Summary of Benefits

San Bernardino County - Actives
Effective July 25, 2026
PPO Plan

Custom PPO Needles 0-250 100/70

This Summary of Benefits shows the amount you will pay for Covered Benefits 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 Benefits 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 Benefits under the Plan.

		When using a Participating Provider[3]	When using a Non-Participating Provider[4]
Calendar Year medical Deductible	*Individual coverage*	$0	$250
	Family coverage	$0: individual	$250: individual
		$0: Family - 2 members	$500: Family - 2 members
		$0: Family - 3 or more members	$750: Family - 3 or more members

Calendar Year Out-of-Pocket Maximum[5]

An Out-of-Pocket Maximum is the most a Member will pay for Covered Benefits 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	$1,500	$2,250
Family coverage	$1,500: individual	$2,250: individual
	$3,000: Family	$4,750: 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 Benefits.

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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		30%	✔
California Prenatal Screening Program	$0		$0	
Physician services				
Primary care office visit	$10/visit		30%	✔
Specialist care office visit	$10/visit		30%	✔
Office visit for allergy serum injection	$10/visit		30%	✔
Physician home visit	$0		30%	✔
Physician or surgeon services in an Outpatient Facility	$0		30%	✔
Physician or surgeon services in an inpatient facility	$0		30%	✔
Other professional services				
Other practitioner office visit	$10/visit		30%	✔
Includes nurse practitioners, physician assistants, therapists, and podiatrists.				
Acupuncture services	$0		$0	✔
Up to 20 visits per Member, per Calendar Year.				
Chiropractic services	$10/visit		30%	✔
Up to 30 visits per Member, per Calendar Year.				
Teladoc Health consultation	$0		Not covered	
Family planning				
• Counseling, consulting, and education	$0		30%	✔
• Injectable contraceptive, diaphragm fitting, intrauterine device (IUD), implantable contraceptive, and related procedure.	$0		30%	✔
• Tubal ligation	$0		50%	✔
• Vasectomy	$75/surgery		50%	✔
Medical nutrition therapy, not related to diabetes	$0		30%	✔
Infertility Services				
Physician or surgeon services in an Outpatient Facility	$0		30%	✔
Artificial Inseminations limited to 6 per lifetime	$0		30%	✔
Oocyte (egg) retrieval limited to 3 per lifetime				
• Ambulatory Surgery Center	$0		30%	✔
• Outpatient Department of a Hospital	$0		30%	✔

Benefits[6]	Your payment			
	When using a Participating Provider[3]	CYD[2] applies	When using a Non-Participating Provider[4]	CYD[2] applies
In vitro fertilization (IVF)	$0		30%	✔
Embryo transfer				
• Ambulatory Surgery Center	$0		30%	✔
• Outpatient Department of a Hospital	$0		30%	✔
Cryopreservation limited to 1 year of storage per lifetime for each of the following: sperm, reproductive tissue, oocytes (eggs), and embryos	$0		30%	✔
Pregnancy and maternity care				
Physician office visits: prenatal and postnatal	$10/visit		30%	✔
Abortion and abortion-related services	$0		$0	
Emergency Services				
Emergency room services	$50/visit		$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		$0	
Urgent care center services	$10/visit		30%	✔
Ambulance services	$0		$0	
This payment is for emergency or authorized transport.				
Outpatient Facility services				
Ambulatory Surgery Center	$0		30%	✔
Outpatient Department of a Hospital: surgery	$0		30%	✔
Outpatient Department of a Hospital: treatment of illness or injury, radiation therapy, chemotherapy, and necessary supplies	$0		30%	✔
Inpatient facility services				
Hospital services and stay	$0		30%	✔
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	

