

## Custom Access+ HMO Zero Admit 10

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).<sup>1</sup> Please read both documents carefully for details.

### Medical Provider Network:

### Access+ HMO Network

This Plan uses a specific network of Health Care Providers, called the Access+ 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)<sup>2</sup>

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

Calendar Year medical Deductible	When using a Participating Provider <sup>3</sup>	
	<i>Individual coverage</i>	\$0
<i>Family coverage</i>	\$0: individual	\$0: Family

### Calendar Year Out-of-Pocket Maximum<sup>4</sup>

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.

### 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.

When using a Participating Provider <sup>3</sup>	
<i>Individual coverage</i>	\$3,500
<i>Family coverage</i>	\$3,500: individual \$7,000: Family

**Benefits<sup>5</sup>**

**Your payment**

	<b>When using a Participating Provider<sup>3</sup></b>	<b>CYD<sup>2</sup> applies</b>
<b>Preventive Health Services<sup>6</sup></b>		
Preventive Health Services	\$0	
California Prenatal Screening Program	\$0	
<b>Physician services</b>		
Primary care office visit	\$10/visit	
Access+ specialist care office visit (self-referral)	\$20/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	
<b>Other professional services</b>		
Other practitioner office visit <i>Includes nurse practitioners, physician assistants, and therapists.</i>	\$10/visit	
Teladoc consultation	\$0	
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	
Podiatric services	\$10/visit	
<b>Pregnancy and maternity care</b>		
Physician office visits: prenatal and postnatal	\$0	
Physician services for pregnancy termination	\$0	
<b>Emergency Services</b>		
Emergency room services	\$50/visit	
<i>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.</i>		
Emergency room Physician services	\$0	

**Benefits<sup>5</sup>**

**Your payment**

	<b>When using a Participating Provider<sup>3</sup></b>	<b>CYD<sup>2</sup> applies</b>
<b>Urgent care center services</b>	\$10/visit	
<b>Ambulance services</b> <i>This payment is for emergency or authorized transport.</i>	\$0	
<b>Outpatient Facility services</b>		
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	
<b>Inpatient facility services</b>		
Hospital services and stay	\$0	
Transplant services <i>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.</i>		
• Special transplant facility inpatient services	\$0	
• Physician inpatient services	\$0	
<b>Diagnostic x-ray, imaging, pathology, and laboratory services</b> <i>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.</i>		
Laboratory services <i>Includes diagnostic Papanicolaou (Pap) test.</i>		
• Laboratory center	\$0	
• Outpatient Department of a Hospital	\$0	
X-ray and imaging services <i>Includes diagnostic mammography.</i>		
• Outpatient radiology center	\$0	
• Outpatient Department of a Hospital	\$0	
Other outpatient diagnostic testing <i>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.</i>		
• Office location	\$0	
• Outpatient Department of a Hospital	\$0	
Radiological and nuclear imaging services		
• Outpatient radiology center	\$0	
• Outpatient Department of a Hospital	\$0	

**Benefits<sup>5</sup>**

**Your payment**

	<b>When using a Participating Provider<sup>3</sup></b>	<b>CYD<sup>2</sup> applies</b>
<b>Rehabilitative and Habilitative Services</b>		
<i>Includes physical therapy, occupational therapy, respiratory therapy, and speech therapy services.</i>		
Office location	\$10/visit	
Outpatient Department of a Hospital	\$10/visit	
<b>Durable medical equipment (DME)</b>		
DME	\$0	
Breast pump	\$0	
Orthotic equipment and devices	\$0	
Prosthetic equipment and devices	\$0	
<b>Home health care services</b>		
	\$10/visit	
<i>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.</i>		
<b>Home infusion and home injectable therapy services</b>		
Home infusion agency services	\$0	
<i>Includes home infusion drugs and medical supplies.</i>		
Home visits by an infusion nurse	\$10/visit	
Hemophilia home infusion services	\$0	
<i>Includes blood factor products.</i>		
<b>Skilled Nursing Facility (SNF) services</b>		
<i>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.</i>		
Freestanding SNF	\$0	
Hospital-based SNF	\$0	
<b>Hospice program services</b>		
	\$0	
<i>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.</i>		
<b>Other services and supplies</b>		
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 billed separately from an office visit	\$0	

