

# County of San Bernardino – Retiree Shield Signature – Low Option

## Benefit Summary

(Uniform Health Plan Benefits and Coverage Matrix)

### Blue Shield of California

Effective January 1, 2014

**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.**

|  | Signature Level I:<br>HMO Plan Providers                              | Signature Level II<br>Preferred Providers <sup>2</sup> :       |
|--|---|--|
| <b>Calendar Year Medical Deductible</b>  | None  | None   |
| <b>Calendar Year Copayment Maximum<sup>3</sup></b> (For many covered services)   | \$3,000 per Individual<br>\$6,000 per 2-persons<br>\$9,000 per Family | None   |
| <b>LIFETIME BENEFIT MAXIMUM</b>  | None  | None   |
| <b>Covered Services</b>  | <b>Member Copayment</b>   |  |
| <b>PROFESSIONAL SERVICES</b>   | <b>Signature Level I:<br/>HMO Plan Providers</b>                      | <b>Signature Level II<br/>Preferred Providers<sup>2</sup>:</b> |
| <b>Professional (Physician) Benefits</b>   |   |  |
| <ul style="list-style-type: none"> <li>Physician and specialist office visits (Note: For network benefits provider level, a woman may self-refer to an OB/GYN or family practice physician in her Personal Physician's medical group or IPA for OB/GYN services.)</li> </ul> | \$50 per visit  | \$80 per visit   |
| <ul style="list-style-type: none"> <li>Specialist office visits (Specialist includes all other provider designations)</li> </ul>   | \$70 per visit  | \$80 per visit   |
| <ul style="list-style-type: none"> <li>Outpatient X-ray, pathology and laboratory (In a Physician Office)</li> </ul>   | No Charge   | No Charge <sup>9</sup>   |
| <ul style="list-style-type: none"> <li>Outpatient X-ray, pathology and laboratory</li> </ul>   | No Charge   | Not Covered  |
| <b>Allergy Testing and Treatment Benefits</b>  |   |  |
| <ul style="list-style-type: none"> <li>Office visits (includes visits for allergy serum injections &amp; allergy serum)</li> </ul>   | No Charge   | No Charge  |
| <ul style="list-style-type: none"> <li>Allergy Testing</li> </ul>  | No Charge   | \$80 per visit   |
| <b>Preventive Health Benefits</b>  |   |  |
| <ul style="list-style-type: none"> <li>Preventive Health Services (As required by applicable federal and California law.)</li> </ul>   | No Charge   | \$80 per visit   |
| <b>OUTPATIENT SERVICES</b>   |   |  |
| <b>Hospital Benefits (Facility Services)</b>   |   |  |
| <ul style="list-style-type: none"> <li>Outpatient surgery performed at an Ambulatory Surgery Center</li> </ul>   | \$750 per surgery   | Not Covered  |
| <ul style="list-style-type: none"> <li>Outpatient surgery in a hospital</li> </ul>   | \$750 per surgery   | Not Covered  |
| <ul style="list-style-type: none"> <li>Outpatient Services for treatment of illness or injury and necessary supplies (Except as described under "Rehabilitation Benefits" and "Speech Therapy Benefits")</li> </ul>  | No Charge   | Not Covered  |
| <ul style="list-style-type: none"> <li>Bariatric Surgery (prior authorization required by the Plan; medically necessary surgery for weight loss, for morbid obesity only)<sup>4</sup></li> </ul>   | \$750 per surgery   | Not Covered  |
| <b>HOSPITALIZATION SERVICES</b>  |   |  |
| <b>Hospital Benefits (Facility Services)</b>   |   |  |
| <ul style="list-style-type: none"> <li>Inpatient Physician Services</li> </ul>   | No Charge   | Not Covered  |
| <ul style="list-style-type: none"> <li>Inpatient Non-emergency Facility Services (Semi-private room and board, and medically-necessary Services and supplies, including Subacute Care)</li> </ul>  | \$1,000 per admission   | Not Covered  |
| <ul style="list-style-type: none"> <li>Bariatric Surgery (prior authorization required by the Plan; medically necessary surgery for weight loss, for morbid obesity only)<sup>4</sup></li> </ul>   | \$1,000 per admission   | Not Covered  |
| <ul style="list-style-type: none"> <li>Inpatient Medically Necessary skilled nursing Services including Subacute Care<sup>5</sup></li> </ul>   | \$1,000 per admission   | Not Covered  |
| <b>EMERGENCY HEALTH COVERAGE</b>   |   |  |
| <ul style="list-style-type: none"> <li>Emergency room Services not resulting in admission (The ER copayment does not apply if the member is directly admitted to the hospital for inpatient services)</li> </ul>   | \$250 per visit   | \$250 per visit  |
| <ul style="list-style-type: none"> <li>Emergency room Physician Services</li> </ul>  | No Charge   | No Charge  |
| <b>AMBULANCE SERVICES</b>  |   |  |
| <ul style="list-style-type: none"> <li>Emergency or authorized transport</li> </ul>  | \$300   | \$300  |