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	$0		Not covered	
Outpatient Facility services	$0		Not covered	
Physician services	$0		Not covered	
Diagnostic x-ray, imaging, pathology, and laboratory services				
This payment is for Covered Benefits that are diagnostic, non-Preventive Health Services, and diagnostic radiological procedures. For the payments for Covered Benefits that are considered Preventive Health Services, see Preventive Health Services.				
Laboratory and pathology services				
Includes diagnostic Papanicolaou (Pap) test.				
• Laboratory center	$0		30%	✔
• Outpatient Department of a Hospital	$0		30%	✔
Basic imaging services				
Includes plain film X-rays, ultrasounds, and diagnostic mammography.				
• Outpatient radiology center	$0		30%	✔
• Outpatient Department of a Hospital	$0		30%	✔
Other outpatient non-invasive diagnostic testing				
Testing to diagnose illness or injury such as vestibular function tests, EKG, cardiac monitoring, non-invasive vascular studies, sleep medicine testing, muscle and range of motion tests, EEG, and EMG.				
• Office location	$0		30%	✔
• Outpatient Department of a Hospital	$0		30%	✔

Benefits[6]	**Your payment**			
	When using a Participating Provider[3]	**CYD**[2] **applies**	**When using a Non-Participating Provider**[4]	**CYD**[2] **applies**
Advanced imaging services				
Includes diagnostic radiological and nuclear imaging such as CT scans, MRIs, MRAs, and PET scans.				
• Outpatient radiology center	$0		30%	✔
• Outpatient Department of a Hospital	$0		30%	✔
Rehabilitative and Habilitative Services				
Includes physical therapy, occupational therapy, and respiratory therapy.				
Office location	$10/visit		30%	✔
Outpatient Department of a Hospital	$10/visit		30%	✔
Speech Therapy services				
Office location	$10/visit		$10/visit	✔
Outpatient Department of a Hospital	$10/visit		30%	✔
Durable medical equipment (DME)				
DME	$0		30%	✔
Breast pump	$0		Not covered	
Orthotic equipment and devices	$0		30%	✔
Prosthetic equipment and devices	$0		30%	✔
Home health care services	$0		Not covered	
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.				
Home infusion and home injectable therapy services				
Home infusion agency services	$0		Not covered	
Includes home infusion drugs, medical supplies, and visits by a nurse.				
Hemophilia home infusion services	$0		Not covered	
Includes blood factor products.				

Benefits[6]	Your payment			
	When using a Participating Provider[3]	CYD[2] applies	When using a Non-Participating Provider[4]	CYD[2] applies
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		30%	✔
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	$0		30%	✔
• Self-management training	$10/visit		30%	✔
• Medical nutrition therapy	$10/visit		30%	✔
Dialysis services	$0		30%	✔
PKU product formulas and special food products	$0		$0	
Allergy serum billed separately from an office visit	$0		30%	✔
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 or Substance Use Disorder Benefits

Your payment

	When using a Participating Provider[3]	CYD[2] applies	When using a Non-Participating Provider[4]	CYD[2] applies
Outpatient services				
Office visit, including Physician office visit	$0 for the first 3 visits, then $10/visit		30%	✔
Teladoc Health mental health	$0		Not covered	
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		30%	✔
Partial Hospitalization Program	$0		30%	✔
Psychological Testing	$0		30%	✔
Inpatient services				
Physician inpatient services	$0		30%	✔
Hospital services	$0		30%	✔
Residential Care	$0		30%	✔

Prior Authorization

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

- Advanced imaging services
- Outpatient mental health services, except office visits and office-based opioid treatment
- 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.

Notes

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 Benefits under the Plan.

If this Plan has any Calendar Year Deductible(s), Covered Benefits 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.

3 Using Participating Providers:

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

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

- Coinsurance is calculated from the Allowable Amount.

4 Using Non-Participating Providers:

Non-Participating Providers do not have a contract to provide health care services to Members. When you receive Covered Benefits 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.

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

- Coinsurance is calculated from the Allowable Amount, which is subject to any stated Benefit maximum.
- Charges above the Allowable Amount 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 Benefits in a Calendar Year. Once you reach your Out-of-Pocket Maximum, Blue Shield will pay 100% of the Allowable Amount for Covered Benefits 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 and charges above the Allowable Amount.

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

This 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.

Notes

6 Separate Member Payments When Multiple Covered Benefits are Received:

Each time you receive multiple Covered Benefits, 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.

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 by a Participating Provider. If you receive both Preventive Health Services and other Covered Benefits 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.

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