

County of San Bernadino – Retiree- COB PPO - 500-80/60 – High Option

Benefit Summary

(Uniform Health Plan Benefits and Coverage Matrix)

Blue Shield of California

Highlights: A description of the prescription drug coverage is provided separately

Effective January 1, 2013

THIS MATRIX IS INTENDED TO BE USED TO HELP YOU COMPARE COVERAGE BENEFITS AND IS A SUMMARY ONLY. THE EVIDENCE OF COVERAGE AND PLAN CONTRACT SHOULD BE CONSULTED FOR A DETAILED DESCRIPTION OF COVERAGE BENEFITS AND LIMITATIONS.

| | Preferred Providers ¹ | Non-Preferred Providers ¹ |
|---|--|---|
| Calendar Year Medical Deductible (All providers combined)² | \$500 per individual / \$1,000 per family | |
| Calendar Year Copayment Maximum² (Copayments for Preferred Providers accrue to both Preferred and Non-Preferred Provider Calendar-year Copayment Maximum amounts.) | \$2,500 per individual / \$5,000 per family | \$5,000 per individual / \$10,000 per family |
| LIFETIME BENEFIT MAXIMUM | None | |
| Covered Services | | |
| | Member Copayment | |
| | Preferred Providers ¹ | Non-Preferred Providers ¹ |
| PROFESSIONAL SERVICES | | |
| Professional (Physician) Benefits | | |
| <ul style="list-style-type: none"> Physician and specialist office visits | 20% (Not subject to the Calendar-Year Deductible) | 40% |
| <ul style="list-style-type: none"> CT scans, MRIs, MRAs, PET scans, and cardiac diagnostic procedures utilizing nuclear medicine³ (prior authorization is required) | 20% | 40% |
| <ul style="list-style-type: none"> Other outpatient X-ray, pathology and laboratory (Diagnostic testing by providers other than outpatient laboratory, pathology, and imaging departments of hospitals/facilities)³ | 20% | 40% |
| Allergy Testing and Treatment Benefits | | |
| <ul style="list-style-type: none"> Office visits (includes visits for allergy serum injections) | 20% | 40% |
| <ul style="list-style-type: none"> Allergy serum | 20% (Not subject to the Calendar-Year Deductible) | 40% |
| Preventive Health Benefits | | |
| <ul style="list-style-type: none"> Preventive Health Services (As required by applicable federal and California law.) | No Charge (Not subject to the Calendar-Year Deductible) | 40% |
| OUTPATIENT SERVICES | | |
| Hospital Benefits (Facility Services) | | |
| <ul style="list-style-type: none"> Outpatient surgery performed at an Ambulatory Surgery Center⁴ | \$250 per surgery + 20% | 40% |
| <ul style="list-style-type: none"> Outpatient surgery in a hospital | \$250 per surgery + 20% | 40% |
| <ul style="list-style-type: none"> Outpatient Services for treatment of illness or injury and necessary supplies (Except as described under "Rehabilitation Benefits") | 20% | 40% |
| <ul style="list-style-type: none"> CT scans, MRIs, MRAs, PET scans, and cardiac diagnostic procedures utilizing nuclear medicine performed in a hospital (prior authorization is required)³ | 20% | 40% |
| <ul style="list-style-type: none"> Other outpatient X-ray, pathology and laboratory performed in a hospital³ | 20% | 40% |
| <ul style="list-style-type: none"> Bariatric Surgery (prior authorization required by the Plan; medically necessary surgery for weight loss, for morbid obesity only)⁵ | \$250 per surgery + 20% | 40% |
| HOSPITALIZATION SERVICES | | |
| Hospital Benefits (Facility Services) | | |
| <ul style="list-style-type: none"> Inpatient Physician Services | 20% | 40% |
| <ul style="list-style-type: none"> Inpatient Non-emergency Facility Services (Semi-private room and board, and medically-necessary Services and supplies, including Subacute Care) | \$250 per admission + 20% | 40% |
| <ul style="list-style-type: none"> Bariatric Surgery (prior authorization required by the Plan; medically necessary surgery for weight loss, for morbid obesity only)⁵ | \$250 per admission + 20% | 40% |
| Skilled Nursing Facility Benefits^{6,7} (Combined maximum of up to 100 prior authorized days per Calendar Year; semi-private accommodations) | | |
| <ul style="list-style-type: none"> Services by a free-standing Skilled Nursing Facility | 20% | 20% ⁷ |
| <ul style="list-style-type: none"> Skilled Nursing Unit of a Hospital | 20% | 40% |

