blue of california

Superior Court of California, County of San Bernardino
Effective January 1, 2019
HMO Benefit Plan

Summary of Benefits

Superior Court of California, San Bernardino Custom Trio HMO Zero Admit 10

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: Trio ACO HMO Network

This benefit Plan uses a specific network of Health Care Providers, called the Trio ACO HMO provider network. Medical Groups, Independent Practice Associations (IPAs), and Physicians in this network are called Participating Providers. You must select a Primary Care Physician from this network to provide your primary care and help you access services, but there are some exceptions. Please review your Evidence of Coverage for details about how to access care under this Plan. 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.

		When using a Participating Provider[3]
Calendar Year medical Deductible	*Individual coverage*	$0
	Family coverage	$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 EOC.

	When using a Participating Provider[3]
Individual coverage	$3,500
Family coverage	$3,500: individual
	$7,000: 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	
	When using a Participating Provider[3]	CYD[2] applies
Preventive Health Services[6]	$0	
California Prenatal Screening Program	$0	
Physician services		
Primary care office visit	$10/visit	
Trio+ specialist care office visit (self-referral)	$10/visit	
Other specialist care office visit (referred by PCP)	$10/visit	
Physician home visit	$10/visit	
Physician or surgeon services in an Outpatient Facility	$0	
Physician or surgeon services in an inpatient facility	$0	
Other professional services		
Other practitioner office visit	$10/visit	
Includes nurse practitioners, physician assistants, and therapists.		
Teladoc consultation	$5/consult	
Family planning		
• Counseling, consulting, and education	$0	
• Injectable contraceptive; diaphragm fitting, intrauterine device (IUD), implantable contraceptive, and related procedure.	$0	
• Tubal ligation	$0	
• Vasectomy	$0	
• Infertility services	$0	
Podiatric services	$10/visit	
Pregnancy and maternity care[6]		
Physician office visits: prenatal and postnatal	$0	
Physician services for pregnancy termination	$0	
Emergency services		
Emergency room services	$50/visit	
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.		
Emergency room Physician services	$0	

Benefits[5]	Your payment	
	When using a Participating Provider[3]	CYD[2] applies
Urgent care center services	$10/visit	
Ambulance services *This payment is for emergency or authorized transport.*	$0	
Outpatient Facility services		
Ambulatory Surgery Center	$100/surgery	
Outpatient department of a Hospital: surgery	$100/surgery	
Outpatient department of a Hospital: treatment of illness or injury, radiation therapy, chemotherapy, and necessary supplies	$0	
Inpatient facility services		
Hospital services and stay	$0	
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	
• Physician inpatient services	$0	
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	
• Outpatient department of a Hospital	$0	
X-ray and imaging services *Includes diagnostic mammography.*		
• Outpatient radiology center	$0	
• Outpatient department of a Hospital	$0	
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	
• Outpatient department of a Hospital	$0	

Benefits[5]	Your payment	
	When using a Participating Provider[3]	CYD[2] applies
Radiological and nuclear imaging services		
• Outpatient radiology center	$0	
• Outpatient department of a Hospital	$0	
Rehabilitative and Habilitative Services		
Includes Physical Therapy, Occupational Therapy, Respiratory Therapy, and Speech Therapy services.		
Office location	$10/visit	
Outpatient department of a Hospital	$10/visit	
Durable medical equipment (DME)		
DME	$0	
Breast pump	$0	
Orthotic equipment and devices	$0	
Prosthetic equipment and devices	$0	
Home health 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, except hemophilia and home infusion nursing visits.		
Home health agency services	$10/visit	
Includes home visits by a nurse, Home Health Aide, medical social worker, physical therapist, speech therapist, or occupational therapist.		
Home visits by an infusion nurse	$10/visit	
Home health medical supplies	$0	
Home infusion agency services	$0	
Hemophilia home infusion services	$0	
Includes blood factor products.		
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	
Hospital-based SNF	$0	
Hospice program services	$0	
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.		

