blue of california

County of San Bernardino-Retirees
Effective January 1, 2021
PPO Plan

Summary of Benefits

County of San Bernardino - Retiree Custom PPO Hybrid 0/500 - 100/60

This Summary of Benefits shows the amount you will pay for Covered Services under this Blue Shield of California Plan. It is only a summary and it is included as part of the Evidence of Coverage (EOC).[1] Please read both documents carefully for details.

Medical Provider Network: Full PPO Network

This Plan uses a specific network of Health Care Providers, called the Full PPO provider network. Providers in this network are called Participating Providers. You pay less for Covered Services when you use a Participating Provider than when you use a Non-Participating Provider. You can find Participating Providers in this network at blueshieldca.com.

Calendar Year Deductibles (CYD)[2]

A Calendar Year Deductible (CYD) is the amount a Member pays each Calendar Year before Blue Shield pays for Covered Services under the Plan.

		When using a Participating Provider[3]	When using a Non-Participating Provider[4]
Calendar Year medical Deductible	*Individual coverage*	$0	$500
	Family coverage	$0: individual	$500: individual
		$0: Family	$1,500: Family

Calendar Year Out-of-Pocket Maximum[5]

An Out-of-Pocket Maximum is the most a Member will pay for Covered Services each Calendar Year. Any exceptions are listed in the Notes section at the end of this Summary of Benefits.

	When using a Participating Provider[3]	When using a Non-Participating Provider[4]
Individual coverage	$2,000	$5,000
Family coverage	$2,000: individual	$5,000: individual
	$4,000: Family	$10,000: Family

No Annual or Lifetime Dollar Limit

Under this Plan there is no annual or lifetime dollar limit on the amount Blue Shield will pay for Covered Services.

Blue Shield of California is an independent member of the Blue Shield Association

Benefits[6]	Your payment			
	When using a Participating Provider[3]	CYD[2] applies	When using a Non-Participating Provider[4]	CYD[2] applies
Preventive Health Services[7]				
Preventive Health Services	$0		40%	✔
California Prenatal Screening Program	$0		$0	
Physician services				
Primary care office visit	$10/visit		40%	✔
Specialist care office visit	$10/visit		40%	✔
Physician home visit	$0		40%	✔
Physician or surgeon services in an outpatient facility	$0		40%	✔
Physician or surgeon services in an inpatient facility	$0		40%	✔
Other professional services				
Other practitioner office visit *Includes nurse practitioners, physician assistants, and therapists.*	$10/visit		40%	✔
Acupuncture services *Up to 20 visits per Member, per Calendar Year.*	$25/visit		$25/visit	✔
Chiropractic services *Up to 30 visits per Member, per Calendar Year.*	$10/visit		40%	✔
Teladoc consultation	$0		Not covered	
Family planning				
• Counseling, consulting, and education	$0		Not covered	
• Injectable contraceptive; diaphragm fitting, intrauterine device (IUD), implantable contraceptive, and related procedure.	$0		Not covered	
• Tubal ligation	$0		Not covered	
• Vasectomy	$0		Not covered	
Podiatric services	$10/visit		40%	✔
Pregnancy and maternity care				
Physician office visits: prenatal and postnatal	$10/visit		40%	✔
Physician services for pregnancy termination	$0		40%	✔

Benefits[6]	Your payment			
	When using a Participating Provider[3]	CYD[2] applies	When using a Non-Participating Provider[4]	CYD[2] applies
Emergency services				
Emergency room services *If admitted to the Hospital, this payment for emergency room services does not apply. Instead, you pay the Participating Provider payment under Inpatient facility services/ Hospital services and stay.*	$20/visit		$20/visit	
Emergency room Physician services	$0		$0	
Urgent care center services	$10/visit		40%	✔
Ambulance services *This payment is for emergency or authorized transport.*	$0		$0	
Outpatient facility services				
Ambulatory Surgery Center	$0		40%	✔
Outpatient Department of a Hospital: surgery	$0		40%	✔
Outpatient Department of a Hospital: treatment of illness or injury, radiation therapy, chemotherapy, and necessary supplies	$0		40%	✔
Inpatient facility services				
Hospital services and stay	$0		40%	✔
Transplant services *This payment is for all covered transplants except tissue and kidney. For tissue and kidney transplant services, the payment for Inpatient facility services/ Hospital services and stay applies.*				
• Special transplant facility inpatient services	$0		Not covered	
• Physician inpatient services	$0		Not covered	
Bariatric surgery services, designated California counties *This payment is for bariatric surgery services for residents of designated California counties. For bariatric surgery services for residents of non-designated California counties, the payments for Inpatient facility services/ Hospital services and stay and Physician inpatient and surgery services apply for inpatient services; or, if provided on an outpatient basis, the outpatient facility services and Outpatient Physician services payments apply.*				
Inpatient facility services	$0		Not covered	

