blue of california

Summary of Benefits

San Bernardino County - Actives
Effective July 29, 2023
Shield Signature Benefit Plan

Custom Shield Signature Plan

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

Provider Network: Shield Signature Network

This benefit Plan uses a specific network of Health Care Providers, called the Shield Signature provider network. This Plan provides Benefits at two different levels:

- **Shield Signature Level I (HMO Participating Providers):** Services must be provided or prior authorized by your Primary Care Physician or Medical Group/IPA, except in an Emergency or as otherwise specified. Please review your EOC for details about how to access care under this level.
- **Shield Signature Level II (PPO Participating Providers):** Services are provided by Participating Providers for outpatient professional services provided in an office setting. Any Copayment or Coinsurance is calculated from the Allowable Amount.

You are responsible for any Copayment or Coinsurance and any charges over the Allowable Amount. 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 benefit Plan. Blue Shield pays for some Covered Services before the Calendar Year Deductible is met, as noted in the Benefits chart below.

		Shield Signature Level I HMO Plan providers[3]	Shield Signature Level II Participating Providers[3]
Calendar Year medical Deductible	*Individual coverage*	$0	$0
	Family Coverage	$0: individual $0: Family	$0: individual $0: Family

Calendar Year Out-of-Pocket Maximum[4]

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.

	Shield Signature Level I HMO Plan providers[3]	Shield Signature Level II Participating Providers[3]
Individual coverage	$1,500	No maximum
Family Coverage	$1,500: individual $3,000: Family	

No Lifetime Benefit Maximum

Under this benefit Plan there is no dollar limit on the total amount Blue Shield will pay for Covered Services in a Member's lifetime.

Benefits[5]	Your payment			
	Shield Signature Level I HMO Plan providers[3]	**CYD[2] applies**	**Shield Signature Level II Participating Providers[3]**	**CYD[2] applies**
Preventive Health Services[6]				
Preventive Health Services	$0		$30/visit	
California Prenatal Screening Program	$0		$0	
Physician services				
Primary care office visit	$10/visit		$30/visit	
Specialist care office visit	$10/visit		$30/visit	
Physician home visit	$10/visit		Not covered	
Physician inpatient, outpatient, and surgery services	$0		Not covered	
Other professional services				
Other practitioner office visit *Includes nurse practitioners, physician assistants, and therapists.*	$10/visit		$30/visit	
Acupuncture services	Not covered		Not covered	
Chiropractic services	Not covered		Not covered	
Teladoc consultation	$0		Not covered	
Family Planning				
• Counseling, consulting, and education	$0		Not covered	
• Diaphragm fitting, intrauterine device (IUD), implantable contraceptive, and related procedure.	$0		Not covered	
• Injectable contraceptive *Under Level II, services are only covered if received in a Physician's office.*	$0		$30/visit	
• Tubal ligation	$0		Not covered	
• Vasectomy	$10/surgery		Not covered	
• Infertility services	50%		Not covered	
Podiatric services	$10/visit		$30/visit	
Medical nutrition therapy, not related to diabetes	$0		Not covered	
Pregnancy and maternity care				
Physician office visits: prenatal and postnatal	$0		Not covered	
Physician services for pregnancy termination	$0		Not covered	
Emergency Services				

Benefits[5]	Your payment			
	Shield Signature Level I HMO Plan providers[3]	**CYD[2] applies**	**Shield Signature Level II Participating Providers[3]**	**CYD[2] applies**
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.*	$50/visit		$50/visit	
Emergency room Physician services	$0		$0	
Urgent care center services	$10/visit		$10/visit	
Ambulance services	$0		$0	
Outpatient facility services				
Ambulatory Surgery Center	$0		Not covered	
Outpatient department of a Hospital: surgery	$0		Not covered	
Outpatient department of a Hospital: treatment of illness or injury, radiation therapy, chemotherapy, and necessary supplies	$0		Not covered	
Inpatient facility services				
Hospital services and stay	$0		Not covered	
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	
Outpatient Facility services	$0		Not covered	
Physician services	$0		Not covered	

Benefits[5]	Your payment			
	Shield Signature Level I HMO Plan providers[3]	**CYD[2] applies**	**Shield Signature Level II Participating Providers[3]**	**CYD[2] applies**
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 Papanicolau (Pap) test.				
• Laboratory center	$0		$0	
Under Level II, services are only covered if received in a Physician's office.				
• Outpatient department of a Hospital	$0		Not covered	
X-ray and imaging services				
Includes diagnostic mammography.				
• Outpatient radiology center	$0		$0	
Under Level II, services are only covered if received in a Physician's office.				
• Outpatient Department of a Hospital	$0		Not covered	
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		$0	
Under Level II, services are only covered if received in a Physician's office.				
• Outpatient Department of a Hospital	$0		Not covered	
Radiological and nuclear imaging services				
• Outpatient radiology center	$0		Not covered	
• Outpatient Department of a Hospital	$0		Not covered	
Rehabilitative and habilitative services				
Includes physical therapy, occupational therapy, and respiratory therapy services. Under Level II, up to 12 visits per Member, per Calendar Year.				
Office location	$10/visit		$30/visit	
Outpatient Department of a Hospital	$0		Not covered	
Speech therapy services				