## Mental Health and Substance Use Disorder Benefits

## Your payment

<i>Mental health and substance use disorder Benefits are provided through Blue Shield's Mental Health Service Administrator (MHSA).</i>	<b>When using a MHSA Participating Provider<sup>3</sup></b>	<b>CYD<sup>2</sup> applies</b>
<b>Outpatient services</b>		
Office visit, including Physician office visit	\$10/visit	
Teladoc behavioral health	\$0	
Other outpatient services, including intensive outpatient care, electroconvulsive therapy, transcranial magnetic stimulation, 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	
<b>Inpatient services</b>		
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 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 Calendar Year 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.

### 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).

### 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 Allowed Charges for Covered Services for the rest of the Calendar Year.

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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 Allowed Charges, and charges for services above any Benefit maximum.

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 payment in addition to an allergy serum payment 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.



**Blue Shield of California Life & Health Insurance Company**  
**Summary of Benefits**

Superior Court of California, County  
of San Bernardino  
Effective January 1, 2022

**PPO Plan**

**Eye Exam Only**

This Summary of Benefits shows the amount you will pay for Covered Services under this Blue Shield of California Life & Health Insurance Company (Blue Shield Life) Plan. It is only a summary and it is included as part of the Certificate of Insurance (COI).<sup>1</sup> Please read both documents carefully for details.

**Provider Network:**

This Plan uses a contracted network of vision care providers. 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](http://blueshieldca.com).

**Benefit Frequency Limits**

This Plan pays up to the Allowance and frequency limits as listed for Covered Services.

<b>Comprehensive exam</b>	One every 24 consecutive months
<b>Diabetes management referral</b>	One every Calendar Year

**Waiting Period**

A waiting period is the length of time you must be covered under the Plan before Blue Shield Life will pay for Covered Services.

<b>Waiting period</b>	No waiting period
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**No Deductible**

Under this Plan there is no dollar amount an Insured must pay before Blue Shield Life will pay for Covered Services.

**No Lifetime Dollar Limit**

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

Blue Shield of California Life & Health Insurance Company is an independent licensee of the Blue Shield Association.

**Benefits<sup>2</sup>**

**Your payment**

	<b>When using a Participating Provider<sup>3</sup></b>	<b>When using a Non-Participating Provider<sup>4</sup></b>
<b>Eye examinations</b>		
Comprehensive exam <i>One per Insured every 24 months.</i>		
Ophthalmologic visit	\$10	All charges above \$60
Optometric visit	\$10	All charges above \$50
Retinal Imaging  <i>One per Insured every 24 months by a Participating Provider instead of a standard comprehensive exam with dilation.</i>	\$39	Not covered
Standard contact lens fitting and evaluation  <i>One per Insured every 12 months by a Participating Provider if administered at the same time as the comprehensive exam.</i>	Not covered	Not covered
<b>Other services</b>		
Low-vision testing and equipment  <i>One per Insured every 12 months by a Participating Provider. Exam must be Medically Necessary, requires a report from the provider and prior authorization from the VPA.</i>	Not covered	Not covered
Diabetes management referral  <i>One per Insured, per Calendar Year to a Participating Provider when you are known to have or be at risk for diabetes.</i>	\$0	Not covered

**Notes**

**1 Certificate of Insurance (COI):**

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

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

**2 Vision Care Services:**

All vision Benefits are provided through Blue Shield Life's Vision Plan Administrator (VPA).

**3 Using Participating Providers:**

Participating Providers have a contract to provide vision care services to Insureds. When you receive Covered Services from a Participating Provider, you are responsible for:

- the Copayment, and
- any charges above the stated Allowance, which is the Benefit maximum.

**4 Using Non-Participating Providers:**



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

- the Copayment, and
- any charges above the stated Allowance, which is the Benefit maximum.



