

County of San Bernadino - Retiree 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		
• Physician and specialist office visits	20% (Not subject to the Calendar-Year Deductible)	40%
• CT scans, MRIs, MRAs, PET scans, and cardiac diagnostic procedures utilizing nuclear medicine ³ (prior authorization is required)	20%	40%
• 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		
• Office visits (includes visits for allergy serum injections)	20%	40%
• Allergy serum	20% (Not subject to the Calendar-Year Deductible)	40%
Preventive Health Benefits		
• 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)		
• Outpatient surgery performed at an Ambulatory Surgery Center ⁴	\$250 per surgery + 20%	40%
• Outpatient surgery in a hospital	\$250 per surgery + 20%	40%
• Outpatient Services for treatment of illness or injury and necessary supplies (Except as described under "Rehabilitation Benefits")	20%	40%
• CT scans, MRIs, MRAs, PET scans, and cardiac diagnostic procedures utilizing nuclear medicine performed in a hospital (prior authorization is required) ³	20%	40%
• Other outpatient X-ray, pathology and laboratory performed in a hospital ³	20%	40%
• 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)		
• Inpatient Physician Services	20%	40%
• Inpatient Non-emergency Facility Services (Semi-private room and board, and medically-necessary Services and supplies, including Subacute Care)	\$250 per admission + 20%	40%
• 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)		
• Services by a free-standing Skilled Nursing Facility	20%	20% ⁷
• Skilled Nursing Unit of a Hospital	20%	40%
EMERGENCY HEALTH COVERAGE		

<ul style="list-style-type: none"> 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%
<ul style="list-style-type: none"> Emergency room Services resulting in admission (when the member is admitted directly from the ER) 	\$250 per admission + 20%	\$250 per admission + 20%
<ul style="list-style-type: none"> Emergency room Physician Services 	20%	20%
AMBULANCE SERVICES		
<ul style="list-style-type: none"> 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		
<ul style="list-style-type: none"> Prosthetic equipment and devices (Separate office visit copay may apply) 	20%	40%
<ul style="list-style-type: none"> Orthotic equipment and devices (Separate office visit copay may apply) 	20%	40%
DURABLE MEDICAL EQUIPMENT		
<ul style="list-style-type: none"> Breast pump 	No Charge (Not subject to the Calendar-Year Deductible)	Not Covered
<ul style="list-style-type: none"> Other Durable Medical Equipment 	20%	40%
MENTAL HEALTH SERVICES (PSYCHIATRIC)⁸		
	MHSA Participating Providers¹	MHSA Non-Participating Providers¹
<ul style="list-style-type: none"> Inpatient Hospital Services 	\$250 per admission + 20%	40%
<ul style="list-style-type: none"> 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		
<ul style="list-style-type: none"> Chemical dependency and substance abuse services 	Not Covered	Not Covered
HOME HEALTH SERVICES¹⁰		
	Preferred Providers¹	Non-Preferred Providers¹
<ul style="list-style-type: none"> Home health care agency Services⁶ (up to 100 prior authorized visits per Calendar Year) 	20%	Not Covered ¹⁰
<ul style="list-style-type: none"> 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		
<ul style="list-style-type: none"> Routine home care 	No Charge	Not Covered ¹⁰
<ul style="list-style-type: none"> Inpatient Respite Care 	No Charge	Not Covered ¹⁰
<ul style="list-style-type: none"> 24-hour Continuous Home Care 	20%	Not Covered ¹⁰
<ul style="list-style-type: none"> General Inpatient care 	20%	Not Covered ¹⁰
Chiropractic Benefits⁶		
<ul style="list-style-type: none"> Chiropractic Services - (provided by a chiropractor) (up to 30 visits per Calendar Year) 	20%	40%
Acupuncture Benefits⁶		
<ul style="list-style-type: none"> Acupuncture (up to 20 visits per Calendar Year) 	20%	20%
Rehabilitation Benefits (Physical, Occupational and Respiratory Therapy)		
<ul style="list-style-type: none"> Office location 	20%	40%
Speech Therapy Benefits		
<ul style="list-style-type: none"> Office Visit - Services by licensed speech therapists 	20%	20%
Pregnancy and Maternity Care Benefits		
<ul style="list-style-type: none"> 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.

