blue of california

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

Summary of Benefits

Superior Court of California, San Bernardino Custom Full PPO Combined Deductible 20%-250 80/70

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: **Full PPO Network**

This benefit 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 benefit Plan. Blue Shield pays for some Covered Services before the Calendar Year Deductible is met, as noted in the Benefits chart below.

		When using a Participating[3] or Non-Participating[4] Provider
Calendar Year medical Deductible	*Individual coverage*	$250
	Family coverage	$250: individual $750: 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 any combination of Participating[3] or Non-Participating[4] Providers
Individual coverage	$3,500	$4,400
Family coverage	$3,500: individual $7,000: Family	$4,400: individual $8,800: 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[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]	$0		Not covered	
California Prenatal Screening Program	$0		$0	
Physician services				
Primary care office visit	20%		30%	✔
Specialist care office visit	20%		30%	✔
Physician home visit	20%		30%	✔
Physician or surgeon services in an Outpatient Facility	20%	✔	30%	✔
Physician or surgeon services in an inpatient facility	20%	✔	30%	✔
Other professional services				
Other practitioner office visit	20%		30%	✔
Includes nurse practitioners, physician assistants, and therapists.				
Acupuncture services	20%	✔	30%	✔
Up to 12 visits per Member, per Calendar Year.				
Chiropractic services	20%		30%	✔
Up to 30 visits per Member, per Calendar Year.				
Teladoc consultation	$5/consult		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	20%	✔	Not covered	
• Infertility services	Not covered		Not covered	
Podiatric services	20%		30%	✔
Pregnancy and maternity care[7]				
Physician office visits: prenatal and postnatal	$0		30%	✔
Physician services for pregnancy termination	20%	✔	30%	✔

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.*	$50/visit plus 20%		$50/visit plus 20%	
Emergency room Physician services	20%	✔	20%	✔
Urgent care center services	20%		30%	✔
Ambulance services *This payment is for emergency or authorized transport.*	20%	✔	20%	✔
Outpatient Facility services				
Ambulatory Surgery Center	20%	✔	30% up to $600/day plus 100% of additional charges	✔
Outpatient department of a Hospital: surgery	20%	✔	30% up to $600/day plus 100% of additional charges	✔
Outpatient department of a Hospital: treatment of illness or injury, radiation therapy, chemotherapy, and necessary supplies	20%	✔	30% up to $600/day plus 100% of additional charges	✔
Inpatient facility services				
Hospital services and stay	20%	✔	30% up to $1500/day plus 100% of additional charges	✔
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	20%	✔	Not covered	
• Physician inpatient services	20%	✔	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
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	20%	✔	Not covered	
Outpatient Facility services	20%	✔	Not covered	
Physician services	20%	✔	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	20%	✔	30%	✔
• Outpatient department of a Hospital	20%	✔	30% up to $600/day plus 100% of additional charges	✔
X-ray and imaging services				
Includes diagnostic mammography.				
• Outpatient radiology center	20%	✔	30%	✔
• Outpatient department of a Hospital	20%	✔	30% up to $600/day plus 100% of additional charges	✔

Benefits[6]	Your payment			
	When using a Participating Provider[3]	CYD[2] applies	When using a Non-Participating Provider[4]	CYD[2] applies
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	20%	✔	30%	✔
• Outpatient department of a Hospital	20%	✔	30% up to $600/day plus 100% of additional charges	✔
Radiological and nuclear imaging services				
• Outpatient radiology center	20%	✔	30%	✔
• Outpatient department of a Hospital	20%	✔	30% up to $600/day plus 100% of additional charges	✔
Rehabilitative and Habilitative Services *Includes Physical Therapy, Occupational Therapy, Respiratory Therapy, and Speech Therapy services.*				
Office location	20%		30%	✔
Outpatient department of a Hospital	20%		30% up to $600/day plus 100% of additional charges	✔
Durable medical equipment (DME)				
DME	50%	✔	50%	✔
Breast pump	$0		Not covered	
Orthotic equipment and devices	20%	✔	30%	✔
Prosthetic equipment and devices	20%	✔	30%	✔

Benefits[6]	Your payment			
	When using a Participating Provider[3]	CYD[2] applies	When using a Non-Participating Provider[4]	CYD[2] applies
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	20%	✔	Not covered	
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	20%	✔	Not covered	
Home health medical supplies	20%	✔	Not covered	
Home infusion agency services	20%	✔	Not covered	
Hemophilia home infusion services	20%	✔	Not covered	
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	20%	✔	20%	✔
Hospital-based SNF	20%	✔	30% up to $1500/day plus 100% of additional charges	✔
Hospice program services	$0		Not covered	
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.				
Other services and supplies				
Diabetes care services				
• Devices, equipment, and supplies	20%	✔	30%	✔
• Self-management training	20%		30%	✔
Dialysis services	20%	✔	30% up to $600/day plus 100% of additional charges	✔