| EMERGENCY HEALTH COVERAGE | | |
|--|---|---|
| • Emergency room Services not resulting in admission (Copayment does not apply if the member is directly admitted to the hospital for inpatient services) (If ER services do not result in a direct admission the Calendar-Year Deductible does not apply) | \$100 per visit + 20% | \$100 per visit + 20% |
| • Emergency room Services resulting in admission (when the member is admitted directly from the ER) | \$250 per admission + 20% | \$250 per admission + 20% |
| • Emergency room Physician Services | 20% | 20% |
| AMBULANCE SERVICES | | |
| • Emergency or authorized transport | 20% | 20% |
| PRESCRIPTION DRUG COVERAGE | | |
| Outpatient Prescription Drug Benefits | A description of your outpatient prescription drug coverage is provided separately. If you do not have the separate drug summary that goes with this benefit summary, please contact your benefits administrator or call Customer Service at 800-200-3242. | |
| PROSTHETICS/ORTHOTICS | | |
| • Prosthetic equipment and devices (Separate office visit copay may apply) | 20% | 40% |
| • Orthotic equipment and devices (Separate office visit copay may apply) | 20% | 40% |
| DURABLE MEDICAL EQUIPMENT | | |
| • Breast pump | No Charge (Not subject to the Calendar-Year Deductible) | Not Covered |
| • Other Durable Medical Equipment | 20% | 40% |
| MENTAL HEALTH SERVICES (PSYCHIATRIC)⁸ | | |
| | MHSA Participating Providers¹ | MHSA Non-Participating Providers¹ |
| • Inpatient Hospital Services | \$250 per admission + 20% | 40% |
| • Outpatient Mental Health Services | Visits 1- 3 No Charge, 20% thereafter (Not subject to the Calendar-Year Deductible) | 40% |
| CHEMICAL DEPENDENCY SERVICES (SUBSTANCE ABUSE)⁹ | | |
| Please see footnote 13 | | |
| • Chemical dependency and substance abuse services | Not Covered | Not Covered |
| HOME HEALTH SERVICES¹⁰ | | |
| | Preferred Providers¹ | Non-Preferred Providers¹ |
| • Home health care agency Services ⁶ (up to 100 prior authorized visits per Calendar Year) | 20% | Not Covered ¹⁰ |
| • Home infusion/home intravenous injectable therapy and infusion nursing visits provided by a Home Infusion Agency | 20% | Not Covered ¹⁰ |
| OTHER | | |
| Vision Eye Exam | One self-referred comprehensive eye examination per 12 consecutive months (no age limit) 20% copayment for services provided by the vision plan administrator's providers. For visits by non-participating providers the maximum reimbursement for an Ophthalmologic exam is \$60 or \$50 if the member has an Optometric exam. | |
| Hospice Program Benefits¹⁰ | | |
| • Routine home care | No Charge | Not Covered ¹⁰ |
| • Inpatient Respite Care | No Charge | Not Covered ¹⁰ |
| • 24-hour Continuous Home Care | 20% | Not Covered ¹⁰ |
| • General Inpatient care | 20% | Not Covered ¹⁰ |
| Chiropractic Benefits⁶ | | |
| • Chiropractic Services - (provided by a chiropractor) (up to 30 visits per Calendar Year) | 20% | 40% |
| Acupuncture Benefits⁶ | | |
| • Acupuncture (up to 20 visits per Calendar Year) | 20% | 20% |
| Rehabilitation Benefits (Physical, Occupational and Respiratory Therapy) | | |
| • Office location | 20% | 40% |
| Speech Therapy Benefits | | |
| • Office Visit - Services by licensed speech therapists | 20% | 20% |
| Pregnancy and Maternity Care Benefits | | |

| | | |
|--|-----|-----|
| • Prenatal and postnatal Physician office visits (For inpatient hospital services, see "Hospitalization Services.") | 20% | 40% |
|--|-----|-----|

Family Planning Benefits

| | | |
|---|--|-----|
| • Counseling and consulting ¹¹ | No Charge (Not subject to the Calendar-Year Deductible) | 40% |
| • Elective abortion ¹² | 20% | 40% |
| • Tubal ligation | No Charge (Not subject to the Calendar-Year Deductible) | 40% |
| • Vasectomy ¹² | 30% | 40% |

Diabetes Care Benefits

| | | |
|---|-----|-----|
| • Devices, equipment, and non-testing supplies (for testing supplies see Outpatient Prescription Drug Benefits.) | 20% | 40% |
| • Diabetes self-management training (If billed by your provider, you will also be responsible for the office visit copayment) | 20% | 40% |

Care Outside of Plan Service Area (Benefits provided through the BlueCard®)

Program for out-of-state emergency and non-emergency care are provided at the preferred level of the local Blue Plan allowable amount when you use a Blue Cross/Blue Shield provider)

| | | |
|-------------------------------------|------------------------|------------------------|
| • Within US: BlueCard Program | See Applicable Benefit | See Applicable Benefit |
| • Outside of US: BlueCard Worldwide | See Applicable Benefit | See Applicable Benefit |

Optional Benefits Optional dental, vision, substance abuse treatment, infertility and hearing aid benefits are available.

If your employer purchased any of these benefits, a description of the benefit is provided separately.

