

County of San Bernardino
 Shield PPO Savings Plus Individual Member
 Deductible 4000
 Benefit Summary (For groups of 300 and above)
 (Uniform Health Plan Benefits and Coverage Matrix)

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.

Blue Shield of California

Highlights: \$4,000 individual coverage deductible
 or \$8,000 family coverage deductible

Effective July 26, 2014

| | Preferred Providers ¹ | Non-Preferred Providers ¹ |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------|--------------------------------------------------|
| Calendar Year Deductible (All providers combined) (Note: For individual on family coverage plan, enrollee can receive benefits for covered services once individual deductible is met.) | \$4,000 per Individual / \$8,000 per Family | |
| Calendar Year Out-of-Pocket Maximum¹ (Includes the plan deductible) (For individual on family coverage plan, enrollee can receive 100% benefits for covered services once individual out-of-pocket maximum is met.) (Out-of-Pocket maximum accumulates separately for preferred and non-preferred providers.) | \$5,500 per Individual / \$11,000 per Family | \$10,000 per Individual / \$20,000 per Family |
| LIFETIME BENEFIT MAXIMUM | None | |
| Covered Services | Member Copayment | |
| PROFESSIONAL SERVICES | Preferred Providers¹ | Non-Preferred Providers¹ |
| Professional (Physician) Benefits | | |
| • Physician and specialist office visits | 20% | 50% |
| • CT scans, MRIs, MRAs, PET scans, and cardiac diagnostic procedures utilizing nuclear medicine ² (prior authorization is required) | 20% | 50% |
| • Other outpatient X-ray, pathology and laboratory (Diagnostic testing by providers other than outpatient laboratory, pathology, and imaging departments of hospitals/facilities) ² | 20% | 50% |
| Allergy Testing and Treatment Benefits | | |
| • Office visits (includes visits for allergy serum injections) | 20% | 50% |
| Preventive Health Benefits | | |
| • Preventive Health Services (As required by applicable federal and California law.) | No Charge (Not subject to the Calendar-Year Deductible) | Not Covered |
| OUTPATIENT SERVICES | | |
| Hospital Benefits (Facility Services) | | |
| • Outpatient surgery performed at an Ambulatory Surgery Center ³ | 20% | 50% ⁴ |
| • Outpatient surgery in a hospital | 20% | 50% ⁴ |
| • Outpatient Services for treatment of illness or injury and necessary supplies (Except as described under "Rehabilitation Benefits") | 20% | 50% ⁴ |
| • CT scans, MRIs, MRAs, PET scans, and cardiac diagnostic procedures utilizing nuclear medicine performed in a hospital (prior authorization is required) ² | \$100 per visit + 20% | 50% ⁴ |
| • Other outpatient X-ray, pathology and laboratory performed in a hospital ² | \$25 per visit + 20% | 50% ⁴ |
| • Bariatric Surgery ⁵ (prior authorization required by the Plan; medically necessary surgery for weight loss, for morbid obesity only) | 20% | 50% ⁴ |
| HOSPITALIZATION SERVICES | | |
| Hospital Benefits (Facility Services) | | |
| • Inpatient Physician Services | 20% | 50% |
| • Inpatient Non-emergency Facility Services (Semi-private room and board, and medically-necessary Services and supplies, including Subacute Care) | \$100 per admission + 20% | 50% ⁶ |
| • Bariatric Surgery ⁵ (prior authorization required by the Plan; medically necessary surgery for weight loss, for morbid obesity only) | \$100 per admission + 20% | 50% ⁶ |
| Skilled Nursing Facility Benefits^{7, 8} (Combined maximum of up to 100 prior authorized days per Calendar Year; semi-private accommodations) | | |
| • Services by a free-standing Skilled Nursing Facility | 20% | 20% ⁸ |
| • Skilled Nursing Unit of a Hospital | 20% | 50% ⁶ |

