blue of california

Summary of Benefits

EXELIXIS, INC.
Effective January 1, 2025
PPO Savings Plan

ASO Custom Full PPO Savings 1650/3300/3300

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.

Pharmacy Network: **Rx Ultra**

Drug Formulary: **Plus Formulary**

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 and pharmacy Deductible	*Individual coverage*	$1,650	$1,650
This Plan combines medical and pharmacy Deductibles into one Calendar Year Deductible	*Family coverage*	$3,300: individual $3,300: Family	$3,300: individual $3,300: 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	$2,500	$2,500
Family coverage	$4,500: individual $4,500: Family	$4,500: individual $4,500: 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		20%	✔
Physician services				
Primary care office visit	$0	✔	20%	✔
Specialist care office visit	$0	✔	20%	✔
Physician home visit	$0	✔	20%	✔
Physician or surgeon services in an Outpatient Facility	$0	✔	20%	✔
Physician or surgeon services in an inpatient facility	$0	✔	20%	✔
Other professional services				
Other practitioner office visit	$0	✔	20%	✔
Includes nurse practitioners, physician assistants, and therapists.				
Acupuncture services	$0	✔	20%	✔
Up to 20 visits per Member, per Calendar Year.				
Chiropractic services	$0	✔	20%	✔
Up to 20 visits per Member, per Calendar Year.				
Teladoc consultation	$0	✔	Not covered	
Family planning				
• Counseling, consulting, and education	$0		20%	✔
• Injectable contraceptive	$0		20%	✔
• Diaphragm fitting	$0		20%	✔
• Intrauterine device (IUD)	$0		20%	✔
• Insertion and/or removal of intrauterine device (IUD)	$0		20%	✔
• Implantable contraceptive	$0		20%	✔
• Tubal ligation	$0		20%	✔
• Vasectomy	$0	✔	Not covered	
• Diagnosis and Treatment of the Cause of Infertility	$0	✔	20%	✔
Podiatric services	$0	✔	20%	✔
Medical nutrition therapy, not related to diabetes	$0	✔	20%	✔
Pregnancy and maternity care				
Physician office visits: prenatal and postnatal	$0	✔	20%	✔
Physician services for pregnancy termination	$0	✔	20%	✔

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 *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.*	$0	✔	$0	✔
Emergency room Physician services	$0	✔	$0	✔
Urgent care center services	$0	✔	20%	✔
Ambulance services *This payment is for emergency or authorized transport.*	$0	✔	$0	✔
Outpatient Facility services				
Ambulatory Surgery Center	$0	✔	20% Subject to a Benefit maximum of $350/day	✔
Outpatient Department of a Hospital: surgery	$0	✔	20% Subject to a Benefit maximum of $350/day	✔
Outpatient Department of a Hospital: treatment of illness or injury, radiation therapy, chemotherapy, and necessary supplies	$0	✔	20% Subject to a Benefit maximum of $350/day	✔
Inpatient facility services				
Hospital services and stay	$0	✔	20% Subject to a Benefit maximum of $600/day	✔
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	$0	✔	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	$0	✔	Not covered	
Outpatient Facility services	$0	✔	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	✔	20%	✔
• Outpatient Department of a Hospital	$0	✔	20% Subject to a Benefit maximum of $350/day	✔
Basic imaging services *Includes plain film X-rays, ultrasounds, and diagnostic mammography.*				
• Outpatient radiology center	$0	✔	20%	✔
• Outpatient Department of a Hospital	$0	✔	20% Subject to a Benefit maximum of $350/day	✔

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 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, EEG, and EMG.*				
• Office location	$0	✔	20%	✔
• Outpatient Department of a Hospital	$0	✔	20% Subject to a Benefit maximum of $350/day	✔
Advanced imaging services *Includes diagnostic radiological and nuclear imaging such as CT scans, MRIs, MRAs, and PET scans.*				
• Outpatient radiology center	$0	✔	20%	✔
• Outpatient Department of a Hospital	$0	✔	20% Subject to a Benefit maximum of $350/day	✔
Rehabilitative and Habilitative Services *Includes physical therapy, occupational therapy, and respiratory therapy.*				
Office location	$0	✔	20%	✔
Outpatient Department of a Hospital	$0	✔	20% Subject to a Benefit maximum of $350/day	✔
Speech Therapy services				
Office location	$0	✔	20%	✔
Outpatient Department of a Hospital	$0	✔	20% Subject to a Benefit maximum of $350/day	✔
Durable medical equipment (DME)				
DME	$0	✔	20%	✔
Breast pump	$0		20%	✔
Glucose monitor	$0		20%	✔
Peak Flow Meter	$0		20%	✔
Orthotic equipment and devices	$0	✔	20%	✔

Benefits[6]	Your payment			
	When using a Participating Provider[3]	CYD[2] applies	When using a Non-Participating Provider[4]	CYD[2] applies
Prosthetic equipment and devices	$0	✔	20%	✔
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.*	$0	✔	Not covered	
Home infusion and home injectable therapy services				
Home infusion agency services *Includes home infusion drugs, medical supplies, and visits by a nurse.*	$0	✔	Not covered	
Hemophilia home infusion services *Includes blood factor products.*	$0	✔	Not covered	
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	$0	✔	$0	✔
Hospital-based SNF	$0	✔	20% Subject to a Benefit maximum of $600/day	✔
Hospice program services				
Pre-Hospice consultation	$0	✔	Not covered	
Routine home care	$0	✔	Not covered	
24-hour continuous home care	$0	✔	Not covered	
Short-term inpatient care for pain and symptom management	$0	✔	Not covered	
Inpatient respite care	$0	✔	Not covered	
Other services and supplies				
Diabetes care services				
• Devices, equipment, and supplies	$0	✔	20%	✔
• Self-management training	$0	✔	20%	✔
• Medical nutrition therapy	$0	✔	20%	✔