- 1 Member is responsible for copayment in addition to any charges above allowable amounts. The copayment percentage indicated is a percentage of allowable amounts. Preferred providers accept Blue Shield's allowable amount as full payment for covered services. Non-preferred providers can charge more than these amounts. When members use non-preferred providers, they must pay the applicable copayment plus any amount that exceeds Blue Shield's allowable amount. Charges above the allowable amount do not count toward the calendar-year deductible or copayment maximum.
- 2 Deductible and copayments marked with this footnote do not accrue to calendar-year copayment maximum. Copayments and charges for services not accruing to the member's calendar-year copayment maximum continue to be the member's responsibility after the calendar-year copayment maximum is reached. Deductible does not apply toward the calendar-year maximum. Please refer to the Evidence of Coverage and the Plan Contract for exact terms and conditions of coverage.
- 3 Participating non Hospital based ("freestanding") outpatient X-ray, pathology and laboratory facilities centers may not be available in all areas. Regardless of their availability, you can obtain outpatient X-ray, pathology and laboratory services from a hospital or an ambulatory surgery center affiliated with a hospital, with payment according to your health plan's hospital services benefits.
- 4 Participating ambulatory surgery facilities centers may not be available in all areas. Regardless of their availability, you can obtain outpatient surgery services from a hospital or an ambulatory surgery center affiliated with a hospital, with payment according to your health plan's hospital services benefits.
- 5 Bariatric surgery is covered when pre-authorized by the Plan. However, for members residing in Imperial, Kern, Los Angeles, Orange, Riverside, San Bernardino, San Diego, Santa Barbara and Ventura Counties ("Designated Counties"), bariatric surgery services are covered only when performed at designated contracting bariatric surgery facilities and by designated contracting surgeons; coverage is not available for bariatric services from any other preferred provider and there is no coverage for bariatric services from non-preferred providers. In addition, if prior authorized by the Plan, a member in a Designated County who is required to travel more than 50 miles to a designated bariatric surgery facility will be eligible for limited reimbursement for specified travel expenses for the member and one companion. Refer to the Evidence of Coverage for further benefit details.
- 6 For plans with a calendar-year medical deductible amount, services with a day or visit limit accrue to the calendar-year day or visit limit maximum regardless of whether the plan medical deductible has been met.
- 7 Services may require prior authorization by the Plan. When services are prior authorized, members pay the preferred or participating provider amount.
- 8 Mental health services are accessed through Blue Shield's Mental Health Service Administrator (MHSA) - using Blue Shield's MHSA participating and non-participating providers. Only Blue Shield MHSA contracted providers are administered by the Blue Shield MHSA. Behavioral health services rendered by non-participating providers are administered by Blue Shield. For a listing of severe mental illnesses, including serious emotional disturbances of a child, and other benefit details, please refer to the Evidence of Coverage and Plan Contract.
- 9 Inpatient services for acute detoxification are covered under the medical benefit; see hospitalization services for benefit details. Services for medical acute detoxification are accessed through Blue Shield using Blue Shield's preferred providers or non-preferred providers.
- 10 Out of network home health care, home infusion and hospice services are not covered unless pre-authorized. When these services are pre-authorized, the member pays the Preferred Provider copayment.
- 11 Includes insertion of IUD as well as injectable contraceptives for women.
- 12 Copayment shown is for physician's services. If the procedure is performed in a facility setting (hospital or outpatient surgery center), an additional facility copayment may apply. Services from non-participating providers and non-preferred facilities are not covered under this benefit.
- 13 **Optional substance abuse treatment benefits are available. If your employer purchased these benefits, a description of the benefit is attached hereto as "Additional Substance Abuse Treatment Benefits."**

Plan designs may be modified to ensure compliance with state and federal requirements.

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Blue Shield believes this plan/policy is a "grandfathered health plan" under the Patient Protection and Affordable Care Act (the Affordable Care Act). As permitted by the Affordable Care Act, a grandfathered health plan can preserve certain basic health coverage that was already in effect when that law was enacted.

Being a grandfathered health plan means that your plan or policy is not required to include certain consumer protections of the Affordable Care Act that apply to other plans, for example, the requirement for the provision of preventive health services without any cost sharing. However, grandfathered health plans must comply with certain other consumer protections in the Affordable Care Act, for example, the elimination of lifetime limits on benefits. Note, even though they are not required to be included, many of the protections of the Affordable Care Act are included in your current plan/policy.

Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to Blue Shield at the telephone number on your identification card. If you obtain this plan/policy through your employer and your plan is subject to ERISA, you may also contact the Employee Benefits Security Administration, U.S. Department of Labor at 1-866-444-3272 or www.dol.gov/ebsa/healthreform. This website has a table summarizing which protections do and do not apply to grandfathered health plans. If you obtain your coverage through a nonfederal governmental employer, you may also contact the U.S. Department of Health and Human Services at www.healthreform.gov.

summary of benefits

Blue Shield of California Medicare Rx Plan (PDP)

**An employer-sponsored Medicare Prescription Drug Plan for
County of San Bernardino retirees
January 1, 2013 – December 31, 2013
State of California**

Custom PPOSM Plan – Group 970675

A Medicare-approved Part D sponsor.

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SECTION I – Introduction to Summary of Benefits

Hello County of San Bernardino retiree, spouse, or eligible dependent!

Thank you for your interest in Blue Shield of California Medicare Rx Plan (PDP). Our plan is offered by CA PHYSICIANS' SERVICE DBA BLUE SHIELD OF CA/Blue Shield of California, a Medicare Prescription Drug Plan that contracts with the Federal government. This Summary of Benefits tells you some features of our plan. It doesn't list every drug we cover, every limitation, or exclusion. To get a complete list of our benefits, please call Blue Shield of California Medicare Rx Plan (PDP) and ask for the *Evidence of Coverage*.

YOU HAVE CHOICES IN YOUR MEDICARE PRESCRIPTION DRUG COVERAGE

As a Medicare beneficiary, you can choose from different Medicare prescription drug coverage options. One option is to get prescription drug coverage through a Medicare Prescription Drug Plan, like Blue Shield of California Medicare Rx Plan (PDP). Another option is to get your prescription drug coverage through a Medicare Advantage Plan that offers prescription drug coverage. You may have other options offered by your former employer group/union. You make the choice. However, this Blue Shield of California Medicare Rx Plan (PDP) is offered as part of your former employer group/union's medical plan and if you decide you don't want this drug coverage, check with your Benefits Administrator to understand how that decision impacts your retiree benefits coverage.

HOW CAN I COMPARE MY OPTIONS?

The charts in this booklet list some important drug benefits. You can use this Summary of Benefits to compare the benefits offered by Blue Shield of California Medicare Rx Plan (PDP) to the benefits offered by other Medicare Prescription Drug Plans or Medicare Advantage Plans with prescription drug coverage.

WHERE IS BLUE SHIELD OF CALIFORNIA MEDICARE RX PLAN (PDP) AVAILABLE?

