blue california

Summary of Benefits

San Bernardino County - Actives
Effective July 25, 2026
Shield Signature Benefit Plan

Custom Shield Signature Plan

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: Shield Signature Network

This Plan uses a specific network of Health Care Providers, called the Shield Signature provider network. This Plan provides benefits at three 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 Benefits under the Plan. Blue Shield pays for some Covered Benefits 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 Benefits 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 Annual or Lifetime Dollar Limit

Under this Benefit Plan there is no annual or lifetime dollar limit on the amount Blue Shield will pay for Covered Benefits.

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 or surgeon services in an Outpatient Facility	$0		Not covered	
Physician or surgeon services in an inpatient facility	$0		Not covered	
Other professional services				
Other practitioner office visit *Includes nurse practitioners, physician assistants, therapists, and podiatrists.*	$10/visit		$30/visit	
Acupuncture services	Not covered		Not covered	
Chiropractic services *Up to 20 visits per Member, per Calendar Year.*	$10/visit		Not covered	
Teladoc Health 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	

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**
Medical nutrition therapy, not related to diabetes	$0		Not covered	
Infertility Services				
Physician or surgeon services in an Outpatient Facility	$0		Not covered	
Artificial Inseminations limited to 6 per lifetime	$0		Not covered	
Oocyte (egg) retrieval limited to 3 per lifetime				
• Ambulatory Surgery Center	$0		Not covered	
• Outpatient Department of a Hospital	$0		Not covered	
In vitro fertilization (IVF)	$0		Not covered	
Embryo transfer				
• Ambulatory Surgery Center	$0		Not covered	
• Outpatient Department of a Hospital	$0		Not covered	
Cryopreservation limited to 1 year of storage per lifetime for each of the following: sperm, reproductive tissue, oocytes (eggs), and embryos	$0		Not covered	
Pregnancy and maternity care				
Physician office visits: prenatal and postnatal	$0		Not covered	
Abortion and abortion-related services	$0		Not covered	
Emergency Services				
Emergency room services *If admitted to the Hospital, this payment for emergency room services does not apply. Instead, you pay the participating member payment under Inpatient facility services/ Hospital services and stay.*	$75/visit		$75/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	

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**
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	
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 Under Level II, services are only covered if received in a physician's office.	$0		$0	
• Outpatient Department of a Hospital	$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**
Basic imaging services *Includes plain film X-rays, ultrasounds, and 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 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		$0	
Under Level II, services are only covered if received in a physician's office.				
• Outpatient Department of a Hospital	$0		Not covered	
Advanced imaging services *Includes diagnostic radiological and nuclear imaging such as CT scans, MRIs, MRAs, and PET scans.*				
• 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				
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 care 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	
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/Calendar year plus 100% of additional charges	
• Optometric exam	$10/visit		$0 up to $50/Calendar year plus 100% of additional charges	

Mental Health or Substance Use Disorder Benefits	Your payment			
	Shield Signature Level I Participating providers[3]	**CYD[2] applies**	**Shield Signature Level II Participating providers[3]** All Benefits are covered under Level 1	**CYD[2] applies**
Outpatient services				
Office visit, including Physician office visit	$0 first 3 visits, then $10/visit		Not covered	
Teladoc Health mental health	$0		Not covered	
Intensive outpatient care	$0		Not covered	
Behavioral health treatment in an office setting	$0		Not covered	
Behavioral health treatment in home or other non-institutional facility setting	$0		Not covered	
Office-based opioid treatment	$0		Not covered	
Partial Hospitalization Program	$0		Not covered	
Psychological Testing	$0		Not covered	
Inpatient services			Not covered	
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 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 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.

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

This Plan has a separate Participating Provider Deductible and Non-Participating Provider Deductible.

Notes

3 Using Shield Signature Level 1 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 Benefits 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 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, and charges for services above any Benefit maximum..

Under Shield Signature Level I Participating Providers, Copayments not accruing to the Calendar Year Out-of-Pocket Maximum continue to be the Member's responsibility after the Calendar Year Out-of-Pocket Maximum is reached.

Under Shield Signature Level II Participating Providers, there is neither a Calendar Year Deductible nor a Calendar Year Out-of-Pocket Maximum for Shield Signature Level II Covered Services. However, the Member will be responsible for applicable Copayments and non-covered charges, and for non-Shield Signature Providers all charges above the Allowable Amount.

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.

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 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.

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.

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

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