**PRESCRIPTION DRUG COVERAGE**  
**Outpatient Prescription Drug Benefits<sup>3</sup>**

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 the Member Services number on your identification card.

**PROSTHETICS/ORTHOTICS**

- |                                    |           |             |
|------------------------------------|-----------|-------------|
| • Prosthetic equipment and devices | No Charge | Not Covered |
| • Orthotic equipment and devices   | No Charge | Not Covered |

**DURABLE MEDICAL EQUIPMENT**

- |  |           |             |
|--|-----------|-------------|
| • Breast pump  | No Charge | Not Covered |
| • Other Durable Medical Equipment (member share is based upon allowed charges, Level I only) | No Charge | Not Covered |

**MENTAL HEALTH SERVICES (PSYCHIATRIC)<sup>9</sup>**

- |                                     | <b>Signature Level I<br/>MHSA Participating<br/>Providers<sup>1</sup></b> | <b>MHSA Participating<br/>Providers Outpatient<br/>Professional Services<br/>Provided in an Office<br/>Setting<sup>1</sup></b> |
|-------------------------------------|---|--|
| • Inpatient Hospital Services       | \$1,000 per admission   | Not Covered  |
| • Outpatient Mental Health Services | 1-3 visits-No Charge<br>\$30 per visit thereafter                         | 1-3 visits-No Charge<br>\$30 per visit thereafter  |

**CHEMICAL DEPENDENCY SERVICES  
(SUBSTANCE ABUSE)<sup>7</sup>, Please see footnote 8**

- |  |             |             |
|--|-------------|-------------|
| • Chemical dependency and substance abuse services | Not Covered | Not Covered |
|--|-------------|-------------|

**HOME HEALTH SERVICES**

- |   | <b>Signature Level I<br/>HMO Plan Providers</b> | <b>Signature Level II<br/>Preferred Providers<sup>3</sup></b> |
|---|---|---|
| • Home health care agency Services  | \$50 per visit                                  | Not Covered   |
| • Medical supplies (See "Prescription Drug Coverage" for specialty drugs) | No Charge                                       | Not Covered   |

**OTHER**

**Vision Eye Exam**

One self-referred comprehensive eye examination per 12 consecutive months (no age limit) \$10 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 Benefits**

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|--------------------------------|-----------|-------------|
| • Routine home care            | No Charge | Not Covered |
| • Inpatient Respite Care       | No Charge | Not Covered |
| • 24-hour Continuous Home Care | No Charge | Not Covered |
| • General Inpatient care       | No Charge | Not Covered |

**Pregnancy and Maternity Care Benefits**

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|--|----------------|-------------|
| • Prenatal and Postnatal Physician Office Visits<br>(For inpatient hospital services, see "Hospitalization Services.") | \$50 per visit | Not Covered |
|--|----------------|-------------|