The service area for this plan is all counties in all 50 states. You must live in the U.S. to join this plan.

WHO IS ELIGIBLE TO JOIN?

You can join this plan if you are entitled to Medicare Part A and/or enrolled in Medicare Part B, meet your former employer group/union's eligibility requirements, and live in the service area. Your Medicare-eligible dependents may also join this plan if they meet these requirements.

If you are enrolled in an MA coordinated care (HMO or PPO) plan or an MA PFFS plan that includes Medicare prescription drugs, you may not enroll in a PDP unless you disenroll from the HMO, PPO or MA PFFS plan.

Enrollees in a private fee-for-service plan (PFFS) that does not provide Medicare prescription drug coverage, or an MA Medical Savings Account (MSA) plan may enroll in a PDP. Enrollees in an 1876 Cost plan may enroll in a PDP.

WHERE CAN I GET MY PRESCRIPTIONS?

Blue Shield of California Medicare Rx Plan (PDP) has formed a network of pharmacies. You must use a network pharmacy to receive plan benefits. We will not pay for your prescriptions if you use an out-of-network pharmacy, except in certain cases.

Blue Shield of California Medicare Rx Plan (PDP) has a list of preferred pharmacies. At these pharmacies, you may get your drugs at a lower co-pay or co-insurance. A non-preferred pharmacy is still a network pharmacy, but you may have to pay more for your prescription drugs.

The pharmacies in our network can change at any time. You can ask for a Pharmacy Directory or visit us at www.blueshieldca.com/med_pharmacy. Our customer service number is listed at the end of this introduction.

DOES MY PLAN COVER MEDICARE PART B OR PART D DRUGS?

Blue Shield of California Medicare Rx Plan (PDP) does not cover drugs that are covered under Medicare Part B as prescribed and dispensed. Generally, we only cover drugs, vaccines, biological products and medical supplies associated with the delivery of insulin that are covered under the Medicare Prescription Drug Benefit (Part D) and that are on our formulary

WHAT IS A PRESCRIPTION DRUG FORMULARY?

Blue Shield of California Medicare Rx Plan (PDP) uses a formulary. A formulary is a list of drugs covered by your plan to meet patient needs. We may periodically add, remove, or make changes to coverage limitations on certain drugs or change how much you pay for a drug. If we make any formulary change that limits our members' ability to fill their prescriptions, we will notify the affected enrollees before the change is made. We will send a formulary to you and you can see our complete formulary on our Web site at www.blueshieldca.com/med_formulary.

If you are currently taking a drug that is not on our formulary or subject to additional requirements or limits, you may be able to get a temporary supply of the drug. You can contact us to request an exception or switch to an alternative drug listed on our formulary with your physician's help. Call us to see if you can get a temporary supply of the drug or for more details about our drug transition policy.

WHAT SHOULD I DO IF I HAVE OTHER INSURANCE IN ADDITION TO MEDICARE?

If you have a Medigap (Medicare Supplement) policy that includes prescription drug coverage, you must contact your Medigap Issuer to let them know that you have joined a Medicare Prescription Drug Plan. If you decide to keep your current Medigap supplement policy, your Medigap Issuer will remove the prescription drug coverage portion of your policy. Call your Medigap Issuer for details.

If you or your spouse has, or is able to get, employer group coverage, you should talk to your employer to find out how your benefits will be affected if you join Blue Shield of California Medicare Rx Plan (PDP). Get this information before you decide to enroll in this plan.

HOW CAN I GET EXTRA HELP WITH MY PRESCRIPTION DRUG PLAN COSTS OR GET EXTRA HELP WITH OTHER MEDICARE COSTS?

You may be able to get extra help to pay for your prescription drug premiums and costs as well as get help with other Medicare costs. To see if you qualify for getting extra help, call:

* 1-800-MEDICARE (1-800-633-4227). TTY/TDD users should call 1-877-486-2048, 24 hours a day/7 days a week; and see www.medicare.gov 'Programs for People with Limited Income and Resources' in the publication Medicare & You.

* The Social Security Administration at 1-800-772-1213 between 7 a.m. and 7 p.m., Monday through Friday. TTY/TDD users should call 1-800-325-0778; or

* Your State Medicaid Office.

WHAT ARE MY PROTECTIONS IN THIS PLAN?

All Medicare Prescription Drug Plans agree to stay in the program for a full calendar year at a time. Plan benefits and cost-sharing may change from calendar year to calendar year. Each year, plans can decide whether to continue to participate with the Medicare Prescription Drug Program. A plan may continue in their entire service area (geographic area where the plan accepts members) or choose to continue only in certain areas. Also, Medicare may decide to end a contract with a plan. Even if your Medicare Prescription Drug Plan leaves the program, you will not lose Medicare coverage. If a plan decides not to continue for an additional calendar year, it must send you a letter at least 90 days before your coverage will end. The letter will explain your options for Medicare coverage in your area.

As a member of a Blue Shield of California Medicare Rx Plan (PDP), you have the right to request a coverage determination, which includes the right to request an exception, the right to file an appeal if we deny coverage for a prescription drug, and the right to file a grievance. You have the right to request a coverage determination if you want us to cover a Part D drug that you believe should be covered. An exception is a type of coverage determination. You may ask us for an exception if you believe you need a drug that is not on our list of covered drugs or believe you should get a non-preferred drug at a lower out-of-pocket cost. You can also ask for an exception to cost utilization rules, such as a limit on the quantity of a drug. If you think you need an exception, you should contact us before you try to fill your prescription at a pharmacy. Your doctor must provide a statement to support your exception request. If we deny coverage for your prescription drug(s), you have the right to appeal and ask us to review our decision. Finally, you have the right to file a grievance if you have any type of problem with us or one of our network pharmacies that does not involve coverage for a prescription drug. If your problem involves quality of care, you also have the right to file a grievance with the Quality Improvement Organization (QIO) for your state. Please refer to the Evidence of Coverage (EOC) for the QIO contact information.