Benefits[5]	Your payment			
	Shield Signature Level I HMO Plan providers[3]	**CYD[2] applies**	**Shield Signature Level II Participating Providers[3]**	**CYD[2] applies**
Office location	$10/visit		$30/visit	
Outpatient Department of a Hospital	$0		Not covered	
Durable medical equipment (DME)				
DME	$0		Not covered	
Breast pump	$0		Not covered	
Orthotic equipment and devices	$0		Not covered	
Prosthetic equipment and devices	$0		Not covered	
Home health services				
Home health agency services *Includes home visits by a nurse, Home Health Aide, medical social worker, physical therapist, speech therapist, or occupational therapist.*	$0		Not covered	
Home visits by an infusion nurse	$0		Not covered	
Home health medical supplies	$0		Not covered	
Home infusion agency services	$0		Not covered	
Hemophilia home infusion services *Includes blood factor products.*	$0		Not covered	
Skilled Nursing Facility (SNF) services				
Freestanding SNF	$0		Not covered	
Hospital-based SNF	$0		Not covered	
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		Not covered	
• Self-management training	$0		$30/visit	
• Medical nutrition therapy	$0		$30/visit	
Dialysis services	$0		Not covered	
PKU product formulas and Special Food Products	$0		Not covered	
Allergy serum	$0		$0	
Travel immunizations and vaccinations	$10/injection		$30/injection	

Benefits[5]	Your payment			
	Shield Signature Level I HMO Plan providers[3]	**CYD[2] applies**	**Shield Signature Level II Participating Providers[3]**	**CYD[2] applies**
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 Services Administrator (MHSA).	**Shield Signature Level I MHSA Participating Providers[3]**	**CYD[2] applies**	**Shield Signature Level II MHSA Non-Participating Providers[3]**	**CYD[2] applies**
Outpatient services				
Office visit, including Physician office visit	$0 for the first 3 visits, then $10/visit		$0 for the first 3 visits, then $10/visit	
Teladoc consultation	$0		Not covered	
Intensive outpatient care	$0		Not covered	
Behavioral health treatment in an office setting	$0		$0	
Behavioral health treatment in home or other non-institutional facility setting	$0		$0	
Office-based opioid treatment	$0		$0	
Partial Hospitalization Program	$0		Not covered	
Psychological Testing	$0		Not covered	
Inpatient services				
Physician inpatient services	$0		Not covered	
Hospital services	$0		Not covered	
Residential Care	$0		Not covered	

Notes

1 Evidence of Coverage (EOC):

The Evidence of Coverage (EOC) describes the Benefits, limitations, and exclusions that apply to coverage under this benefit 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.

Defined terms are 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 benefit Plan.

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

3 Using Shield Signature Level I and Shield Signature Level II Participating Providers:

Shield Signature Level I and Shield Signature Level II 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.

4 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 Calender 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.

Any Deductibles count towards the OOPM. Any amounts you pay that count towards the medical Calendar Year Deductible also count towards the Calendar Year Out-of-Pocket Maximum.

Under Shield Signature Level I Participating Providers, *your payment after you reach the Calendar Year OOPM.*

Under Shield Signature Level II Participating Providers, you will continue to be responsible for Copayments or Coinsurance for Covered Services and for all expenses for Non-Covered Services.

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.

5 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.

Notes

6 Preventive Health Services:

If you only receive Preventive Health Services during a Physician office visit, there is no Copayment or Coinsurance for the visit under the Shield Signature Level I provider network. 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.

Benefit Plans may be modified to ensure compliance with State and Federal requirements.
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Outpatient Prescription Drug Rider

San Bernardino County – Actives
Effective July 29, 2023
Shield Signature Rx Plan

Custom Summary of Benefits

This Summary of Benefits shows the amount you will pay for covered Drugs under this prescription Drug Benefit.

Calendar Year Brand Drug Deductible (CYD)[1]

A Calendar Year Brand Drug Deductible (CYD) is the amount a Member pays each Calendar Year before Blue Shield pays for covered Drugs under the outpatient prescription Drug Benefit. Blue Shield pays for some prescription Drugs before the Calendar Year Brand Drug Deductible is met, as noted in the Prescription Drug Benefits chart below.