Benefits[6]	Your payment			
	When using a Participating Provider[3]	CYD[2] applies	When using a Non-Participating Provider[4]	CYD[2] applies
Outpatient facility services	$0		Not covered	
Physician services	$0		Not covered	
Diagnostic x-ray, imaging, pathology, and laboratory services				
This payment is for Covered Services that are diagnostic, non-Preventive Health Services, and diagnostic radiological procedures, such as CT scans, MRIs, MRAs, and PET scans. For the payments for Covered Services that are considered Preventive Health Services, see Preventive Health Services.				
Laboratory services				
Includes diagnostic Papanicolaou (Pap) test.				
• Laboratory center	$0		40%	✔
• Outpatient Department of a Hospital	$0		40%	✔
X-ray and imaging services				
Includes diagnostic mammography.				
• Outpatient radiology center	$0		40%	✔
• Outpatient Department of a Hospital	$0		40%	✔
Other outpatient diagnostic testing				
Testing to diagnose illness or injury such as vestibular function tests, EKG, ECG, cardiac monitoring, non-invasive vascular studies, sleep medicine testing, muscle and range of motion tests, EEG, and EMG.				
• Office location	$0		40%	✔
• Outpatient Department of a Hospital	$0		40%	✔
Radiological and nuclear imaging services				
• Outpatient radiology center	$0		40%	✔
• Outpatient Department of a Hospital	$0		40%	✔
Rehabilitative and Habilitative Services				
Includes physical therapy, occupational therapy, and respiratory therapy.				
Office location	$0		40%	✔
Outpatient Department of a Hospital	$0		40%	✔
Speech Therapy services				
Office location	$0		$0	✔
Outpatient Department of a Hospital	$0		40%	✔

Benefits[6]	Your payment			
	When using a Participating Provider[3]	CYD[2] applies	When using a Non-Participating Provider[4]	CYD[2] applies
Durable medical equipment (DME)				
DME	$0		40%	✔
Breast pump	$0		Not covered	
Orthotic equipment and devices	$0		40%	✔
Prosthetic equipment and devices	$0		40%	✔
Home health care services *Up to 100 visits per Member, per Calendar Year, by a home health care agency. All visits count towards the limit, including visits during any applicable Deductible period. Includes home visits by a nurse, Home Health Aide, medical social worker, physical therapist, speech therapist, or occupational therapist, and medical supplies.*	$0		Not covered	
Home infusion and home injectable therapy services				
Home infusion agency services *Includes home infusion drugs and medical supplies.*	$0		Not covered	
Home visits by an infusion nurse	$0		Not covered	
Hemophilia home infusion services *Includes blood factor products.*	$0		Not covered	
Skilled Nursing Facility (SNF) services *Up to 100 days per Member, per Benefit Period, except when provided as part of a Hospice program. All days count towards the limit, including days during any applicable Deductible period and days in different SNFs during the Calendar Year.*				
Freestanding SNF	$0		$0	
Hospital-based SNF	$0		40%	✔
Hospice program services *Includes pre-Hospice consultation, routine home care, 24-hour continuous home care, short-term inpatient care for pain and symptom management, and inpatient respite care.*	$0		Not covered	
Other services and supplies				
Diabetes care services				
• Devices, equipment, and supplies	$0		40%	✔
• Self-management training	$0		40%	✔

Benefits[6]	Your payment			
	When using a Participating Provider[3]	**CYD[2] applies**	**When using a Non-Participating Provider[4]**	**CYD[2] applies**
Dialysis services	$0		40%	✔
PKU product formulas and Special Food Products	$0		$0	
Allergy serum billed separately from an office visit	$0		40%	✔
Eye examination *One comprehensive eye examination in a consecutive 12-month period provided through the contracted VPA.*				
Ophthalmologic exam	$10/visit		$0 up to $60/year plus 100% of additional charges	
Optometric exam	$10/visit		$0 up to $50/year plus 100% of additional charges	

Mental Health and Substance Use Disorder Benefits	Your payment			
Mental health and substance use disorder Benefits are provided through Blue Shield's Mental Health Service Administrator (MHSA).	**When using a MHSA Participating Provider[3]**	**CYD[2] applies**	**When using a MHSA Non-Participating Provider[4]**	**CYD[2] applies**
Outpatient services				
Office visit, including Physician office visit	$0 for the first 3 visits, then $10/visit		40%	✔
Teladoc behavioral health	$0		Not covered	
Intensive outpatient care	$0 for the first 3 visits, then $10/visit		40%	✔
Behavioral health treatment in an office setting	$0		40%	✔
Behavioral health treatment in home or other non-institutional facility setting	$0		40%	✔
Office-based opioid treatment	$0 for the first 3 visits, then $10/visit		40%	✔
Partial Hospitalization Program	$0		40%	✔
Psychological Testing	$0		40%	✔
Inpatient services				
Physician inpatient services	$0		40%	✔
Hospital services	$0		40%	✔