WHAT IS A MEDICATION THERAPY MANAGEMENT (MTM) PROGRAM?

A Medication Therapy Management (MTM) Program is a free service we offer. You may be invited to participate in a program designed for your specific health and pharmacy needs. You may decide not to participate but it is recommended that you take full advantage of this covered service if you are selected. Contact Blue Shield of California Medicare Rx Plan (PDP) for more details.

WHERE CAN I FIND INFORMATION ON PLAN RATINGS?

The Medicare program rates how well plans perform in different categories (for example, detecting and preventing illness, ratings from patients and customer service). If you have access to the web, you may use the web tools on www.medicare.gov and select “Health and Drug Plans” then “Compare Drug and Health Plans” to compare the plan ratings for Medicare plans in your area. You can also call us directly to obtain a copy of the plan ratings for our plans. Our customer service number is listed below.

Please call your Benefits Administrator or Blue Shield of California for more information about Blue Shield of California Medicare Rx Plan (PDP).

Visit us at www.blueshieldca.com or, call us:

Customer Service Hours for October 1 – February 14:

Sunday, Monday, Tuesday, Wednesday, Thursday, Friday, Saturday, 7:00 a.m. - 8:00 p.m. Pacific

Customer Service Hours for February 15 – September 30:

Monday, Tuesday, Wednesday, Thursday, Friday, 7:00 a.m. - 8:00 p.m. Pacific

Current members should call toll-free (888)-239-6469 (TTY/TDD (888)-239-6482)

Prospective members should call toll-free (888)-239-6469 (TTY/TDD (888)-239-6482)

For more information about Medicare, please call Medicare at 1-800-MEDICARE (1-800-633-4227).

TTY users should call 1-877-486-2048. You can call 24 hours a day, 7 days a week.

Or, visit www.medicare.gov on the web.

This document may be available in other formats such as Braille, large print or other alternate formats.

If you have any questions about this plan's benefits or costs, please contact Blue Shield of California for details.

SECTION II: SUMMARY OF BENEFITS for Blue Shield of California Medicare Rx Plan (PDP), an employer-sponsored Medicare Prescription Drug Plan for retirees, spouses, and their eligible dependents.

Prepared for: County of San Bernardino

Effective: January 1, 2013

| Benefit | Original Medicare | Blue Shield of California Medicare Rx Plan (PDP) |
|-----------------------------------|---|--|
| PRESCRIPTION DRUG BENEFITS | | |
| Outpatient Prescription Drugs | Most drugs are not covered under Original Medicare. You can add prescription drug coverage to Original Medicare by joining a Medicare Prescription Drug Plan, or you can get all your Medicare coverage, including prescription drug coverage, by joining a Medicare Advantage Plan or a Medicare Cost Plan that offers prescription drug coverage. | <p>Drugs covered under Medicare Part D General</p> <p>This plan uses a formulary. The plan will send you the formulary. You can also see the formulary at blueshieldca.com/med_formulary on the web.</p> <p>Different out-of-pocket costs may apply for people who</p> <ul style="list-style-type: none"> -have limited incomes, -live in long term care facilities, or -have access to Indian/Tribal/Urban (Indian Health Service) providers. <p>Your former employer group/union is responsible for paying premiums beyond your monthly Medicare Part B premium. If you are responsible for any contribution to the premiums, your Benefits Administrator will tell you the amount and how to pay your former employer group/union.</p> <p>Most people will pay their Part D premium. However, some people will pay a higher premium because of their yearly income (over \$85,000 for singles, \$170,000 for married couples). For more information about Part D premiums based on income, call Medicare at 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048. You may also call Social Security at 1-800-772-1213. TTY users should call 1-800-325-0778.</p> |

If you have any questions about this plan's benefits or costs, please contact Blue Shield of California for details.

| Benefit | Original Medicare | Blue Shield of California Medicare Rx Plan (PDP) |
|----------------|--------------------------|---|
| | | <p>The plan offers national in-network prescription coverage (i.e., this would include 50 states and the District of Columbia). This means that you will pay the same cost-sharing amount for your prescription drugs if you get them at an in-network pharmacy outside of the plan's service area (for instance when you travel).</p> <p>Total yearly drug costs are the total drug costs paid by both you and a Part D plan.</p> <p>The plan may require you to first try one drug to treat your condition before it will cover another drug for that condition.</p> <p>Some drugs have quantity limits.</p> <p>Your provider must get prior authorization from Blue Shield of California Medicare Rx Plan (PDP) for certain drugs.</p> <p>You must go to certain pharmacies for a very limited number of drugs, due to special handling, provider coordination, or patient education requirements that cannot be met by most pharmacies in your network. These drugs are listed on the plan's website, formulary, printed materials, as well as on the Medicare Prescription Drug Plan Finder on Medicare.gov.</p> <p>If the actual cost of a drug is less than the normal cost-sharing amount for that drug, you will pay the actual cost, not the higher cost-sharing amount.</p> <p>The plan charges a minimum cost sharing amount for certain low-cost drugs.</p> <p>If you request a formulary exception for a drug and Blue Shield of California Medicare Rx Plan (PDP) approves the exception, you will pay the applicable drug tier cost sharing for the drug.</p> |

