	✔
Urgent care center services	$20/visit		40%	✔
Ambulance services	20%	✔	20%	✔
This payment is for emergency or authorized transport.				
Outpatient facility services				
Ambulatory Surgery Center	20%	✔	40% of up to $350/day plus 100% of additional charges	✔
Outpatient Department of a Hospital: surgery	20%	✔	40% of up to $350/day plus 100% of additional charges	✔
Outpatient Department of a Hospital: treatment of illness or injury, radiation therapy, chemotherapy, and necessary supplies	20%	✔	40% of up to $350/day plus 100% of additional charges	✔
Inpatient facility services				
Hospital services and stay	20%	✔	40% of up to $600/day plus 100% of additional charges	✔
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	20%	✔	Not covered	
• Physician inpatient services	20%	✔	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	20%	✔	Not covered	
Outpatient facility services	20%	✔	Not covered	
Physician services	20%	✔	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, 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	20%	✔	40%	✔
• Outpatient Department of a Hospital	20%	✔	40% of up to $350/day plus 100% of additional charges	✔
X-ray and imaging services				
Includes diagnostic mammography.				
• Outpatient radiology center	20%	✔	40%	✔
• Outpatient Department of a Hospital	20%	✔	40% of up to $350/day plus 100% of additional charges	✔

Benefits[6]	Your payment			
	When using a Participating Provider[3]	CYD[2] applies	When using a Non-Participating Provider[4]	CYD[2] applies
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	20%	✔	40%	✔
• Outpatient Department of a Hospital	20%	✔	40% of up to $350/day plus 100% of additional charges	✔
Radiological and nuclear imaging services				
• Outpatient radiology center	20%	✔	40% of up to $800/day plus 100% of additional charges	✔
• Outpatient Department of a Hospital	20%	✔	40% of up to $350/day plus 100% of additional charges	✔
Rehabilitative and Habilitative Services				
Includes Physical Therapy, Occupational Therapy, and Respiratory Therapy.				
Office location	20%	✔	40%	✔
Outpatient Department of a Hospital	20%	✔	40% of up to $350/day plus 100% of additional charges	✔
Speech Therapy services				
Office location	20%	✔	40%	✔
Outpatient Department of a Hospital	20%	✔	40% of up to $350/day plus 100% of additional charges	✔
Durable medical equipment (DME)				
DME	20%	✔	40%	✔
Breast pump	$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
Orthotic equipment and devices	20%	✔	40%	✔
Prosthetic equipment and devices	20%	✔	40%	✔
Home health care services	20%	✔	Not covered	
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.				
Home infusion and home injectable therapy services				
Home infusion agency services	20%	✔	Not covered	
Includes home infusion drugs and medical supplies.				
Home visits by an infusion nurse	20%	✔	Not covered	
Hemophilia home infusion services	20%	✔	Not covered	
Includes blood factor products.				
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% of up to $600/day plus 100% of additional charges	✔
Hospice program services				
Pre-Hospice consultation	$0	✔	Not covered	
Routine home care	$0	✔	Not covered	
24-hour continuous home care	20%	✔	Not covered	
Short-term inpatient care for pain and symptom management	20%	✔	Not covered	
Inpatient respite care	$0	✔	Not covered	
Other services and supplies				
Diabetes care services				
• Devices, equipment, and supplies	20%	✔	40%	✔

Benefits[6]	Your payment			
	When using a Participating Provider[3]	CYD[2] applies	When using a Non-Participating Provider[4]	CYD[2] applies
• Self-management training	$20/visit		40%	✔
Dialysis services	20%	✔	40% of up to $300/day plus 100% of additional charges	✔
PKU product formulas and Special Food Products	20%	✔	20%	✔
Allergy serum billed separately from an office visit	20%	✔	40%	✔
Hearing services				
• Hearing aids and equipment *Up to $1000 combined maximum per Member, per 24 months.*	20%	✔	40%	✔
• Audiological evaluations	20%	✔	40%	✔

Mental Health 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	$20/visit		40%	✔
Teladoc behavioral health consultation	$20/consult		Not covered	
Intensive outpatient care	20%	✔	40%	✔
Behavioral Health Treatment in an office setting	Not covered		Not covered	
Behavioral Health Treatment in home or other non-institutional setting	Not covered		Not covered	
Partial Hospitalization Program	20%	✔	40% of up to $350/day plus 100% of additional charges	✔
Psychological Testing	20%	✔	40%	✔
Inpatient services				
Physician inpatient services	20%	✔	40%	✔
Hospital services	20%	✔	40% of up to $600/day plus 100% of additional charges	✔

Mental Health Benefits

	Your payment			
	When using a Participating Provider[3]	CYD[2] applies	When using a Non-Participating Provider[4]	CYD[2] applies
Residential Care	20%	✔	40% of up to $600/day plus 100% of additional charges	✔

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 combined Participating Provider and Non-Participating Provider Calendar Year 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 or Benefit maximum, whichever is less.

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, or
- any charges above the stated dollar amount, which is the Benefit maximum.

"Allowable Amount" is defined in the Benefit Booklet. In addition:

- Coinsurance is calculated from the Allowable Amount or Benefit maximum, whichever is less.
- Charges above the Allowable Amount or Benefit maximum 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):

Your payment after you reach the Calendar Year OOPM. You will continue to pay all charges above a Benefit maximum.

Essential health benefits count towards the OOPM.

Any Deductibles count towards the OOPM. Any amounts you pay that count towards the medical Calendar Year Deductible also count towards the Calendar Year Out-of-Pocket Maximum.

This Plan has a separate Participating Provider OOPM 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 Copayment in addition to an allergy serum Copayment 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 by a Participating Provider. 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 Federal requirements.