Mental Health and Substance Use Disorder Benefits	Your payment			
Mental health and substance use disorder Benefits are provided through Blue Shield's Mental Health Service Administrator (MHSA).	**When using a MHSA Participating Provider[3]**	**CYD[2] applies**	**When using a MHSA Non-Participating Provider[4]**	**CYD[2] applies**
Residential Care	$0		40%	✔

Prior Authorization

The following are some frequently-utilized Benefits that require prior authorization:

- Radiological and nuclear imaging services
- Outpatient mental health services, except office visits
- Inpatient facility services
- Hospice program services

Please review the Evidence of Coverage for more about Benefits that require prior authorization.

Notes

1 Evidence of Coverage (EOC):

The Evidence of Coverage (EOC) describes the Benefits, limitations, and exclusions that apply to coverage under this Plan. Please review the EOC for more details of coverage outlined in this Summary of Benefits. You can request a copy of the EOC at any time.

Capitalized terms are defined in the EOC. Refer to the EOC for an explanation of the terms used in this Summary of Benefits.

2 Calendar Year Deductible (CYD):

Calendar Year Deductible explained. A Deductible is the amount you pay each Calendar Year before Blue Shield pays for Covered Services under the Plan.

If this Plan has any Calendar Year Deductible(s), Covered Services subject to that Deductible are identified with a check mark (✔) in the Benefits chart above.

Family coverage has an individual Deductible within the Family Deductible. This means that the Deductible will be met for an individual with Family coverage who meets the individual Deductible prior to the Family meeting the Family Deductible within a Calendar Year. Once the individual Deductible or Family Deductible is reached, cost sharing applies until the Out-of-Pocket Maximum is reached.

3 Using Participating Providers:

Participating Providers have a contract to provide health care services to Members. When you receive Covered Services from a Participating Provider, you are only responsible for the Copayment or Coinsurance, once any Calendar Year Deductible has been met.

Teladoc. Teladoc mental health and substance use disorder (behavioral health) consultations are provided through Teladoc. These services are not administered by Blue Shield's Mental Health Service Administrator (MHSA).

"Allowable Amount" is defined in the EOC. In addition:

Notes

- Coinsurance is calculated from the Allowable Amount or Benefit maximum, whichever is less.

4 Using Non-Participating Providers:

Non-Participating Providers do not have a contract to provide health care services to Members. When you receive Covered Services from a Non-Participating Provider, you are responsible for:

- the Copayment or Coinsurance (once any Calendar Year Deductible has been met), and
- any charges above the Allowable Amount, or
- any charges above the stated dollar amount, which is the Benefit maximum.

"Allowable Amount" is defined in the EOC. In addition:

- Coinsurance is calculated from the Allowable Amount or Benefit maximum, whichever is less.
- Charges above the Allowable Amount or Benefit maximum do not count towards the Out-of-Pocket Maximum, and are your responsibility for payment to the provider. This out-of-pocket expense can be significant.

5 Calendar Year Out-of-Pocket Maximum (OOPM):

Calendar Year Out-of-Pocket Maximum explained. The Out-of-Pocket Maximum is the most you are required to pay for Covered Services in a Calendar Year. Once you reach your Out-of-Pocket Maximum, Blue Shield will pay 100% of the Allowable Amount for Covered Services for the rest of the Calendar Year.

Your payment after you reach the Calendar Year OOPM. You will continue to pay all charges for services that are not covered, charges above the Allowable Amount, and charges for services above any Benefit maximum.

This Plan has a separate Participating Provider OOPM and Non-Participating Provider OOPM.

Family coverage has an individual OOPM within the Family OOPM. This means that the OOPM will be met for an individual with Family coverage who meets the individual OOPM prior to the Family meeting the Family OOPM within a Calendar Year.

6 Separate Member Payments When Multiple Covered Services are Received:

Each time you receive multiple Covered Services, you might have separate payments (Copayment or Coinsurance) for each service. When this happens, you may be responsible for multiple Copayments or Coinsurance. For example, you may owe an office visit Copayment in addition to an allergy serum Copayment when you visit the doctor for an allergy shot.

7 Preventive Health Services:

If you only receive Preventive Health Services during a Physician office visit, there is no Copayment or Coinsurance for the visit. If you receive both Preventive Health Services and other Covered Services during the Physician office visit, you may have a Copayment or Coinsurance for the visit.

Plans may be modified to ensure compliance with State and Federal requirements.

PENDING REGULATORY APPROVAL