If you have any questions about this plan's benefits or costs, please contact Blue Shield of California for details.

| Benefit | Original Medicare | Blue Shield of California Medicare Rx Plan (PDP) |
|----------------|--------------------------|---|
| | | <p>In-Network</p> <p>\$0 deductible.</p> <p>Supplemental drugs don't count toward your out-of-pocket drug costs.</p> |
| | | <p>Initial Coverage</p> <p>You pay the following until total yearly drug costs reach \$2,970:</p> |
| | | <p>Retail Pharmacy</p> <p>Tier 1: Preferred Generic</p> <ul style="list-style-type: none"> - \$10 copay for a one-month (30-day) supply of drugs in this tier from a preferred pharmacy - \$20 copay for a three-month (90-day) supply of drugs in this tier from a preferred pharmacy - \$10 copay for a one-month (30-day) supply of drugs in this tier from an other network pharmacy - \$30 copay for a three-month (90-day) supply of drugs in this tier from an other network pharmacy <p>Tier 2: Preferred Brand</p> <ul style="list-style-type: none"> - \$25 copay for a one-month (30-day) supply of drugs in this tier from a preferred pharmacy - \$50 copay for a three-month (90-day) supply of drugs in this tier from a preferred pharmacy - \$25 copay for a one-month (30-day) supply of drugs in this tier from an other network pharmacy - \$75 copay for a three-month (90-day) supply of drugs in this tier from an other network pharmacy |

If you have any questions about this plan's benefits or costs, please contact Blue Shield of California for details.

| Benefit | Original Medicare | Blue Shield of California Medicare Rx Plan (PDP) |
|----------------|--------------------------|---|
| | | <p>Tier 3 - Non-Preferred Brand</p> <ul style="list-style-type: none"> - \$35 copay for a one-month (30-day) supply of drugs in this tier from a preferred pharmacy - \$70 copay for a three-month (90-day) supply of drugs in this tier from a preferred pharmacy - \$35 copay for a one-month (30-day) supply of drugs in this tier from an other network pharmacy - \$105 copay for a three-month (90-day) supply of drugs in this tier from an other network pharmacy <p>Tier 4: Injectable Drugs</p> <ul style="list-style-type: none"> - \$10 copayment for a one-month (30-day) supply of drugs in this tier from a preferred pharmacy - \$30 copayment for a three-month (90-day) supply of drugs in this tier from a preferred pharmacy - \$10 copayment for a one-month (30-day) supply of drugs in this tier from an other network pharmacy - \$30 copayment for a three-month (90-day) supply of drugs in this tier from an other network pharmacy <p>Tier 5: Specialty Tier</p> <ul style="list-style-type: none"> - \$10 copayment for a one-month (30-day) supply of drugs in this tier from a preferred pharmacy - \$30 copayment for a three-month (90-day) supply of drugs in this tier from a preferred pharmacy - \$10 copayment for a one-month (30-day) supply of drugs in this tier from an other network pharmacy - \$30 copayment for a three-month (90-day) supply of drugs in this tier from an other network pharmacy |

If you have any questions about this plan's benefits or costs, please contact Blue Shield of California for details.

| Benefit | Original Medicare | Blue Shield of California Medicare Rx Plan (PDP) |
|---------|-------------------|--|
| | | <p>Long Term Care Pharmacy</p> <p>Tier 1: Preferred Generic - \$10 copay for a one-month (31-day) supply of drugs in this tier</p> <p>Tier 2: Preferred Brand - \$25 copay for a one-month (31-day) supply of drugs in this tier</p> <p>Tier 3: Non-Preferred Brand - \$35 copay for a one-month (31-day) supply of drugs in this tier.</p> <p>Tier 4: Injectable Drugs - \$10 copayment for a one-month (31-day) supply of drugs in this tier</p> <p>Tier 5: Specialty Tier Drugs - \$10 copayment for a one-month (31-day) supply of drugs in this tier</p> <p>Please note that brand drugs must be dispensed incrementally in long-term care facilities. Generic drugs may be dispensed incrementally. Contact your plan about cost-sharing billing/collection when less than a one-month supply is dispensed.</p> |

If you have any questions about this plan’s benefits or costs, please contact Blue Shield of California for details.

| Benefit | Original Medicare | Blue Shield of California Medicare Rx Plan (PDP) |
|----------------|--------------------------|--|
| | | <p>Mail Order</p> <p>Tier 1: Preferred Generic - \$20 copay for a three-month (90-day) supply of drugs in this tier</p> <p>Tier 2: Preferred Brand - \$50 copay for a three-month (90-day) supply of drugs in this tier</p> <p>Tier 3: Non-Preferred Brand - \$70 copay for a three-month (90-day) supply of drugs in this tier</p> <p>Tier 4: Injectable Drugs - \$30 copayment for a three-month (90-day) supply of drugs in this tier</p> <p>Tier 5: Specialty Tier - \$30 copayment for a three-month (90-day) supply of drugs in this tier</p> |
| | | <p>Coverage Gap</p> <p>The plan covers all formulary drugs through the coverage gap. You pay the applicable drug tier cost sharing amount listed under “Initial Coverage” above.</p> |
| | | <p>Catastrophic Coverage</p> <p>After your yearly out-of-pocket drug costs reach \$4,750, you pay the lesser of:</p> <ul style="list-style-type: none"> - 5% coinsurance, or - the applicable drug tier copay. |
| | | <p>Out-of-Network</p> <p>What you pay for plan drugs while out-of-network depends upon whether or not you are getting prescriptions filled under special circumstances (such as when you are traveling, you need prescriptions filled, and there are no</p> |

