

County of San Bernardino - Retiree Shield Signature – High Option

Benefit Summary

(Uniform Health Plan Benefits and Coverage Matrix)

Blue Shield of California

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.

Calendar Year Medical Deductible	Signature Level I HMO Plan Providers None	Signature Level II Preferred Providers ² None
Calendar Year Copayment Maximum ³ (For many covered services)	\$1,500 per Individual \$3,000 per Family	None
LIFETIME BENEFIT MAXIMUM	None	None
Covered Services	Member Copayment	
	Signature Level I HMO Plan Providers	Signature Level II Preferred Providers ²
PROFESSIONAL SERVICES		
Professional (Physician) Benefits		
<ul style="list-style-type: none"> 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.) Outpatient X-ray, pathology and laboratory (In a Physician Office) Outpatient X-ray, pathology and laboratory 	<p>\$10 per visit</p> <p>No Charge</p> <p>No Charge</p>	<p>\$30 per visit</p> <p>No Charge⁸</p> <p>Not Covered</p>
Allergy Testing and Treatment Benefits		
<ul style="list-style-type: none"> Office visits (includes visits for allergy serum injections) 	\$10 per visit	\$30 per visit
Preventive Health Benefits		
<ul style="list-style-type: none"> Preventive Health Services (as required by applicable federal and California law) 	No Charge	\$30 per visit
OUTPATIENT SERVICES		
Hospital Benefits (Facility Services)		
<ul style="list-style-type: none"> Outpatient surgery performed at an Ambulatory Surgery Center Outpatient surgery in a hospital Outpatient Services for treatment of illness or injury and necessary supplies (Except as described under "Rehabilitation Benefits" and "Speech Therapy Benefits") Bariatric Surgery (prior authorization required by the Plan; medically necessary surgery for weight loss, for morbid obesity only)⁴ 	<p>No Charge</p> <p>No Charge</p> <p>No Charge</p> <p>No Charge</p>	<p>Not Covered</p> <p>Not Covered</p> <p>Not Covered</p> <p>Not Covered</p>
HOSPITALIZATION SERVICES		
Hospital Benefits (Facility Services)		
<ul style="list-style-type: none"> Inpatient Physician Services Inpatient Non-emergency Facility Services (Semi-private room and board, and medically-necessary Services and supplies, including Subacute Care) Bariatric Surgery (prior authorization required by the Plan; medically necessary surgery for weight loss, for morbid obesity only)⁴ Inpatient Medically Necessary skilled nursing Services including Subacute Care 	<p>No Charge</p> <p>No Charge</p> <p>No Charge</p> <p>No Charge</p>	<p>Not Covered</p> <p>Not Covered</p> <p>Not Covered</p> <p>Not Covered</p>
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) Emergency room Physician Services 	<p>\$50 per visit</p> <p>No Charge</p>	<p>\$50 per visit</p> <p>No Charge</p>
AMBULANCE SERVICES		
<ul style="list-style-type: none"> Emergency or authorized transport 	No Charge	No Charge

PRESCRIPTION DRUG COVERAGE		
Outpatient Prescription Drug Benefits³	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.	
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
• Durable Medical Equipment (member share is based upon allowed charges, Signature Level I only)	No Charge	Not Covered
MENTAL HEALTH SERVICES (PSYCHIATRIC)⁵		
	Signature Level I MHPA Participating Providers¹	MHPA Participating Provider Outpatient Professional Services Provided in an Office Setting¹
• Inpatient Hospital Services	No Charge	Not Covered
• Outpatient Mental Health Services	1-3 visits- No Charge \$10 per visit thereafter	1-3 visits- No Charge \$10 per visit thereafter
CHEMICAL DEPENDENCY SERVICES (SUBSTANCE ABUSE)⁶, Please see footnote⁷		
• Chemical dependency and substance abuse services	Not Covered	Not Covered
HOME HEALTH SERVICES		
	Signature Level I HMO Plan Providers	Signature Level II Preferred Providers³
• Home health care agency Services	No Charge	Not Covered
• Medical supplies and laboratory Services (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		
• 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		
• Prenatal and Postnatal Physician Office Visits (For inpatient hospital services, see "Hospitalization Services.")	No Charge	Not Covered
Family Planning and Infertility Benefits		
• Counseling and consulting ⁹	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 and ZIFT)	50%	Not Covered
• Tubal ligation ^{10,11}	No Charge	Not Covered
• Elective abortion ¹⁰	\$10 per surgery	Not Covered
• Vasectomy ¹⁰	\$10 per surgery	Not Covered
Rehabilitation Benefits (Physical, Occupational, and Respiratory Therapy)		
• Office location (Copayment applies to professional services for Signature Level I and II.) (Up to 12 combined visits per Calendar Year on Signature Level II.)	\$10 per visit	\$30 per visit
• Facility location (Copayment applies to facility services for Signature Level I.)	No Charge	Not Covered
Speech Therapy Benefits		

• Office location – Services by licensed speech therapists (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

Diabetes Care Benefits

• 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	No Charge	\$30 per visit

Urgent Care Benefits (BlueCard® Program)

• Urgent Services outside your Personal Physician Service Area	\$10 per visit ¹²	\$10 per visit
--	------------------------------	----------------

Optional Benefits³ Optional dental, vision, 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.

- 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 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 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),
- 7 **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."**
- 8 In Physician's office only - excludes CT, MRI, MUGA, PET & SPECT.
- 9 Includes insertion of IUD as well as injectable contraceptives for women.
- 10 Copayment shown is for physician's services.
- 11 Copayment does not apply when procedure is performed in conjunction with delivery or abdominal surgery
- 12 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.

