

County of San Bernardino  
PPO Needles - 0/250 100/70  
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 THE PLAN CONTRACT SHOULD BE CONSULTED FOR A DETAILED DESCRIPTION OF COVERAGE BENEFITS AND LIMITATIONS.**

**Blue Shield of California**

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

Effective July 26, 2014

	Preferred Providers <sup>1</sup>	Non-Preferred Providers <sup>1</sup>
<b>Calendar Year Medical Deductible</b>	\$0 per individual / \$0 per 2-persons / \$0 per family	\$250 per individual / \$500 per two persons / \$750 per family
<b>Calendar Year Copayment Maximum</b> (Includes the plan deductible) (Copayments/Coinsurance for Preferred Providers accrue to both Preferred and Non-Preferred Provider Calendar-year Copayment Maximum amounts.)	\$1,500 per individual / \$3,000 per family	\$2,250 per individual / \$4,750 per family
<b>LIFETIME BENEFIT MAXIMUM</b>	None	
<b>Covered Services</b>		
	<b>Member Copayment</b>	
	Preferred Providers <sup>1</sup>	Non-Preferred Providers <sup>1</sup>
<b>PROFESSIONAL SERVICES</b>		
<b>Professional (Physician) Benefits</b>		
• Physician and specialist office visits	\$10 per visit	30%
• CT scans, MRIs, MRAs, PET scans, and cardiac diagnostic procedures utilizing nuclear medicine <sup>2</sup> (prior authorization is required)	No Charge	30%
• Other outpatient X-ray, pathology and laboratory (Diagnostic testing by providers other than outpatient laboratory, pathology, and imaging departments of hospitals/facilities) <sup>2</sup>	No Charge	30%
<b>Allergy Testing and Treatment Benefits</b>		
• Office visits (includes visits for allergy serum injections)	\$10 per visit	30%
<b>Preventive Health Benefits</b>		
• Preventive Health Services (As required by applicable federal and California law.)	No Charge	30%
<b>OUTPATIENT SERVICES</b>		
<b>Hospital Benefits (Facility Services)</b>		
• Outpatient surgery performed at an Ambulatory Surgery Center <sup>3</sup>	No Charge	30%
• Outpatient surgery in a hospital	No Charge	30%
• Outpatient Services for treatment of illness or injury and necessary supplies (Except as described under "Rehabilitation Benefits")	No Charge	30%
• CT scans, MRIs, MRAs, PET scans, and cardiac diagnostic procedures utilizing nuclear medicine performed in a hospital (prior authorization is required) <sup>2</sup>	No Charge	30%
• Other outpatient X-ray, pathology and laboratory performed in a hospital <sup>2</sup>	No Charge	30%
• Bariatric Surgery (prior authorization required by the Plan; medically necessary surgery for weight loss, for morbid obesity only) <sup>4</sup>	No Charge	30%
<b>HOSPITALIZATION SERVICES</b>		
<b>Hospital Benefits (Facility Services)</b>		
• Inpatient Physician Services	No Charge	30%
• Inpatient Non-emergency Facility Services (Semi-private room and board, and medically-necessary Services and supplies, including Subacute Care)	No Charge	30%
• Bariatric Surgery (prior authorization required by the Plan; medically necessary surgery for weight loss, for morbid obesity only) <sup>4</sup>	No Charge	30%
<b>Skilled Nursing Facility Benefits<sup>5,6</sup></b> (Combined maximum of up to 100 prior authorized days per Calendar Year; semi-private accommodations)		
• Services by a free-standing Skilled Nursing Facility	No Charge	No Charge <sup>6</sup>
• Skilled Nursing Unit of a Hospital	No Charge	30%