		When using a Participating[2] or Non-Participating[3] Pharmacy
Calendar Year Brand Drug Deductible	*Per Member*	$0

Prescription Drug Benefits[4,5]

	Your payment			
	When using a Participating Pharmacy[2]	**CYD[1] applies**	**When using a Non-Participating Pharmacy[3]**	**CYD[1] applies**
Retail pharmacy prescription Drugs				
Per prescription, up to a 30-day supply.				
Formulary Generic (Level 1)	$5/prescription		Not covered	
Formulary Brand (Level 2)	$10/prescription		Not covered	
Non-Formulary Brand (Level 3)	$25/prescription		Not covered	
Contraceptive Drugs and devices	$0		Not covered	
Lancets	$0		Not Covered	
Drugs used for the treatment of Sexual Dysfunction	50%/prescription		Not Covered	
Mail service pharmacy prescription Drugs				
Per prescription, up to a 90-day supply.				
Formulary Generic Drugs (Level 1)	$10/prescription		Not covered	
Formulary Brand Drugs (Level 2)	$20/prescription		Not covered	
Non-Formulary Brand Drugs (Level 3)	$50/prescription		Not covered	
Contraceptive Drugs and devices	$0		Not covered	
Lancets	$0		Not Covered	
Specialty Pharmacies	$10/prescription		Not covered	
Per prescription, up to a 30-day supply.				
Per prescription. Specialty Drugs are covered only when dispensed by a Network Specialty Pharmacy. Specialty Drugs from Non-Participating Pharmacies are not covered except in emergency situations.				

Notes

1 Calendar Year Brand Drug Deductible (CYD):

Calendar Year Brand Drug Deductible explained. A Calendar Year Brand Drug Deductible is the amount you pay each Calendar Year before Blue Shield pays for outpatient prescription Drugs under this Benefit.

If this Benefit has a Calendar Year Brand Drug Deductible, outpatient prescription Drugs subject to the Deductible are identified with a check mark (✔) in the Benefits chart above.

Any applicable Copayment, Coinsurance and CYD you pay does not count towards the Calendar Year Out-of-Pocket Maximum. *Outpatient prescription Drugs not subject to the Calendar Year Brand Drug Deductible.* Some outpatient prescription Drugs received from Participating Pharmacies are paid by Blue Shield before you meet any Calendar Year Brand Drug Deductible. These outpatient prescription Drugs do not have a check mark (✔) next to them in the "CYD applies" column in the Prescription Drug Benefits chart above.

2 Using Participating Pharmacies:

Participating Pharmacies have a contract to provide outpatient prescription Drugs to Members. When you obtain covered prescription Drugs from a Participating Pharmacy, you are only responsible for the Copayment or Coinsurance, once any Calendar Year Brand Drug Deductible has been met.

Participating Pharmacies and Drug Formulary. You can find a Participating Pharmacy and the Drug Formulary by visiting https://www.blueshieldca.com/wellness/drugs/formulary#heading2.

3 Using Non-Participating Pharmacies:

Non-Participating Pharmacies do not have a contract to provide outpatient prescription Drugs to Members. When you obtain prescription Drugs from a Non-Participating Pharmacy, you must pay all charges for the prescription, then submit a completed claim form for reimbursement. You will be reimbursed based on the price you paid for the Drug.

4 Outpatient Prescription Drug Coverage:

Medicare Part D-creditable coverage-

This 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 prescription Drug coverage is creditable, you do not have to enroll in Medicare Part D while you maintain this coverage; however, you should be aware that if you have a later break in this coverage of 63 days or more before enrolling in Medicare Part D you could be subject to payment of higher Medicare Part D premiums.

5 Outpatient Prescription Drug Coverage:

Brand Drug coverage when a Generic Drug is available. If you select a Brand Drug when a Generic Drug equivalent is available, you are responsible for the difference between the cost to Blue Shield for the Brand Drug and its Generic Drug equivalent plus the Formulary Generic Copayment or Coinsurance. This difference in cost will not count towards any Calendar Year Brand Drug Deductible, medical Deductible, or the Calendar Year Out-of-Pocket Maximum. If your Physician or Health Care Provider prescribes a Brand Drug and indicates that a Generic Drug equivalent should not be substituted, you pay your applicable tier Copayment or Coinsurance. If your Physician or Health Care Provider does not indicate that a Generic Drug equivalent should not be substituted, you may request a Medical Necessity Review. If approved, the Brand Drug will be covered at the applicable Copayment or Coinsurance.

Short-Cycle Specialty Drug program. This program allows initial prescriptions for select Specialty Drugs to be filled for a 15-day supply with your approval. When this occurs, the Copayment or Coinsurance will be pro-rated.

Specialty Drugs. Specialty Drugs are only available from a Network Specialty Pharmacy, up to a 30-day supply.

Benefit designs may be modified to ensure compliance with State and Federal requirements. Pb050423 GF