A16053 (1/13) PC 092412 100512

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 Bernadino - Retiree
Shield Signature – High Option

Outpatient Prescription Drug Coverage

THIS DRUG SUMMARY IS INTENDED TO BE USED WITH THE ACCESS+ HMO OR ADDED ADVANTAGE POS 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.

Blue Shield of California

- Highlight: 3-Tier/Incentive Formulary
 \$0 Calendar Year Brand-Name Drug Deductible
 \$5 Formulary Generic/\$10 Formulary Brand Name/\$25 Non-Formulary Brand Name Drug - Retail Pharmacy
 \$10 Formulary Generic/\$20 Formulary Brand Name/\$50 Non-Formulary Brand-Name Drug - Mail Service

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
Retail Prescriptions (up to a 30-day supply)		
• Contraceptive Drugs and Devices ²	\$0 per prescription	Not Covered
• Formulary Generic Drugs	\$5 per prescription	Not Covered
• Formulary Brand Name Drugs ^{3, 4}	\$10 per prescription	Not Covered
• Non-Formulary Brand Name Drugs ^{3, 4}	\$25 per prescription	Not Covered
Mail Service Prescriptions (up to a 90-day supply)		
• Contraceptive Drugs and Devices ²	\$0 per prescription	Not Covered
• Formulary Generic Drugs	\$10 per prescription	Not Covered
• Formulary Brand Name Drugs ^{3, 4}	\$20 per prescription	Not Covered
• Non-Formulary Brand Name Drugs ^{3, 4}	\$50 per prescription	Not Covered
Specialty Pharmacies (up to a 30-day supply) ⁵		
• Specialty Drugs ⁶	Applicable Retail Tier Copayment	Not Covered

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

A16149-a (1/13) PC 102612

County of San Bernardino Substance Abuse Treatment Benefits

Attachment to Benefit Summary (Uniform Benefits and Coverage Matrix)
For Shield Signature (Hi option)

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 under your Shield Signature Level I coverage.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 a MHSA participating provider

Covered Services	Member Copayment ³	
	Shield Signature Level I MHSA Participating Provider	Shield Signature Level II MHSA Participating Provider Outpatient Professional Services Provided in an Office Setting ²
Inpatient Hospital	Inpatient Hospitalization Copay Applies	Not Covered
Professional (Physician) Services - Inpatient	Physician Visit Copay Applies	Not Covered
Professional (Physician) Services - Outpatient Physician Visit (per calendar year)	1-3 visits- No Charge \$10 per visit thereafter	1-3 visits- No Charge \$10 per visit thereafter
Partial Hospitalization/Day Treatment	No Charge	Not Covered
<ol style="list-style-type: none"> Except for emergencies, benefits are covered only when pre-authorized by the MHSA. MHSA participating providers accept Blue Shield's allowable amount as full payment for covered services. Please refer to the Medical Benefit Summary for applicable copayment responsibility. 		

This document is only a summary for informational purposes. It is not a contract. Please refer to the *Evidence of Coverage* and the *Plan Contract* for the exact terms and conditions of coverage.

A17278 (01/13) PC0 092412

An Independent Member of the Blue Shield Association

County of San Bernardino Residential Care for Substance Abuse Condition Benefits

Attachment to Benefit Summary (Uniform Benefits and Coverage Matrix)
For Shield Signature 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

Coverage Details

Covered Services	Member Copayment ³	
	Shield Signature Level I MHSA Participating Provider*	Signature Level II MHSA Participating Provider Outpatient Professional Services Provided in an Office Setting 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	Not Covered
Residential Care for Substance Abuse Condition Physician Services	Inpatient Physician Visit Copay Applies	Not Covered

- Except for emergencies, benefits are covered only when pre-authorized by the MHSA.
- Please refer to the Medical Benefit Summary for applicable copayment responsibility.
*Copayments are calculated based on the negotiated rate with participating providers.
- Residential Care Substance Abuse Benefits may only be purchased if you have purchased the Substance Abuse Condition Benefits Supplement.
- The Copayments listed are subject to the Deductible, Member Maximum Calendar Year Copayment Responsibility and other applicable provisions of your Plan.
- 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.
- 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.

An Independent Member of the Blue Shield Association

County of San Bernardino Residential Care for Mental Health Condition Benefits

Attachment to Benefit Summary (Uniform Benefits and Coverage Matrix)
For Shield Signature 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. Blue Shield of California does not provide benefits for services provided by non-participating providers. ^{1,3,4,5,6}

Coverage Details

Covered Services	Member Copayment ⁷	
	Shield Signature Level I MHSA Participating Provider	Signature Level II MHSA Participating Provider Outpatient Professional Services Provided in an Office Setting ²
Residential Care for Mental Health Condition Facility Services Benefits are provided for Services for Mental Health Conditions in a Residential Mental Health Program up to a maximum of 100 days per Calendar Year per Member	Inpatient Medically Necessary Skilled Nursing Services including Subacute Care Copay Applies	Not Covered
Residential Care for Mental Health Condition Physician Services	Inpatient Physician Visit Copay Applies	Not Covered

1. Except for emergencies, benefits are covered only when pre-authorized by the MHSA.
 2. Please refer to the Medical Benefit Summary for applicable copayment responsibility.
 3. Residential Care Mental Health Benefits may only be purchased if you have purchased the Substance Abuse Condition Benefits Supplement.
 4. The Copayments listed are subject to the Deductible, Member Maximum Calendar Year Copayment Responsibility and other applicable provisions of your Plan.
 5. 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.
 6. 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 document is only a summary for informational purposes. It is not a contract. Please refer to the *Evidence of Coverage* and the *Plan Contract* for the exact terms and conditions of coverage.

An Independent Member of the Blue Shield Association