blue of california

Summary of Benefits

Municipalities, Colleges, Schools Insurance Group (MCSIG)
Effective January 1, 2022
PPO Plan

PPO 60

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.

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	*Per member*	$5,000

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]
Per member	$6,350	Unlimited

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		Not covered	
Physician services				
Primary care office visit	$60/visit	✔	Not covered	
Specialist care office visit	$70/visit	✔	Not covered	
Office visit for allergy serum injection	30%	✔	Not covered	
Physician home visit	$60/visit	✔	Not covered	
Physician or surgeon services in an Outpatient Facility	30%	✔	Not covered	
Physician or surgeon services in an inpatient facility	30%	✔	Not covered	
Other professional services				
Other practitioner office visit *Includes nurse practitioners, physician assistants, and therapists.*	$60/visit	✔	Not covered	
Acupuncture services *Up to a $2,000 maximum per Member, per Calendar Year.*	$0		$0	
Teladoc consultation	$0		Not covered	
Teladoc dermatology consultation	$0		Not covered	
Family planning				
• Counseling, consulting, and education	$0		Not covered	
• Injectable contraceptive	$0		Not covered	
• Diaphragm fitting	$0		Not covered	
• Intrauterine device (IUD)	$0		Not covered	
• Insertion and/or removal of intrauterine device (IUD)	$0		Not covered	
• Implantable contraceptive	$0		Not covered	
• Tubal ligation	$0		Not covered	
• Vasectomy	30%	✔	Not covered	
• Diagnosis and Treatment of the Cause of Infertility	Not covered		Not covered	
Podiatric services	$70/visit	✔	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
Pregnancy and maternity care *Pregnancy and maternity care services are covered the same as any other Covered Service.* *See the Pregnancy and Maternity Care Benefits section of your Benefit Booklet for more information about your benefits.*				
Physician office visits: prenatal and postnatal	30%	✔	Not covered	
Physician services for pregnancy termination	30%	✔	Not covered	
Emergency Services *For Emergency services performed on a non-emergency basis, you are responsible for a $500 penalty in addition to your Emergency services cost share.*				
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.*	30%	✔	30%	✔
Emergency room Physician services	30%	✔	30%	✔
Urgent care center services	$60/visit	✔	Not covered	
Ambulance services *This payment is for emergency or authorized transport.*	30%	✔	30%	✔
BridgeHealth surgery program[8] *The surgery program is administered by BridgeHealth. This program is not administered by Blue Shield. For more information, call BridgeHealth customer service at (888) 387-3909.*	$0		$0	
Outpatient Facility services				
Ambulatory Surgery Center	15%	✔	Not covered	
Outpatient Department of a Hospital: surgery	30%	✔	Not covered	
Outpatient Department of a Hospital: treatment of illness or injury, radiation therapy, chemotherapy, and necessary supplies	30%	✔	Not covered	
Inpatient facility services				
Hospital services and stay	30%	✔	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
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	30%	✔	Not covered	
• Physician inpatient services	30%	✔	Not covered	
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	30%	✔	Not covered	
Outpatient Facility services	30%	✔	Not covered	
Physician services	30%	✔	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	30%	✔	Not covered	
• Outpatient Department of a Hospital	30%	✔	Not covered	
X-ray and imaging services				
Includes diagnostic mammography.				
• Independent (non-hospital owned) radiology center	$0	✔	Not covered	
• Outpatient Department of a Hospital	30%	✔	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
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	30%	✔	Not covered	
• Outpatient Department of a Hospital	30%	✔	Not covered	
Radiological and nuclear imaging services				
• Independent (non-hospital owned) radiology center	$0	✔	Not covered	
• Outpatient Department of a Hospital	30%	✔	Not covered	
Rehabilitative and Habilitative Services *Includes physical therapy, occupational therapy, and respiratory therapy.*				
Office location	30%	✔	Not covered	
Outpatient Department of a Hospital	30%	✔	Not covered	
Speech Therapy services				
Office location	30%	✔	Not covered	
Outpatient Department of a Hospital	30%	✔	Not covered	
Durable medical equipment (DME)				
DME	30%	✔	Not covered	
Breast pump	$0		Not covered	
Orthotic equipment and devices	30%	✔	Not covered	
Prosthetic equipment and devices	30%	✔	Not covered	
Home health care services *Up to 120 days 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.*	30%	✔	Not covered	
Home infusion and home injectable therapy services				
Home infusion agency services *Includes home infusion drugs and medical supplies.*	30%	✔	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
Home visits by an infusion nurse	30%	✔	Not covered	
Hemophilia home infusion services *Includes blood factor products.*	30%	✔	Not covered	
Skilled Nursing Facility (SNF) services *Up to 365 days per Member, per lifetime, 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	30%	✔	Not covered	
Hospital-based SNF	30%	✔	Not covered	
Hospice program services				
Pre-Hospice consultation	$0	✔	$0	✔
Routine home care	$0	✔	$0	✔
24-hour continuous home care	$0	✔	$0	✔
Short-term inpatient care for pain and symptom management	$0	✔	$0	✔
Inpatient respite care	$0	✔	$0	✔
Other services and supplies				
Diabetes care services				
• Devices, equipment, and supplies	30%	✔	Not covered	
• Self-management training *Up to a $250 maximum per Member, per Calendar Year.*	$0		Not covered	
Dialysis services	30%	✔	Not covered	
PKU product formulas and special food products	30%	✔	Not covered	
Allergy serum billed separately from an office visit	30%	✔	Not covered	
Travel immunizations and vaccinations	$0		Not covered	
Wigs	30%	✔	Not covered	

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	$60/visit		Not covered	

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
Teladoc behavioral health	$0		Not covered	
Intensive outpatient care	30%	✔	Not covered	
ABA Behavioral Health Treatment in an office setting	$70/visit	✔	Not covered	
ABA Behavioral Health Treatment in home or other non-institutional setting	$70/visit	✔	Not covered	
Office-based opioid treatment	30%	✔	Not covered	
Partial Hospitalization Program	30%	✔	Not covered	
Psychological Testing	30%	✔	Not covered	
Inpatient services				
Physician inpatient services	30%	✔	Not covered	
Hospital services	30%	✔	Not covered	
Residential Care	30%	✔	Not covered	

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.

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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.

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 (behavioral health) consultations are provided through Teladoc.

"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.

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 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,

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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.

8 BridgeHealth surgery program:

There is no Copayment or Coinsurance for services performed through the BridgeHealth surgery program. These services are not subject to the Calendar Year Deductible.

Plans may be modified to ensure compliance with Federal requirements.

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