Benefits[6]	Your payment			
	When using a Participating Provider[3]	CYD[2] applies	When using a Non-Participating Provider[4]	CYD[2] applies
Dialysis services	$0	✔	20% Subject to a Benefit maximum of $350/day	✔
PKU product formulas and special food products	$0	✔	$0	✔
Allergy serum billed separately from an office visit	$0	✔	20%	✔
Hearing aid services Hearing aid services include: • Hearing aid examination for the appropriate type of hearing aid and/or fitting, counseling, and adjustments • Hearing aid device checks • Electroacoustic evaluations for hearing aids • Hearing aid instrument, manual or biaural, including ear mold(s) and the initial battery and cords	All Hearing Aid related services will have a combined Maximum Benefit Allowance of $2,000 per Member, per 24-month period. Any charges beyond the allowance is the responsibility of the member. Services are subject to the Calendar Year Deductible when using any provider.			

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	$0	✔	20%	✔
Teladoc mental health	$0	✔	Not covered	
Intensive outpatient care	$0	✔	20%	✔
Behavioral Health Treatment in an office setting	$0	✔	20%	✔
Behavioral Health Treatment in home or other non-institutional setting	$0	✔	20%	✔
Office-based opioid treatment	$0	✔	20%	✔
Partial Hospitalization Program	$0	✔	20% Subject to a Benefit maximum of $350/day	✔
Psychological Testing	$0	✔	20%	✔
Inpatient services				
Physician inpatient services	$0	✔	20%	✔
Hospital services	$0	✔	20% Subject to a Benefit maximum of $600/day	✔

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
Residential Care	$0	✔	20% Subject to a Benefit maximum of $600/day	✔

Prescription Drug Benefits[8,9]	Your payment			
	When using a Participating Pharmacy[3]	CYD[2] applies	When using a Non-Participating Pharmacy[4]	CYD[2] 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	$10/prescription	✔	25% plus $10/prescription	✔
Tier 2 Drugs	$25/prescription	✔	25% plus $25/prescription	✔
Tier 3 Drugs	$40/prescription	✔	25% plus $40/prescription	✔
Tier 4 Drugs	30% up to $200/prescription	✔	30% up to $200/prescription plus 25% of purchase price	✔
Retail pharmacy prescription Drugs				
Per prescription, for a 90-day supply.				
Contraceptive Drugs and devices	$0		Not covered	
Tier 1 Drugs	$30/prescription	✔	Not covered	
Tier 2 Drugs	$75/prescription	✔	Not covered	
Tier 3 Drugs	$120/prescription	✔	Not covered	
Tier 4 Drugs	30% up to $600/prescription	✔	Not covered	
Mail service pharmacy prescription Drugs				
Per prescription, for a 31-90-day supply.				
Contraceptive Drugs and devices	$0		Not covered	
Tier 1 Drugs	$20/prescription	✔	Not covered	
Tier 2 Drugs	$50/prescription	✔	Not covered	
Tier 3 Drugs	$80/prescription	✔	Not covered	

Prescription Drug Benefits[8,9]

	Your payment			
	When using a Participating Pharmacy[3]	**CYD[2] applies**	**When using a Non-Participating Pharmacy[4]**	**CYD[2] applies**
Tier 4 Drugs	30% up to $400/prescription	✔	Not covered	

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
- Some prescription Drugs (see blueshieldca.com/pharmacy)

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 combined medical and pharmacy Deductible. Some Covered Services received from Participating Providers are paid by the Claims Administrator before you meet any Calendar Year combined medical and pharmacy 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 cross accumulates Participating Provider and Non-Participating Provider Calendar Year Deductibles. This means that any amounts you pay towards your Participating Provider Calendar Year Deductible also count towards your Non-Participating ProviderCalendar Year Deductible. Also, any amounts you pay towards your Non-Participating Provider Calendar Year Deductible counts towards your 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. Once the individual Deductible or Family Deductible is reached, cost sharing applies until the Out-of-Pocket Maximum is reached.

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.

Teladoc. Teladoc mental health and substance use disorder 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 Calendar Year combined medical and 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.

Covered Drugs obtained at Non-Participating Pharmacies. Any amounts you pay for Covered Drugs at Non-Participating Pharmacies count towards the 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 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.

8 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.

9 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 Claims Administrator 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. 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.

See the Obtaining outpatient prescription Drugs at a Participating Pharmacy section of the Benefit Booklet for more information about how a brand contraceptive may be covered without a 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.

High Deductible Health Plan (HDHP) preventive Drugs. HDHP preventive Drugs obtained from a Participating Pharmacy are covered at the applicable Drug tier Copayment but are not subject to the Deductible. HDHP preventive Drugs do not include those preventive Drugs that are required by Health Care Reform to be covered at no charge. Visit blueshieldca.com/pharmacy for lists of these Drugs.

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.

Mail service Drugs. You pay the applicable 30-day retail pharmacy Copayment or Coinsurance for a 30-day supply or less from the mail service pharmacy.

Plans may be modified to ensure compliance with Federal requirements.

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