Benefits[6]	Your payment			
	When using a Participating Provider[3]	CYD[2] applies	When using a Non-Participating Provider[4]	CYD[2] applies
PKU product formulas and Special Food Products	20%	✔	20%	✔
Allergy serum	20%	✔	30%	✔

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	When using a MHSA Non-Participating Provider[4]	CYD[2] applies
Outpatient services				
Office visit, including Physician office visit	20%		30%	✔
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	20%	✔	30%	✔
Partial Hospitalization Program	20%	✔	30% up to $600/day plus 100% of additional charges	✔
Psychological Testing	20%	✔	30%	✔
Inpatient services				
Physician inpatient services	20%	✔	30%	✔
Hospital services	20%	✔	30% up to $1500/day plus 100% of additional charges	✔
Residential Care	20%	✔	30% up to $1500/day plus 100% of additional charges	✔

Prior Authorization

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

- Radiological and nuclear imaging services
- Inpatient facility services
- Home health services from Non-Participating Providers
- Mental health services, except outpatient office visits, electroconvulsive therapy, and Psychological Testing
- 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 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 Calendar Year 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.

Covered Services not subject to the Calendar Year medical Deductible. Some Covered Services received from Participating Providers are paid by Blue Shield before you meet any Calendar Year medical Deductible. These Covered Services do not have a check mark (✔) next to them in the "CYD applies" column 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.

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 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 both:

- the Copayment or Coinsurance (once any Calendar Year Deductible has been met), and

Notes

- any charges above the Allowable Amount (which can be significant).

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

- Any Coinsurance is determined from the Allowable Amount.
- Any charges above the Allowable Amount are not covered, 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.
- Some Benefits from Non-Participating Providers have the Allowable Amount listed in the Benefits chart as a specific dollar ($) amount. You are responsible for any charges above the Allowable Amount, whether or not an amount is listed in the Benefits chart.

5 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.

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.

This benefit Plan has a Participating Provider OOPM as well as a combined Participating Provider and Non-Participating Provider OOPM. This means that any amounts you pay towards your Participating Provider OOPM also count towards your combined Participating 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.

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 $0

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 $15/30/45 - $30/60/90 with $0 Pharmacy Deductible

THIS DRUG COVERAGE SUMMARY IS ADDED TO BE COMBINED WITH THE 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.

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

Blue Shield of California

Highlight: $0 Calendar Year Pharmacy Deductible
$15 Tier 1 /$30 Tier 2 /$45 Tier 3 drug - Retail Pharmacy
$30 Tier 1 /$60 Tier 2 /$90 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]		
Pharmacy Network: Rx Ultra **Drug Formulary**: Plus Formulary	**Participating Pharmacy[4]**	**Non-Participating Pharmacy[5]**
Retail Prescriptions (up to a 30-day supply)		
• Contraceptive drugs and devices[6]	$0 per prescription	Applicable Tier 1, Tier 2, or Tier 3 Copayment
• Tier 1 drugs	$15 per prescription	25% of purchase price + $15 per prescription
• Tier 2 drugs	$30 per prescription	25% of purchase price + $30 per prescription
• Tier 3 drugs	$45 per prescription	25% of purchase price + $45 per prescription
• Tier 4 drugs (excluding Specialty drugs)	30% coinsurance up to $200 per prescription	25% of purchase price + 30% coinsurance up to $200 per prescription
Mail Service Prescriptions (up to a 90-day supply)		
• Contraceptive drugs and devices[6]	$0 per prescription	Not Covered
• Tier 1 drugs	$30 per prescription	Not Covered
• Tier 2 drugs	$60 per prescription	Not Covered
• Tier 3 drugs	$90 per prescription	Not Covered
• Tier 4 drugs (excluding Specialty drugs)	30% coinsurance up to $400 per prescription	Not Covered
Specialty Pharmacies (up to a 30-day supply)[7]		
• Tier 4 - Specialty drugs[8]	30% coinsurance up to $200 per prescription	Not Covered

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

3 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.

4 When the Participating Pharmacy's contracted rate is less than the Member's Copayment or Coinsurance, the Member only pays the contracted rate.

5 To obtain prescription drugs, including contraceptive drugs and devices, at a non-participating pharmacy, the member must first pay all charges for the prescription and submit a completed Prescription Drug Claim Form for reimbursement. The member will be reimbursed the price paid for the drug less any applicable deductible, copayment or coinsurance and any applicable out of network charge.

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

A20046 (1/19)

PENDING REGULATORY APPROVAL