

High Desert & Inland Trust-Premier
 Custom Access+ HMO®
 Benefit Summary (For groups of 300 and above)
 (Uniform Health Plan Benefits and Coverage Matrix)

THIS MATRIX IS INTENDED TO BE USED TO HELP YOU COMPARE COVERAGE BENEFITS AND IS A SUMMARY ONLY. THE EVIDENCE OF COVERAGE, DISCLOSURE FORM AND PLAN CONTRACT SHOULD BE CONSULTED FOR A DETAILED DESCRIPTION OF COVERAGE BENEFITS AND LIMITATIONS.

Blue Shield of California

Highlights: A description of the prescription drug coverage is provided separately.

Effective July 1, 2008

DEDUCTIBLES	
Calendar-year medical deductible	None
Calendar-year copayment maximum¹ (For many covered services)	\$1,000 per individual/ \$2,000 per family
LIFETIME MAXIMUM	
	None
Covered Services	Member Copayment
PROFESSIONAL SERVICES	
Physician services – outpatient	
<ul style="list-style-type: none"> Physician and authorized specialist office visits <small>Note: A woman may self-refer to an OB/GYN or family practice physician in her personal physician's medical group or IPA for OB/GYN services.</small> 	\$5/visit
<ul style="list-style-type: none"> Allergy testing or treatment 	\$5/visit
Access+ SpecialistSM (Self-referred office visits and consultations only) ^{1, 2}	\$30/visit
Laboratory, X-ray and diagnostic tests	No charge
Preventive care	
<ul style="list-style-type: none"> Routine physical exam Eye/ear screenings and immunizations according to age schedule <small>Note: A woman may self-refer to an OB/GYN or family practice physician in her personal physician's medical group or IPA for OB/GYN services.</small> 	No charge
OUTPATIENT SERVICES	
Non-emergency	
<ul style="list-style-type: none"> Outpatient surgery performed in a Participating Ambulatory Surgery Center³(ASC) Outpatient surgery in hospital/facility Outpatient treatment (Except as described under "Rehabilitative therapy services"), and necessary supplies 	No charge
HOSPITALIZATION SERVICES	
<ul style="list-style-type: none"> Inpatient physician services, including pregnancy and maternity care Semi-private room and board, medically necessary services and supplies Skilled nursing facility (SNF) services⁴ 	No charge
EMERGENCY HEALTH COVERAGE	
<ul style="list-style-type: none"> Emergency room facility services (Waived if the member is directly admitted to the hospital for inpatient services) Emergency room physician visits 	\$100/visit
AMBULANCE SERVICES	
	No charge for ground transportation \$50 for emergency air transport
PRESCRIPTION DRUG COVERAGE¹	A description of your outpatient prescription drug coverage is provided separately. If you do not have the separate drug sheet that goes with this benefit summary, please contact your benefits administrator or call Member Services at (800) 642-6155 .
PROSTHETICS/ORTHOTICS (Equipment and devices only)	\$5/visit for physician visit No charge for device
DURABLE MEDICAL EQUIPMENT¹	No charge
MENTAL HEALTH SERVICES (PSYCHIATRIC)⁵	
<ul style="list-style-type: none"> Inpatient hospital facility services Outpatient visits for severe mental health conditions Outpatient visits for non-severe mental health conditions¹ <small>(Up to 20 visits per calendar year combined with outpatient chemical dependency visits)</small> 	No charge \$5/visit \$25/visit
CHEMICAL DEPENDENCY SERVICES (SUBSTANCE ABUSE)⁵ Please see footnote 6	
<ul style="list-style-type: none"> Inpatient services for medical acute detoxification Outpatient visits¹ <small>(Up to 20 visits per calendar year combined with outpatient non-severe mental health visits)</small> 	See "Hospitalization Services" \$25/visit

HOME HEALTH SERVICES

- Agency visits (Up to 100 visits per calendar year) \$5/visit
 - Medical supplies/IV solutions No charge
- (For home self-administered injectable medications, see "Prescription Drug Coverage.")
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OTHER**Hospice**

- Routine home care and inpatient respite care No charge
 - 24 hour continuous home care and general inpatient care No charge
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Pregnancy and maternity care

- Prenatal and postnatal professional (physician) services No charge
- (For all necessary inpatient hospital services, see "Hospitalization Services.")
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Family planning and infertility services

- Family planning counseling \$5/visit
 - Diagnosis and treatment of causes of infertility 50% of allowed charges
(Excludes in vitro fertilization, injectables for infertility, artificial insemination and GIFT)
 - Tubal ligation^{7, 8} and elective abortion^{7, 8} \$100
 - Vasectomy⁸ \$75
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Rehabilitative therapy services

- Outpatient visits \$5/visit
(Copayment applies to all place of services, including professional and facility settings)
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Urgent care outside service area (BlueCard[®] Program)

\$25/visit

Diabetes care

- Equipment, devices and non-testing supplies No charge
(For testing supplies, see "Prescription Drug Coverage.")
 - Self-management training and education \$5/visit
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Optional benefits¹ Optional dental, vision, chiropractic, chiropractic and acupuncture or infertility benefits are available. If your employer purchased any of these benefits, a description of the benefit is provided separately.

- 1 Copayments marked with a (1) do not accrue to calendar-year copayment maximum. Copayments and charges for services not accruing to the member's calendar-year copayment maximum continue to be the member's responsibility after the calendar-year copayment maximum is reached. Please refer to the Evidence of Coverage, the Disclosure Form and the plan contract for exact terms and conditions of coverage.
- 2 To use this option, members must select a personal physician who is affiliated with a medical group or IPA that is an Access+ provider group, which offers the Access+ Specialist feature. Members should then select a specialist within that medical group or IPA. Access+ Specialist visits for mental health or substance abuse services must be provided by a MHSA network participating provider. Access+ Specialist visits for mental health services for non-severe mental illness, or non-serious emotional disturbances of a child or substance abuse will accrue toward the 20 visit per calendar-year maximum.
- 3 Participating ambulatory surgery centers may not be available in all areas. Regardless of their availability, you can obtain outpatient surgery services from a hospital or an ambulatory surgery center affiliated with a hospital, with payment according to your health plan's hospital services benefits.
- 4 Skilled nursing services are limited to 100 preauthorized days during a calendar-year except when received through a hospice program provided by a participating hospice agency. This 100 preauthorized day maximum on skilled nursing services is a combined maximum between SNF in a hospital unit and skilled nursing facilities.
- 5 Mental health and chemical dependency services, other than medical acute detoxification, are accessed through the mental health services administrator (MHSA) - U.S. Behavioral Health Plan, California (USBHPC) - using MHSA participating providers. Services for medical acute detoxification are accessed through Blue Shield using Blue Shield HMO providers. For a listing of severe mental illnesses, including serious emotional disturbances of a child, and other benefit details, please refer to the Evidence of Coverage or plan contract.
- 6 **Optional inpatient substance abuse treatment benefits are available. If your employer purchased these benefits, a description of the benefit is attached hereto as "Additional Substance Abuse Treatment Benefits."**
- 7 Copayment waived when procedure is performed in conjunction with delivery or abdominal surgery.
- 8 Physician services copayment in the office or outpatient hospital facility only. If procedure is performed in a hospital facility setting, additional hospital services copayment may apply.

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