Benefits[5]	Your payment	
	When using a Participating Provider[3]	CYD[2] applies
Other services and supplies		
Diabetes care services		
• Devices, equipment, and supplies	$0	
• Self-management training	$10/visit	
Dialysis services	$0	
PKU product formulas and Special Food Products	$0	
Allergy serum	$0	

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).	When using a MHSA Participating Provider[3]	CYD[2] applies
Outpatient services		
Office visit, including Physician office visit	$10/visit	
Other outpatient services, including intensive outpatient care, Behavioral Health Treatment for pervasive developmental disorder or autism in an office setting, home, or other non-institutional facility setting, and office-based opioid treatment	$0	
Partial Hospitalization Program	$0	
Psychological Testing	$0	
Inpatient services		
Physician inpatient services	$0	
Hospital services	$0	
Residential Care	$0	

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.

Notes

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.

Your payment for services from "Other Providers." You will pay the Copayment or Coinsurance applicable to Participating Providers for Covered Services received from Other Providers. However, Other Providers do not have a contract to provide health care services to Members and so are not Participating Providers. Therefore, you will also pay all charges above the Allowable Amount. This out-of-pocket expense can be significant.

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

Your payment after you reach the Calendar Year OOPM. You will continue to pay all charges above a Benefit maximum.

Essential health benefits count towards the 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.

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.

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. 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.

PENDING REGULATORY APPROVAL

Blue Shield of California Life & Health Insurance Company
Vision Plan

Superior Court of California, San Bernardino

Eye Exam only - Exam copayment $10

Custom Benefit summary
Effective January 1, 2019

THIS MATRIX IS INTENDED TO BE USED TO HELP YOU COMPARE COVERAGE BENEFITS AND IS A SUMMARY ONLY. THE *CERTIFICATE OF INSURANCE* AND POLICY SHOULD BE CONSULTED FOR A DETAILED DESCRIPTION OF COVERAGE BENEFITS AND LIMITATIONS.

Using your vision plan

With this vision plan, you have access to an extensive network of vision providers in California and nationwide[1]. Many of the providers are conveniently located in optical centers at retail stores[2] such as LensCrafters, Sears, Target Optical, Wal-Mart, and Costco (membership required). When you use a network provider for your eye exam, there's no additional charge.

What your vision plan covers

Covered services	Coverage when provided by network providers (after applicable copayment)	Maximum payment when provided by non-network provider
Comprehensive Examination - every 24 months		
Ophthalmologic	100%	up to a maximum of $60
Optometric	100%	up to a maximum of $50

Accessing your vision benefits is easy, just follow these steps:

1. Prior to receiving a service, review your benefit information for coverage details outlined in the chart above.
2. Call and make an appointment with a network provider.

Or:

If you use a non-network provider, you're required to pay the provider's bill at the time of service. You can get your reimbursement by obtaining a claim form from your employer or by logging on to **blueshieldca.com.** Select *Members,* then *Forms* and then select the *Vision Benefit Claim Form (C-4669-61)* link. Complete and submit the claim form with the itemized receipt and a copy of your prescription to:

Blue Shield of California Life & Health Insurance Company
P.O. Box 25208
Santa Ana, CA 92799-5208

You will be reimbursed for your expenses up to the maximum payment allowed (see table above). Note that when your dependents submit a claim form for reimbursement, payment will be made to you. Be sure to use your Blue Shield member identification number when filling out the form.

Your vision coverage is underwritten by Blue Shield of California Life & Health Insurance Company (Blue Shield Life) and administered by a contracted vision plan administrator.

Find a network provider nearest you by going to the *Find a Provider* section on **blueshieldca.com,** or calling Member Services at **(877) 601-9083.** You'll find a complete listing of ophthalmologists, optometrists, and opticians.

1 Nationwide vision providers are available by arrangement through a contracted vision plan administrator.

2 Availability of retail store locations varies by state. Refer to blueshieldcavision.com for out-of-state retail locations.