## Outpatient Prescription Drug Rider

Group Rider  
HMO/POS

### Enhanced Rx \$5/10/25 with \$0 Pharmacy Deductible Summary of Benefits

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

Pharmacy Network:

Rx Ultra

Drug Formulary:

Plus Formulary

#### Calendar Year Pharmacy Deductible(CYPD)<sup>1</sup>


A Calendar Year Pharmacy Deductible (CYPD) 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 Pharmacy Deductible is met, as noted in the Prescription Drug Benefits chart below.

#### When using a Participating<sup>2</sup> Pharmacy

Calendar Year Pharmacy Deductible Per Member \$0

#### Prescription Drug Benefits<sup>3,4</sup>

#### Your payment

	When using a Participating Pharmacy <sup>2</sup>	CYPD <sup>1</sup> applies
<b>Retail pharmacy prescription Drugs</b>		
<i>Per prescription, up to a 30-day supply.</i>		
Contraceptive Drugs and devices	\$0	Blue Shield of California is an independent member of the Blue Shield Association
Tier 1 Drugs	\$5/prescription	
Tier 2 Drugs	\$10/prescription	
Tier 3 Drugs	\$25/prescription	
Tier 4 Drugs	20% up to \$250/prescription	
<b>Retail pharmacy prescription Drugs</b> 		
<i>Per prescription, up to a 90-day supply from a 90-day retail pharmacy.</i>		
Contraceptive Drugs and devices	\$0	
Tier 1 Drugs	\$15/prescription	
Tier 2 Drugs	\$30/prescription	
Tier 3 Drugs	\$75/prescription	

Questions? Visit [blueshieldca.com](https://www.blueshieldca.com), use the Blue Shield mobile app, or call Shield Concierge at 1-855-599-2649.

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

## Prescription Drug Benefits<sup>3,4</sup>

## Your payment

	When using a Participating Pharmacy <sup>2</sup>	CYPD <sup>1</sup> applies
Tier 4 Drugs	20% up to \$750/prescription	
<b>Mail service pharmacy prescription Drugs</b>		
<i>Per prescription, up to a 90-day supply.</i>		
Contraceptive Drugs and devices	\$0	
Tier 1 Drugs	\$10/prescription	
Tier 2 Drugs	\$20/prescription	
Tier 3 Drugs	\$50/prescription	
Tier 4 Drugs	20% up to \$500/prescription	

## Notes

### 1 Calendar Year Pharmacy Deductible (CYPD):

Calendar Year Pharmacy Deductible explained. A Calendar Year Pharmacy 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 Pharmacy Deductible, outpatient prescription Drugs subject to the Deductible are identified with a check mark (✓) in the Benefits chart above.

Any applicable Copayment, Coinsurance and CYPD you pay counts towards the Calendar Year Out-of-Pocket Maximum.

Outpatient prescription Drugs not subject to the Calendar Year Pharmacy Deductible. Some outpatient prescription Drugs received from Participating Pharmacies are paid by Blue Shield before you meet any Calendar Year Pharmacy Deductible. These outpatient prescription Drugs do not have a check mark (✓) next to them in the "CYPD 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 Pharmacy Deductible has been met.

Participating Pharmacies and Drug Formulary. You can find a Participating Pharmacy and the Drug Formulary by visiting [www.blueshieldca.com/pharmacy](http://www.blueshieldca.com/pharmacy).

Non-Participating Pharmacies. Drugs from Non-Participating Pharmacies are not covered except in emergency situations.

### 3 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

## Notes

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aware that if you do not enroll in Medicare Part D within 63 days following termination of this coverage, you could be subject to Medicare Part D premium penalties.

#### 4 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 Tier 1 Copayment or Coinsurance. This difference in cost will not count towards any Calendar Year Pharmacy 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 Drug tier 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.

Oral Anticancer Drugs. You pay up to \$250 for oral Anticancer Drugs from a Participating Pharmacy, up to a 30-day supply. Oral Anticancer Drugs from a Participating Pharmacy are not subject to any Deductible.

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