| EMERGENCY HEALTH COVERAGE | | |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------|-----------------------------------------------------|
| • 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) | \$100 per visit + 20% | \$100 per visit + 20% |
| • Emergency room Services resulting in admission (when the member is admitted directly from the ER) | \$100 per admission + 20% | \$100 per admission + 20% |
| • Emergency room Physician Services | 20% | 20% |
| AMBULANCE SERVICES | | |
| • Emergency or authorized transport | 20% | 20% |
| PRESCRIPTION DRUG COVERAGE^{9, 10, 11, 12, 13, 14, 15} (Subject to deductible) | | |
| | Participating Pharmacy | Non-Participating Pharmacy |
| Outpatient Prescription Drug Benefits | | |
| Retail Prescriptions (For up to a 30-day supply) | | |
| • Contraceptive Drugs and Devices ¹⁶ | No Charge | Not Covered |
| • Formulary Generic Drugs | \$10 per prescription | 25% + \$10 per prescription |
| • Formulary Brand Name Drugs | \$25 per prescription | 25% + \$25 per prescription |
| • Non-Formulary Brand Name Drugs | \$40 per prescription | 25% + \$40 per prescription |
| Mail Service Prescriptions (For up to a 90-day supply) | | |
| • Contraceptive Drugs and Devices ¹⁶ | No Charge | Not Covered |
| • Formulary Generic Drugs | \$20 per prescription | Not Covered |
| • Formulary Brand Name Drugs | \$50 per prescription | Not Covered |
| • Non-Formulary Brand Name Drugs | \$80 per prescription | Not Covered |
| Specialty Pharmacies (up to a 30-day supply) | | |
| • Specialty Drugs | 30% up to \$200 out-of-pocket copayment maximum per prescription | Not Covered |
| PROSTHETICS/ORTHOTICS | | |
| • Prosthetic equipment and devices (Separate office visit copay may apply) | 20% | 50% |
| • Orthotic equipment and devices (Separate office visit copay may apply) | 20% | 50% |
| DURABLE MEDICAL EQUIPMENT | | |
| • Breast pump | No Charge (Not subject to the Calendar-Year Deductible) | Not Covered |
| • Other Durable Medical Equipment | 20% | 50% |
| MENTAL HEALTH SERVICES (PSYCHIATRIC)¹⁷ | | |
| | MHSA Participating Providers¹ | MHSA Non-Participating Providers¹ |
| • Inpatient Hospital Services/Residential Treatment | \$100 per admission + 20% | 50% ⁵ |
| • Outpatient Mental Health Services | 20% | 50% |
| CHEMICAL DEPENDENCY SERVICES (SUBSTANCE ABUSE)¹⁸ | | |
| Please see footnote 22 | | |
| • Chemical dependency and substance abuse services | Not Covered | Not Covered |
| HOME HEALTH SERVICES¹⁹ | | |
| | Preferred Providers¹ | Non-Preferred Providers¹ |
| • Home health care agency Services ⁷ (up to 100 prior authorized visits per Calendar Year) | 20% | Not Covered ¹⁹ |
| • Home infusion/home intravenous injectable therapy and infusion nursing visits provided by a Home Infusion Agency | 20% | Not Covered ¹⁹ |
| OTHER | | |
| Hospice Program Benefits¹⁹ | | |
| • Routine home care | No Charge | Not Covered ¹⁹ |
| • Inpatient Respite Care | No Charge | Not Covered ¹⁹ |
| • 24-hour Continuous Home Care | 20% | Not Covered ¹⁹ |
| • General Inpatient care | 20% | Not Covered ¹⁹ |
| Chiropractic Benefits⁷ | | |
| • Chiropractic Services (provided by a chiropractor) (up to 20 visits per Calendar Year) | 20% | 50% |
| Acupuncture Benefits | | |
| • Acupuncture by a certificated acupuncturist | Not Covered | Not Covered |
| Rehabilitation Benefits (Physical, Occupational and Respiratory Therapy) | | |
| • Office location | 20% | 50% |

Speech Therapy Benefits

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|---------------------------------------------------------|-----|-----|
| • Office Visit - Services by licensed speech therapists | 20% | 20% |
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Pregnancy and Maternity Care Benefits

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| • Prenatal and postnatal Physician office visits (For inpatient hospital services, see "Hospitalization Services.") | 20% | 50% |
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Family Planning Benefits

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|-------------------------------------------|------------------------------------------------------------|-------------|
| • Counseling and consulting ²⁰ | No Charge (Not subject to the Calendar-Year Deductible) | Not Covered |
| • Tubal ligation | No Charge (Not subject to the Calendar-Year Deductible) | Not Covered |
| • Elective abortion ²¹ | 20% | Not Covered |
| • Vasectomy ²¹ | 20% | Not Covered |
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Diabetes Care Benefits

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| • Devices, equipment, and non-testing supplies (for testing supplies see Outpatient Prescription Drug Benefits.) | 20% | 50% |
| • Diabetes self-management training (by a registered dietician or registered nurse that are certified diabetes educators) | 20% | 50% |
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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)

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|-------------------------------------|------------------------|------------------------|
| • Within US: BlueCard Program | See Applicable Benefit | See Applicable Benefit |
| • Outside of US: BlueCard Worldwide | See Applicable Benefit | See Applicable Benefit |
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Optional Benefits Optional dental, vision, substance abuse treatment and infertility benefits are available. If your employer purchased any of these benefits, a description of the benefit is provided separately.