<b>EMERGENCY HEALTH COVERAGE</b>		
• 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)	\$50 per visit	\$50 per visit
• Emergency room Services resulting in admission (when the member is admitted directly from the ER)	No Charge	No Charge
• Emergency room Physician Services	No Charge	No Charge
<b>AMBULANCE SERVICES</b>		
• Emergency or authorized transport	No Charge	No Charge
<b>PRESCRIPTION DRUG COVERAGE</b>		
<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 the Customer Service number on your Identification card.	
<b>PROSTHETICS/ORTHOTICS</b>		
• Prosthetic equipment and devices (Separate office visit copay may apply)	No Charge	30%
• Orthotic equipment and devices (Separate office visit copay may apply)	No Charge	30%
<b>DURABLE MEDICAL EQUIPMENT</b>		
• Breast pump	No Charge	Not Covered
• Other Durable Medical Equipment	No Charge	30%
<b>MENTAL HEALTH SERVICES (PSYCHIATRIC)<sup>7</sup></b>		
	<b>MHSA Participating Providers<sup>1</sup></b>	<b>MHSA Non-Participating Providers<sup>1</sup></b>
• Inpatient Hospital Services/Residential Treatment	No Charge	30%
• Outpatient Mental Health Services	Visits 1-3 - No Charge, \$10 per visit thereafter	30%
<b>CHEMICAL DEPENDENCY SERVICES (SUBSTANCE ABUSE)<sup>8</sup></b>		
<b>Please see footnote 12</b>		
• Chemical dependency and substance abuse services	Not Covered	Not Covered
<b>HOME HEALTH SERVICES<sup>9</sup></b>		
	<b>Preferred Providers<sup>1</sup></b>	<b>Non-Preferred Providers<sup>1</sup></b>
• Home health care agency Services <sup>5</sup> (up to 100 prior authorized visits per Calendar Year)	No Charge	Not Covered <sup>9</sup>
• Home infusion/home intravenous injectable therapy and infusion nursing visits provided by a Home Infusion Agency	No Charge	Not Covered <sup>9</sup>
<b>OTHER</b>		
<b>Vision Eye Exam</b>	One self-referred comprehensive eye examination per 12 consecutive months (no age limit) \$10 per visit 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<sup>9</sup></b>		
• Routine home care	No Charge	Not Covered <sup>9</sup>
• Inpatient Respite Care	No Charge	Not Covered <sup>9</sup>
• 24-hour Continuous Home Care	No Charge	Not Covered <sup>9</sup>
• General Inpatient care	No Charge	Not Covered <sup>9</sup>
<b>Chiropractic Benefits<sup>5</sup></b>		
• Chiropractic Services - (provided by a chiropractor) (up to 30 visits per Calendar Year)	\$10 per visit	30%
<b>Acupuncture Benefits<sup>5</sup></b>		
• Acupuncture by a certificated acupuncturist (up to 20 visits per Calendar Year)	No Charge	No Charge
<b>Rehabilitation Benefits (Physical, Occupational and Respiratory Therapy)</b>		
• Office location	\$10 per visit	30%
<b>Speech Therapy Benefits</b>		
• Office Visit - Services by licensed speech therapists	\$10 per visit	\$10 per visit
<b>Pregnancy and Maternity Care Benefits</b>		
• Prenatal and postnatal Physician office visits (For inpatient hospital services, see "Hospitalization Services.")	\$10 per visit	30%

**Family Planning Benefits**

• Counseling and consulting <sup>11</sup>	No Charge	30%
• Elective abortion <sup>10</sup>	\$150	30%
• Tubal ligation	No Charge	50%
• Vasectomy <sup>10</sup>	\$75	50%
• Intrauterine Device	No Charge	30%

**Diabetes Care Benefits**

• Devices, equipment, and non-testing supplies (for testing supplies see Outpatient Prescription Drug Benefits.)	No Charge	30%
• Diabetes self-management training (by a registered dietician or registered nurse that are certified diabetes educators)	\$10 per visit	30%

**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 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 above the allowable amount do not count toward the calendar-year deductible or copayment 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 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 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.
- 6 Services may require prior authorization by the Plan. When services are prior authorized, members pay the preferred or participating provider amount.
- 7 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.
- 8 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.
- 9 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.
- 10 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.
- 11 Includes insertion of IUD as well as injectable and implantable contraceptives for women.
- 12 **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.

A20303 (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).