County of San Bernardino - Retiree
Custom PPO – High/ Low Option

Outpatient Prescription Drug Coverage

Blue Shield of California

Highlight: 3-Tier/Incentive Formulary
 \$0 Calendar-Year Brand-Name Drug Deductible
 \$10 Formulary Generic/\$25 Formulary Brand Name/\$35 Non-Formulary Brand Name Drug - Retail Pharmacy
 \$20 Formulary Generic/\$50 Formulary Brand Name/\$70 Non-Formulary Brand-Name Drug - Mail Service

THIS DRUG SUMMARY IS INTENDED TO BE USED WITH THE SHIELD SPECTRUM PPO AND SHIELD PPO PLANS UNIFORM HEALTH PLAN BENEFITS AND COVERAGE MATRIX. THE EVIDENCE OF COVERAGE AND PLAN CONTRACT SHOULD BE CONSULTED FOR A DETAILED DESCRIPTION OF COVERAGE BENEFITS AND LIMITATIONS.

Covered Services

Member Copayment

DEDUCTIBLES (Prescription drug coverage benefits are not subject to the medical plan deductible.)

Calendar Year Brand Name Drug Deductible None

PRESCRIPTION DRUG COVERAGE¹

Participating Pharmacy

Non-Participating Pharmacy

Member pays 25% of billed amount plus a copayment of:

Retail Prescriptions (up to a 30-day supply)

• Contraceptive Drugs and Devices ²	\$0 per prescription	Not Covered
• Formulary Generic Drugs	\$10 per prescription	\$10 per prescription
• Formulary Brand Name Drugs ^{3, 4}	\$25 per prescription	\$25 per prescription
• Non-Formulary Brand Name Drugs ^{3, 4}	\$35 per prescription	\$35 per prescription

Mail Service Prescriptions (up to a 90-day supply)

• Contraceptive Drugs and Devices ²	\$0 per prescription	Not Covered
• Formulary Generic Drugs	\$20 per prescription	Not Covered
• Formulary Brand Name Drugs ^{3, 4}	\$50 per prescription	Not Covered
• Non-Formulary Brand Name Drugs ^{3, 4}	\$70 per prescription	Not Covered

Specialty Pharmacies (up to a 30-day supply)⁵

• Specialty Drugs ⁶	Applicable Retail Tier Copayment	Not Covered
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1 Copayments and charges for these covered services are not included in the calculation of the member's medical calendar-year copayment maximum and continue to be the member's responsibility after the calendar-year copayment maximum is reached. Please refer to the Evidence of Coverage and Plan Contract for exact terms and conditions of coverage. 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.

2 Contraceptive Drugs and Devices covered under the outpatient prescription drug benefits will no longer require a copayment and will not be subject to the calendar-year brand-name drug deductible. However, if a brand-name contraceptive is requested when a generic equivalent is available, the member will still be responsible for paying the difference between the cost to the Plan for the brand-name contraceptive and its generic drug equivalent. In addition, select contraceptives may need prior authorization to be covered without a copayment.

3 Selected formulary and non-formulary drugs require prior authorization by Blue Shield for Medical Necessity, and when effective, lower cost alternatives are available.

4 If the member requests a brand-name drug and a generic drug equivalent is available, the member is responsible for paying the generic drug copayment plus the difference in cost to Blue Shield between the brand-name drug and its generic drug equivalent.

5 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. Infused or Intravenous (IV) medications are not included as Specialty Drugs. These 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.

6 Specialty drugs are covered only when dispensed by select pharmacies in the Specialty Pharmacy Network unless Medically Necessary for a covered emergency.

Note: This plan's prescription drug coverage is on average equivalent to or better than the standard benefit set by the federal government for Medicare Part D (also called creditable coverage). Because this plan's prescription drug coverage is creditable, you do not have to enroll in a Medicare prescription drug plan while you maintain this coverage. However, you should be aware that if you have a subsequent break in this coverage of 63 days or more anytime after you were first eligible to enroll in a Medicare prescription drug plan, you could be subject to a late enrollment penalty in addition to your Part D premium.

Important Prescription Drug Information

You can find details about your drug coverage three ways:

1. Check your *Evidence of Coverage*.
2. Go to **blueshieldca.com** and log onto My Health Plan from the home page.
3. Call Member Services at the number listed on your Blue Shield member ID card.

At Blue Shield of California, we're dedicated to providing you with valuable resources for managing your drug coverage. Go online to the *Pharmacy* section of **blueshieldca.com** and select the *Drug Database and Formulary* to access a variety of useful drug information that can affect your out-of-pocket expenses, such as:

- Look up non-formulary drugs with formulary or generic equivalents;
- Look up drugs that require step therapy or prior authorization;
- Find specifics about your prescription copayments;
- Find local network pharmacies to fill your prescriptions.

TIPS!

Using the convenient mail service pharmacy can save you time and money. If you take a consistent dose of a covered maintenance drug for a chronic condition, such as diabetes or high blood pressure, you can receive up to a 90-day supply through the mail service pharmacy with a reduced copayment. Call the mail service pharmacy at (866) 346-7200. Members using TTY equipment can call TTY/TDD 866-346-7197.

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

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County of San Bernardino 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 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
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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 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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