Enhanced Rx $5/10/25 - $10/20/50 with $0 Pharmacy Deductible

Outpatient Prescription Drug Coverage
(For groups of 101 and above)

THIS DRUG COVERAGE SUMMARY IS ADDED TO BE COMBINED WITH THE HMO OR 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: **$0 Calendar Year Pharmacy Deductible**
$5 Tier 1 /$10 Tier 2 /$25 Tier 3 drug - Retail Pharmacy
$10 Tier 1 /$20 Tier 2 /$50 Tier 3 drug - Mail Service

Covered Services	Member Copayment
DEDUCTIBLES (Prescription drug coverage benefits are not subject to the medical plan deductible)	
Calendar Year Pharmacy Deductible (Applicable to all covered drugs not in Tier 1. Does not apply to Contraceptive drugs and devices or oral anticancer drugs.)	None
PRESCRIPTION DRUG COVERAGE[1,2,3,4]	
Pharmacy Network: Rx Ultra **Drug Formulary**: Plus Formulary	**Participating Pharmacy**[5]
Retail Prescriptions (up to a 30-day supply)	
• Contraceptive drugs and devices[6]	$0 per prescription
• Tier 1 drugs	$5 per prescription
• Tier 2 drugs	$10 per prescription
• Tier 3 drugs	$25 per prescription
• Tier 4 drugs (excluding Specialty drugs)	20% coinsurance up to $200 per prescription
Mail Service Prescriptions (up to a 90-day supply)	
• Contraceptive drugs and devices[6]	$0 per prescription
• Tier 1 drugs	$10 per prescription
• Tier 2 drugs	$20 per prescription
• Tier 3 drugs	$50 per prescription
• Tier 4 drugs (excluding Specialty drugs)	20% coinsurance up to $400 per prescription
Specialty Pharmacies (up to a 30-day supply)[7]	
• Tier 4 - Specialty drugs[8]	20% coinsurance up to $200 per prescription

1 Amounts paid through copayments and any applicable pharmacy deductible accrues to the member's medical year out-of-pocket maximum. 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, if applicable, from the previous plan during the year will not carry forward to your new plan.

2 Drugs obtained at a non-participating pharmacy are not covered, unless Medically Necessary for a covered emergency.

3 Select drugs require prior authorization by Blue Shield for medical necessity, or when effective, lower cost alternatives are available.

4 If the member requests a brand drug when a generic drug equivalent is available, the member is responsible for paying the Tier 1 drug copayment plus the difference in cost to Blue Shield between the brand drug and its generic drug equivalent.

5 Coinsurance is calculated based on the contracted rate. When the Participating Pharmacy's contracted rate is less than the Member's Copayment or Coinsurance, the Member only pays the contracted rate.

6 Contraceptive drugs and devices covered under the outpatient prescription drug benefits will not be subject to the calendar year pharmacy deductible when obtained from a participating pharmacy. If a brand contraceptive is requested when a generic equivalent is available, the member will be responsible for paying the difference between the cost to Blue Shield for the brand contraceptive and its generic drug equivalent. In addition, select contraceptives may need prior authorization to be covered without a copayment. The member may receive up to a 12-month supply of contraceptive Drugs.

7 Network Specialty Pharmacies dispense Specialty drugs which require coordination of care, close monitoring, or extensive patient training that generally cannot be met by a retail pharmacy. Network Specialty Pharmacies also dispense Specialty drugs requiring special handling or manufacturing processes, restriction to certain Physicians or pharmacies, or reporting of certain clinical events to the FDA. Specialty drugs are generally high cost.

8 Specialty Drugs are available from a Network Specialty Pharmacy. A Network Specialty Pharmacy provides specialty drugs by mail or upon member request, at an associated retail store for pickup. Oral anticancer medications are not subject to the calendar year pharmacy deductible.

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 83 days or more anytime after you were first eligible to enroll in a Medicare prescription drug plan, you would 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 www.blueshieldca.com/bsca/pharmacy/home.sp 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 www.blueshieldca.com/bsca/pharmacy/home.sp 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 prescription.

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 711.

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

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PENDING REGULATORY APPROVAL