- ¹ Unless otherwise specified, copayments/coinsurance are calculated based on allowable amounts. Preferred providers agree to accept Blue Shield's allowable amount plus the plan's and any applicable member's payment 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 deductibles, copayments or coinsurance plus any amount that exceeds Blue Shield's allowable amount. Charges in excess of the allowable amount do not count toward the calendar-year deductible or out-of-pocket maximum. Payments applied to your calendar-year deductible accrue towards the out-of-pocket maximum.
- ² Participating non Hospital based ("freestanding") laboratory or radiology centers may not be available in all areas. Laboratory and radiology Services may also be obtained from a Hospital or from a laboratory and radiology center that is affiliated with a Hospital, and paid according to the benefit under your health plan's Hospital Benefits.
- ³ Participating Ambulatory Surgery Centers may not be available in all areas. Outpatient surgery Services may also be obtained from a Hospital or from an ambulatory surgery center that is affiliated with a Hospital, and paid according to the benefit under your health plan's Hospital Benefits.
- ⁴ The maximum allowed charges for non-emergency surgery and services performed in a non-participating Ambulatory Surgery Center or outpatient unit of a non-preferred hospital is \$350 per day. Members are responsible for 50% of this \$350 per day, plus all charges in excess of \$350.
- 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 The maximum allowed charge for non-emergency hospital services received from a non-preferred hospital is \$600 per day. Members are responsible for 50% of this \$600 per day, plus all charges in excess of \$600. Payments that exceed the allowed charge do not count toward the calendar-year out-of-pocket maximum, and continue to be owed after the maximum is reached.
- ⁷ For plans with a calendar-year deductible amount, services with a day or visit limit accrue to the calendar-year day or visit limit maximum regardless of whether the plan deductible has been met.
- ⁸ Services may require prior authorization by the Plan. When services are prior authorized, members pay the preferred or participating provider amount.
- ⁹ This plan's prescription drug coverage provides less coverage on average than the standard benefit set by the federal government for Medicare Part D (also called non-credible coverage). It is important to know that generally you may only enroll in a Part D plan from October 15th through December 7th of each year, and if you do not enroll when first eligible you may be subject to payment of higher Part D premiums when you enroll at a later date. For more information about drug coverage, call the Customer Service telephone number on your member identification card, Monday through Thursday 8:00 a.m. and 5:00 p.m. or Friday 9:00 a.m. and 5:00 p.m.
- ¹⁰ If the member requests a brand-name drug when a generic drug equivalent is available, the member is responsible for paying the difference between the cost to Blue Shield for the brand-name Drug and its generic drug equivalent, as well as the applicable generic drug Copayment. This difference in cost that the member must pay is not applied to their calendar-year deductible and is not included in the calendar-year out-of-pocket maximum responsibility calculations.
- ¹¹ Please note that if you switch from another plan, your prescription drug deductible credit from the previous plan during the calendar year, if applicable, will not carry forward to your new plan.
- ¹² For the Outpatient Prescription Drugs Benefit, covered Drugs obtained from Non-Participating Pharmacies will be subject to and accrue to the Calendar Year Deductible and the Calendar Year Out-of-Pocket Maximum for Preferred Providers.
- ¹³ Specialty drugs are covered only when dispensed by select pharmacies in the Specialty Pharmacy Network unless Medically Necessary for a covered emergency.
- ¹⁴ Select formulary and non-formulary drugs require prior authorization by Blue Shield for Medical Necessity, or when effective, lower cost alternatives are available.
- ¹⁵ Specialty Drugs are specific Drugs used to treat complex or chronic conditions which usually require close monitoring such as multiple sclerosis, hepatitis, rheumatoid arthritis, cancers, and other conditions that are difficult to treat with traditional therapies. Specialty Drugs are listed in the Blue Shield Outpatient Drug Formulary. Specialty Drugs may be self-administered in the home by injection by the patient or family member (subcutaneously or intramuscularly), by inhalation, orally or topically. Specialty Drugs may also require special handling, special manufacturing processes, and may have limited prescribing or limited pharmacy availability. Specialty Drugs must be considered safe for self-administration by Blue Shield's Pharmacy & Therapeutics Committee, be obtained from a Blue Shield Specialty Pharmacy and may require prior authorization for Medical Necessity by Blue Shield. Infused or Intravenous (IV) medications are not included as Specialty Drugs.
- ¹⁶ Contraceptive Drugs and Devices covered under the outpatient prescription drug benefits will not be subject to the calendar-year deductible. If a brand-name contraceptive is requested when a generic equivalent is available, the member will be responsible for paying the difference between the cost to Blue Shield for the brand-name contraceptive and its generic drug equivalent. In addition, select contraceptives may need prior authorization to be covered without a copayment.

- 17 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
- 18 Inpatient Services which are Medically Necessary to treat the acute medical complications of detoxification are covered under the medical benefits; see hospitalization services for benefit details. Services for acute medical complications of detoxification are accessed through Blue Shield using Blue Shield's preferred providers or with non-preferred providers.
- 19 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.
- 20 Includes insertion of IUD, as well as injectable and implantable contraceptives for women.
- 21 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.
- 22 **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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