

benefit summary

PPO 2 Plan

High Desert & Inland Employee-Employer Trust

High Desert & Inland Trust

Custom PPOSM 2

Benefit Summary (For groups of 300 and above)

(Uniform Health Plan Benefits and Coverage Matrix)

Blue Shield of California

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

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

Effective July 1, 2010

DEDUCTIBLES ¹ (All providers combined)	Preferred Providers ²	Non-Preferred Providers ²
Calendar year medical deductible		\$500 per individual/ \$1,000 per family
Calendar year Copayment Maximum¹ (Copayments for Preferred Providers accrue to both Preferred and Non-Preferred Provider Calendar-year Copayment Maximum amounts.)	\$1,500 per individual/ \$2,500 per family	\$2,000 per individual/ \$4,000 per family
LIFETIME MAXIMUM		\$6,000,000

Covered Services	Member Copayment	
	Preferred Providers ²	Non-Preferred Providers ²

PROFESSIONAL SERVICES

Professional (physician) benefits

• Physician and specialist office visits	\$20 per visit (Not subject to the Calendar-Year Deductible)	30%
• Diagnostic testing	\$20 per visit (Not subject to the Calendar-Year Deductible)	30%
• Outpatient X-ray, pathology and laboratory	\$20 per visit (Not subject to the Calendar-Year Deductible)	30%

Allergy testing and treatment benefits

• Office visits (includes visits for allergy serum injections)	\$20 per visit (Not subject to the Calendar-Year Deductible)	30%
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Preventive care benefits

• Annual routine physical examination, vision and hearing screening and immunizations	\$20 per visit (Not subject to the Calendar-Year Deductible)	Not covered
• Routine laboratory services, including annual mammography, Papanicolaou test, or cervical cancer and human papillomavirus (HPV) screening (One per calendar year)	\$20 per visit (Not subject to the Calendar-Year Deductible)	Not covered
• Well baby care (Includes: eye/ear screenings, immunizations, vaccinations)	\$20 per visit (Not subject to the Calendar-Year Deductible)	Not covered
• Well baby laboratory	\$20 per visit (Not subject to the Calendar-Year Deductible)	Not covered

OUTPATIENT SERVICES

Hospital benefits (facility services)

The maximum allowed charges for non-emergency surgery and services performed in a non-participating Ambulatory Surgery Center or outpatient unit of a non-preferred hospital is \$350 per day. Members are responsible for 30% of this \$350 per day, plus all charges in excess of \$350.

• Outpatient surgery performed in a Participating Ambulatory Surgery Center (ASC) ³	10%	30%
• Outpatient surgery in a hospital	10%	30%
• Outpatient services for treatment of illness or injury and necessary supplies (Except as described under "Rehabilitation services")	10%	30%
• Bariatric surgery (pre-authorization required; medically necessary surgery for weight loss, only for morbid obesity) ⁵	10%	30%

HOSPITALIZATION SERVICES

Hospital benefits (facility services)

• Inpatient physician benefits	10%	30%
• Semi-private room and board, medically necessary services and supplies	10%	30% ⁴
• Bariatric surgery (pre-authorization required; medically necessary surgery for weight loss, only for morbid obesity) ⁵	10%	30% ⁴

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Skilled nursing facility benefits⁶		
(Combined maximum of up to 100 preauthorized days per calendar year; semi-private accommodations)		
• Skilled nursing free standing facility	10%	10% with prior authorization ⁶ 30% ⁴
• Skilled nursing facility unit of a hospital	10%	
EMERGENCY HEALTH COVERAGE		
• Emergency room services not resulting in admission (If ER services do not result in a direct admission the Calendar-Year Deductible does not apply)	\$100 per visit	\$100 per visit
• Emergency room services resulting in admission (when the member is admitted directly from the ER)	10%	10%
• Emergency room physician services	10%	10%
AMBULANCE SERVICES		
• Emergency or authorized transport	10%	10%
PRESCRIPTION DRUG COVERAGE		
Outpatient prescription drug benefits	A description of your outpatient prescription drug coverage is provided separately. If you do not have the separate drug summary that goes with this benefit summary, please contact your benefits administrator or call Customer Services at (800) 642-6155 .	
PROSTHETICS/ORTHOTICS		
• Prosthetic equipment and devices (Separate office visit copay may apply)	10%	30%
• Orthotic equipment and devices (Separate office visit copay may apply)	10%	30%
DURABLE MEDICAL EQUIPMENT		
• Durable medical equipment services (Plan payment up to \$3,000 maximum per calendar year.)	10%	30%
MENTAL HEALTH SERVICES (PSYCHIATRIC)⁷		
	MHSA Participating Providers²	MHSA Non-Participating Providers²
• Inpatient hospital facility services	10%	30% ⁴
• Outpatient mental health services	\$20 per visit (Not subject to the Calendar-Year Deductible)	30%
CHEMICAL DEPENDENCY SERVICES (SUBSTANCE ABUSE)¹⁰		
Please see footnote 9		
• Chemical dependency and substance abuse services	Not covered	Not covered
HOME HEALTH SERVICES¹¹		
	Preferred Providers²	Non-Preferred Providers²
• Home health care agency services (Maximum of 100 prior authorized visits per calendar year)	10%	Not covered ¹¹
• Home infusion/Home injectable therapy provided by a home infusion agency (See "Prescription Drug Coverage" for home self-administered injectables.)	10%	Not covered ¹¹
OTHER		
Hospice program benefits¹¹		
• Routine home care	No charge	Not covered ¹¹
• Inpatient respite care	No charge	Not covered ¹¹
• 24-hour continuous home care	10%	Not covered ¹¹
• General inpatient care	10%	Not covered ¹¹
Chiropractic benefits⁸		
• Chiropractic services – provided by a chiropractor (Up to 20 visits per calendar year)	10% (Not subject to the Calendar-Year Deductible)	30%
Acupuncture benefits⁸		
• Acupuncture services (Up to 20 visits per calendar year)	\$25 per visit	\$25 per visit
Rehabilitation services (physical, occupational and respiratory therapy)		
• In an office location	\$20 per visit (Not subject to the Calendar-Year Deductible)	30%
Speech therapy benefits		
• In an office location	\$20 per visit (Not subject to the Calendar-Year Deductible)	30%
Pregnancy and maternity care benefits		
• Prenatal and postnatal physician office visits (For inpatient hospital services, see "Hospitalization Services.")	10%	30%