If you have any questions about this plan's benefits or costs, please contact Blue Shield of California for details.

| Benefit | Original Medicare | Blue Shield of California Medicare Rx Plan (PDP) |
|----------------|--------------------------|---|
| | | <p>Network Pharmacies within reasonable driving distance). Plan drugs may be covered at the in-network cost sharing in these special circumstances when you use non-network pharmacies. You may pay more than your normal cost-sharing amount if you get your drugs at an out-of-network pharmacy and these special circumstances don't apply. In either situation, you will likely have to pay the pharmacy's full charge for the drug and submit documentation to receive reimbursement from Blue Shield of California Medicare Rx Plan (PDP).</p> |
| | | <p>Out-of-Network Initial Coverage Special circumstances DO apply (see your Evidence of Coverage for a description of these circumstances)</p> |
| | | <p>You will be reimbursed up to 100% of the submitted cost of the drug, minus the following, for drugs purchased out-of-network until total yearly drug costs reach \$4,750:</p> <p>Tier 1: Preferred Generic - \$10 copay for a one-month (30-day) supply of drugs in this tier</p> <p>Tier 2: Preferred Brand - \$25 copay for a one-month (30-day) supply of drugs in this tier</p> <p>Tier 3: Non-Preferred Brand - \$35 copay for a one-month (30-day) supply of drugs in this tier</p> <p>Tier 4: Injectable Drugs - \$10 copayment for a one-month (30-day) supply of drugs in this tier</p> <p>Tier 5: Specialty Tier - \$10 copayment for a one-month (30-day) supply of drugs in this tier</p> |

If you have any questions about this plan’s benefits or costs, please contact Blue Shield of California for details.

| Benefit | Original Medicare | Blue Shield of California Medicare Rx Plan (PDP) |
|----------------|--------------------------|---|
| | | <p>Out-of-Network Initial Coverage If you choose to go out of network and the special circumstances as noted in your Evidence of Coverage do NOT apply:</p> |
| | | <p>You will be reimbursed up to 75% of the submitted cost of the drug minus the following for drugs purchased out-of-network until total yearly drug costs reach \$4,750:</p> <p>Tier 1: Preferred Generic - \$10 copay for a one-month (30-day) supply of drugs in this tier</p> <p>Tier 2: Preferred Brand - \$25 copay for a one-month (30-day) supply of drugs in this tier</p> <p>Tier 3: Non-Preferred Brand - \$35 copay for a one-month (30-day) supply of drugs in this tier</p> <p>Tier 4: Injectable Drugs - \$10 copayment for a one-month (30-day) supply of drugs in this tier</p> <p>Tier 5: Specialty Tier - \$10 copayment for a one-month (30-day) supply of drugs in this tier</p> |
| | | <p>Out-of-Network Coverage Gap The plan covers all formulary drugs through the coverage gap. You pay the applicable drug tier cost sharing listed under “Initial Coverage” above.</p> |

If you have any questions about this plan's benefits or costs, please contact Blue Shield of California for details.

| Benefit | Original Medicare | Blue Shield of California Medicare Rx Plan (PDP) |
|----------------|--------------------------|---|
| | | Out-of-Network Catastrophic Coverage After your yearly out-of-pocket drug costs reach \$4,750, you will be reimbursed for drugs purchased out-of-network up to the full cost of the drug minus the lower of the following: <ul style="list-style-type: none">- 5% coinsurance or- the applicable drug tier copay |

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County of San Bernardino-COB Substance Abuse Treatment Benefits

Attachment to Benefit Summary (Uniform Benefits and Coverage Matrix)

For Shield Spectrum PPOSM Plans (500-80-60 Plan)

How the Plan Works

In addition to the benefits listed in the Benefit Summary, your health plan also covers inpatient hospital and professional (physician) services for substance abuse treatment and rehabilitation provided via hospitalization or partial hospitalization/day treatment.¹ All services must be medically necessary. Blue Shield of California has contracted with a Mental Health Service Administrator (MHSA), a licensed specialized health care service plan, to administer and deliver these services from MHSA participating providers. The MHSA is only the administrator for participating providers, and does not administer non-participating providers.

Coverage Details

Residential care is not covered. Out of pocket costs are lowest when you receive care from an MHSA participating provider.

| Covered Services | Member Copayment ³ | |
|---|--|--|
| | MHSA Participating Provider* | MHSA Non-Participating Provider ² |
| Inpatient Hospital | Inpatient Hospitalization Copay Applies | Inpatient Hospitalization Copay Applies |
| Professional (Physician) Services - Outpatient Physician Visit | Visits 1- 3 No Charge, 20% thereafter (Not subject to the Calendar-Year Deductible) | 40% |

1. Except for emergencies, benefits are covered only when pre-authorized by the MHSA.
2. Member is responsible for a copayment in addition to any charges above allowable amounts from non-participating providers. MHSA participating providers accept Blue Shield's allowable amount as full payment for covered services. Non-participating providers can charge more than these amounts. When members use non-participating providers, they must pay the applicable copayment plus any amount that exceeds Blue Shield's allowable amount.
3. Please refer to the Medical Benefit Summary for applicable copayment responsibility.

* Copayments are calculated based on the negotiated rate with participating providers.

This is only a summary of the additional substance abuse treatment benefits not described in the Uniform Benefits and Coverage Matrix. It is not a contract. Please refer to the *Plan Contract* and *Evidence of Coverage* for a detailed description of covered benefits and limitations.

