

# County of San Bernardino

## Shield Signature

Benefit Summary (For groups of 300 and above)

(Uniform Health Plan Benefits and Coverage Matrix)

### Blue Shield of California

**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.**

Effective July 26, 2014

	Signature Level I HMO Plan Providers	Signature Level II Preferred Providers <sup>2</sup>
<b>Calendar Year Medical Deductible</b>	None	None
<b>Calendar Year Copayment Maximum</b>	\$1,500 per Individual/ \$3,000 per Family	\$0 per Individual/ \$0 per Family
<b>LIFETIME BENEFIT MAXIMUM</b>	None	None
<b>Covered Services</b>	<b>Member Copayment</b>	
<b>PROFESSIONAL SERVICES</b>	<b>Signature Level I HMO Plan Providers</b>	<b>Signature Level II 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> <li>Outpatient X-ray, pathology and laboratory (In a Physician Office)</li> <li>Outpatient X-ray, pathology and laboratory</li> </ul>	\$10 per visit  No Charge No Charge	\$30 per visit  No Charge <sup>3</sup> Not Covered
<b>Allergy Testing and Treatment Benefits</b>		
<ul style="list-style-type: none"> <li>Office visits (includes visits for allergy serum injections)</li> </ul>	\$10 per visit	\$30 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	\$30 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> <li>Outpatient surgery in a hospital</li> <li>Outpatient Services for treatment of illness or injury and necessary supplies (Except as described under "Rehabilitation Benefits" and "Speech Therapy Benefits")</li> <li>Bariatric Surgery (prior authorization required by the Plan; medically necessary surgery for weight loss, for morbid obesity only)<sup>4</sup></li> </ul>	No Charge No Charge No Charge No Charge	Not Covered Not Covered Not Covered Not Covered
<b>HOSPITALIZATION SERVICES</b>		
<b>Hospital Benefits (Facility Services)</b>		
<ul style="list-style-type: none"> <li>Inpatient Physician Services</li> <li>Inpatient Non-emergency Facility Services (Semi-private room and board, and medically-necessary Services and supplies, including Subacute Care)</li> <li>Bariatric Surgery (prior authorization required by the Plan; medically necessary surgery for weight loss, for morbid obesity only)<sup>4</sup></li> </ul>	No Charge No Charge No Charge	Not Covered Not Covered Not Covered
<b>Skilled Nursing Facility Benefits</b>		
<ul style="list-style-type: none"> <li>Services by a free-standing Skilled Nursing Facility</li> <li>Skilled Nursing Unit of a Hospital</li> </ul>	No Charge No Charge	Not Covered 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> <li>Emergency room Physician Services</li> </ul>	\$50 per visit No Charge	\$50 per visit No Charge
<b>AMBULANCE SERVICES</b>		
<ul style="list-style-type: none"> <li>Emergency or authorized transport</li> </ul>	No Charge	No Charge

<b>Outpatient Prescription Drug Benefits</b>	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 Member Services number on your identification card.	
<b>PROSTHETICS/ORTHOTICS</b>		
• Prosthetic equipment and devices	No Charge	Not Covered
• Orthotic equipment and devices	No Charge	Not Covered
<b>DURABLE MEDICAL EQUIPMENT</b>		
• Durable Medical Equipment (member share is based upon allowed charges, Signature Level I only)	No Charge	Not Covered
• Breast Pumps	No Charge	Not Covered
<b>MENTAL HEALTH SERVICES (PSYCHIATRIC)<sup>5</sup></b>	<b>Signature Level I MHPA Participating Providers<sup>1</sup></b>	<b>MHPA Participating Provider Outpatient Professional Services Provided in an Office Setting<sup>1</sup></b>
• Inpatient Hospital Services/Residential Treatment	No Charge	Not Covered
• Outpatient Mental Health Services	Visits 1-3 – No Charge, \$10 per visit thereafter	Visits 1-3 – No Charge, \$10 per visit thereafter
<b>CHEMICAL DEPENDENCY SERVICES (SUBSTANCE ABUSE)<sup>9</sup>, Please see footnote 10</b>		
• Chemical dependency and substance abuse services	Not Covered	Not Covered
<b>HOME HEALTH SERVICES</b>	<b>Signature Level I HMO Plan Providers</b>	<b>Signature Level II Preferred Providers<sup>2</sup></b>
• Home health care agency Services	No Charge	Not Covered
• Medical supplies (See "Prescription Drug Coverage" for specialty drugs)	No Charge	Not Covered
<b>OTHER</b>		
<b>Vision Eye Exam</b>	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.	
<b>Hospice Program Benefits</b>		
• 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
<b>Pregnancy and Maternity Care Benefits</b>		
• Prenatal and Postnatal Physician Office Visits (For inpatient hospital services, see "Hospitalization Services.")	No Charge	Not Covered
<b>Family Planning and Infertility Benefits</b>		
• Counseling and consulting <sup>7</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 and GIFT)	50%	Not Covered
• Tubal ligation <sup>8,9</sup>	No Charge	Not Covered
• Elective abortion <sup>6</sup>	\$10 per surgery	Not Covered
• Vasectomy <sup>6</sup>	\$10 per surgery	Not Covered
<b>Rehabilitation Benefits (Physical, Occupational and Respiratory Therapy)</b>		
• Office location (Copayment applies to professional services for Signature Level I and II.) (Up to 12 combined visits per Calendar Year for Signature Level II.)	\$10 per visit	\$30 per visit
• Facility location (Copayment applies to facility services for Signature Level I.)	No Charge	Not Covered
<b>Speech Therapy Benefits - Services by licensed speech therapists</b>		
• Office location (Copayment applies to professional services for Signature Level I and II.)	\$10 per visit	\$30 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 (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 (by a registered dietician or registered nurse that are certified diabetes educators)  | No Charge | \$30 per visit |

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**Urgent Care Benefits** (BlueCard<sup>®</sup> Program)

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| • Urgent Services outside your Personal Physician Service Area | \$10 per visit <sup>8</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  | 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 copayment or coinsurance plus any amount that exceeds Blue Shield's allowable amount. Charges above the allowable amount do not count toward the calendar year copayment maximum.  |
| 2  | Participating Providers in Blue Shield's PPO network for Signature Level II.   |
| 3  | In Physician's office only – excludes CT, MRI, MUGA, PET & SPECT.  |
| 4  | 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. |
| 5  | 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.   |
| 6  | 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 with the exception of the Tubal ligation benefit.   |
| 7  | Includes insertion of IUD as well as injectable contraceptives for women.  |
| 8  | 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.  |
| 9  | 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 HMO Plan Providers (Signature Level I).  |
| 10 | <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>   |

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

A16053 (1/14) MP033114

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).