**Family Planning and Infertility Benefits**

- |  |                   |             |
|--|-------------------|-------------|
| • Counseling and consulting <sup>10</sup>  | No Charge         | Not Covered |
| • Infertility Services (member share is based upon allowed charges, Signature Level I only) (Diagnosis and treatment of cause of infertility, artificial insemination and injectables for infertility. Excludes in vitro fertilization, GIFT and ZIFT) | Not Covered       | Not Covered |
| • Tubal ligation <sup>11,12</sup>  | No Charge         | Not Covered |
| • Elective abortion <sup>11</sup>  | \$150 per surgery | Not Covered |
| • Vasectomy <sup>11</sup>  | \$50 per surgery  | Not Covered |

**Rehabilitation Benefits (Physical, Occupational and Respiratory Therapy)**

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|---|----------------|----------------|
| • Office location (Copayment applies to professional services for Signature Level I and II.) (Up to 12 visits per Calendar Year on Signature Level II.) | \$40 per visit | \$80 per visit |
| • Facility location (Copayment applies to professional services for Signature Level I.)   | No Charge      | Not Covered    |

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**Speech Therapy Benefits**

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|--|----------------|----------------|
| • Office location - Services by licensed speech therapists<br>(Copayment applies to professional services for Signature Level I and II.) | \$40 per visit | \$80 per visit |
| • Facility location (copayment applies to facility services for Signature Level I.)  | No Charge      | Not Covered    |

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**Diabetes Care Benefits**

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|---|-----------|----------------|
| • Devices, equipment, and non-testing supplies<br>(member share is based upon allowed charges, Signature Level I only; for testing supplies see Outpatient Prescription Drug Benefits.) | No Charge | Not Covered    |
| • Diabetes self-management training   | No Charge | \$30 per visit |

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**Urgent Care Benefits** (BlueCard® Program)

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|--|------------------------------|----------------|
| • Urgent Services outside your Personal Physician Service Area | \$10 per visit <sup>13</sup> | \$10 per visit |
|--|------------------------------|----------------|

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**Optional Benefits** Optional dental, vision, hearing aid, infertility, substance abuse, chiropractic or chiropractic and acupuncture benefits are available.

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

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|----|---|
| 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. Calendar-year deductible applies to the combined services of Preferred and Non-Preferred Providers.  |
| 2  | Participating Providers in Blue Shield's PPO network for Signature level II.  |
| 3  | Deductible and copayments marked with a "3" 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. Please refer to the Evidence of Coverage and the Plan Contract for exact terms and conditions of coverage.  |
| 4  | All bariatric surgery Services must be prior authorized, in writing, from Blue Shield's Medical Director. Prior authorization is required for all Members, whether residents of a designated or non-designated county. Non Preferred Providers are not covered. Refer to the Evidence of Coverage for further benefit details   |
| 5  | Skilled nursing services are limited to 100 preauthorized days during a calendar year except when received through a hospice program provided by a participating hospice agency. This 100 preauthorized day maximum on skilled nursing services is a combined maximum between SNF in a hospital unit and skilled nursing facilities.  |
| 6  | 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 or plan contract.  |
| 7  | 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 HMO Plan Providers (Signature Level I), Preferred Providers (Signature Level II),   |
| 8  | <b>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."</b>  |
| 9  | In Physician's office only - excludes CT, MRI, MUGA, PET & SPECT.   |
| 10 | Includes insertion of IUD as well as injectable contraceptives for women.   |
| 11 | Copayment shown is for physician's services.  |
| 12 | Copayment does not apply when procedure is performed in conjunction with delivery or abdominal surgery  |
| 13 | For Signature Level I Services outside of California or the United States, Out-of-Area Follow-up Care is covered through any provider or through the BlueCard® Program participating provider network. However, authorization by Blue Shield HMO is required for more than two Out-of-Area Follow-up Care outpatient visits or for care that involves a surgical or other procedure or inpatient stay. For Signature Level I services outside your Personal Physician Service Area but within California, Member Services will assist the patient in receiving Out-of-Area Follow-up Care through a Blue Shield Plan Provider. To receive Signature Level I Services, Blue Shield HMO may direct the patient to receive follow-up Services from the Personal Physician. |

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](http://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](http://www.healthreform.gov).