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County of San Bernardino-COB Residential Care for Substance Abuse Condition Benefits

Attachment to Benefit Summary (Uniform Benefits and Coverage Matrix)
For Shield Spectrum PPOSM Plans

How the Plan Works

All services must be medically necessary. Blue Shield of California has contracted with a Mental Health Service Administrator (MHSA), a licensed specialized health care service plan, to administer and deliver these services from MHSA participating providers. The MHSA is only the administrator for participating providers, and does not administer non-participating providers. 1,3,4,5,6,7

Coverage Details

Out of pocket costs are lowest when you receive care from an MHSA participating provider.

| Covered Services | Member Copayment ³ | |
|--|--|--|
| | MHSA Participating Provider* | MHSA Non-Participating Provider ² |
| Residential Care for Substance Abuse Condition Facility Services Benefits are provided for Services for Substance Abuse Conditions in a Residential Substance Abuse Program up to a maximum of 100 days per Calendar Year per Member | Inpatient Medically Necessary Skilled Nursing Services including Subacute Care Copay Applies | Inpatient Medically Necessary Skilled Nursing Services including Subacute Care Copay Applies |

| | | |
|---|---|---|
| Residential Care for Substance Abuse Condition Physician Services | Inpatient Physician Visit Copay Applies | Inpatient Physician Visit Copay Applies |
|---|---|---|

1. Except for emergencies, benefits are covered only when pre-authorized by the MHSA.
2. Member is responsible for a copayment in addition to any charges above allowable amounts from non-participating providers. MHSA participating providers accept Blue Shield's allowable amount as full payment for covered services. Non-participating providers can charge more than these amounts. When members use non-participating providers, they must pay the applicable copayment plus any amount that exceeds Blue Shield's allowable amount.
3. Please refer to the Medical Benefit Summary for applicable copayment responsibility.
* Copayments are calculated based on the negotiated rate with participating providers.
4. Residential Care Substance Abuse Benefits may only be purchased if you have purchased the Substance Abuse Condition Benefits Supplement.
5. The Copayments listed are subject to the Deductible, Member Maximum Calendar Year Copayment Responsibility and other applicable provisions of your Plan.
6. Blue Shield of California has contracted with a Mental Health Service Administrator (MHSA) to administer and deliver the Substance Abuse Condition Services described in this Supplement. Prior authorization by the MHSA is required for admittance into a Residential Care Substance Abuse Program.
7. For these Services, Benefits are provided up to a maximum of 100 days per Calendar Year per Member for all Services combined. Note: the number of days starts counting on the first day regardless of whether the Deductible has been met or not.

This is only a summary of the additional residential care substance abuse condition benefits not described in the Uniform Benefits and Coverage Matrix. It is not a contract. Please refer to the *Plan Contract* and *Evidence of Coverage* for a detailed description of covered benefits and limitations.

County of San Bernardino-COB Residential Care for Mental Health Condition Benefits

Attachment to Benefit Summary (Uniform Benefits and Coverage Matrix)
For Shield Spectrum PPOSM Plans

How the Plan Works

All services must be medically necessary. Blue Shield of California has contracted with a Mental Health Service Administrator (MHSA), a licensed specialized health care service plan, to administer and deliver these services from MHSA participating providers. The MHSA is only the administrator for participating providers, and does not administer non-participating providers. 1,3,4,5,6,7

Coverage Details

Out of pocket costs are lowest when you receive care from an MHSA participating provider.

| Covered Services | Member Copayment ³ | |
|--|--|--|
| | MHSA Participating Provider* | MHSA Non-Participating Provider ² |
| Residential Care for Mental Health Condition Facility Services Benefits are provided for Mental Health Condition Benefits in a Residential Care Program up to a maximum of 100 days per Calendar Year per Member as described in this Supplement | Inpatient Medically Necessary Skilled Nursing Services including Subacute Care Copay Applies | Inpatient Medically Necessary Skilled Nursing Services including Subacute Care Copay Applies |
| Residential Care for Mental Health Condition Physician Services | Inpatient Physician Visit Copay Applies | Inpatient Physician Visit Copay Applies |

1. Except for emergencies, benefits are covered only when pre-authorized by the MHSA.
2. Member is responsible for a copayment in addition to any charges above allowable amounts from non-participating providers. MHSA participating providers accept Blue Shield's allowable amount as full payment for covered services. Non-participating providers can charge more than these amounts. When members use non-participating providers, they must pay the applicable copayment plus any amount that exceeds Blue Shield's allowable amount.
3. Please refer to the Medical Benefit Summary for applicable copayment responsibility.
 - * Copayments are calculated based on the negotiated rate with participating providers.
4. Residential Care Mental Health Benefits may only be purchased if you have purchased the Substance Abuse Condition Benefits Supplement.
5. The Copayments listed are subject to the Deductible, Member Maximum Calendar Year Copayment Responsibility and other applicable provisions of your Plan.
6. Blue Shield of California has contracted with a Mental Health Service Administrator (MHSA) to administer and deliver the Mental Health Condition Services described in this Supplement. Prior authorization by the MHSA is required for admittance into a Residential Care Mental Health Program.
7. For these Services, benefits are provided up to a maximum of 100 days per Calendar Year per Member for all Services combined. Note: the number of days starts counting on the first day regardless of whether the Deductible has been met or not.

This is only a summary of the additional residential care mental health condition benefits not described in the Uniform Benefits and Coverage Matrix. It is not a contract. Please refer to the *Plan Contract* and *Evidence of Coverage* for a detailed description of covered benefits and limitations.

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