Family planning benefits

• Counseling and consulting	\$20 per visit (Not subject to the Calendar-Year Deductible)	Not covered
• Elective abortion ¹²	10%	Not covered
• Tubal ligation ¹²	10%	Not covered
• Vasectomy ¹²	10%	Not covered

Diabetes care benefits

• Devices, equipment, and non-testing supplies (For testing supplies, see "Outpatient Prescription Drug Coverage Summary.")	10%	30%
• Diabetes self-management training (If billed by your provider, you will also be responsible for the office visit copayment)	\$20 per visit (Not subject to the Calendar-Year Deductible)	30%

Care Outside of Plan Service Area Benefits provided through BlueCard[®] Program, for out-of-state emergency and non-emergency care, are provided at the preferred level of the local Blue Plan allowable amount when you use a Blue Cross/Blue Shield provider.

• Within US: BlueCard Program	See Applicable Benefit	See Applicable Benefit
• Outside of US: BlueCard Worldwide	See Applicable Benefit	See Applicable Benefit

Optional Benefits

Optional dental, vision, substance abuse treatment, infertility and hearing aid benefits are available. If your employer purchased any of these benefits, a description of the benefit is provided separately.

- 1 Deductible and 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. Deductible does not apply toward the calendar-year maximum. Please refer to the Evidence of Coverage, and the Plan Contract for exact terms and conditions of coverage.
- 2 Member is responsible for copayment in addition to any charges above allowable amounts. The copayment percentage indicated is a percentage of allowable amounts. Preferred providers accept Blue Shield's allowable amount as full payment for covered services. Non-preferred providers can charge more than these amounts. When members use non-preferred providers, they must pay the applicable copayment plus any amount that exceeds Blue Shield's allowable amount. Charges above the allowable amount do not count toward the calendar-year deductible or copayment 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 The maximum allowed charge for non-emergency hospital services received from a non-preferred hospital is \$600 per day. Members are responsible for 30 percent of this \$600 per day, plus all charges in excess of \$600.
- 5 Bariatric surgery is covered when pre-authorized by Blue Shield. However, for members residing in Imperial, Kern, Los Angeles, Orange, Riverside, San Bernardino, San Diego, Santa Barbara and Ventura Counties ("Designated Counties"), bariatric surgery services are covered only when performed at designated contracting bariatric surgery facilities and by designated contracting surgeons; coverage is not available for bariatric services from any other preferred provider and there is no coverage for bariatric services from non-preferred Providers. In addition, if prior authorized by Blue Shield of California, a member in a Designated County who is required to travel more than 50 miles to a designated bariatric surgery facility will be eligible for limited reimbursement for specified travel expenses for the member and one companion. Refer to the Evidence of Coverage for further benefit details.
- 6 Services may require prior authorization by Blue Shield. When services are prior authorized, members pay the preferred or participating provider amount.
- 7 Mental health services are accessed through Blue Shield's Mental Health Service Administrator (MHSA) - using Blue Shield's MHSA participating and non-participating providers. Only Blue Shield MHSA contracted providers are administered by the Blue Shield MHSA. Behavioral health services rendered by non participating providers are administered by Blue Shield. 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.
- 8 All outpatient acupuncture and chiropractic visits accrue to the calendar-year visit maximum regardless of whether the plan deductible has been met.
- 9 **Optional 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."**
- 10 Inpatient services for acute detoxification are covered under the medical benefit; see hospitalization services for benefit details. Services for medical acute detoxification are accessed through Blue Shield using Blue Shield's preferred providers or non-preferred providers.
- 11 Out of network home health care, home infusion and hospice services are not covered unless pre-authorized. When these services are pre-authorized, the member pays the Preferred Provider copayment.
- 12 Copayment shown is for physician's services. If the procedure is performed in a facility setting (hospital or outpatient surgery center), an additional facility copayment may apply.

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

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High Desert & Inland Trust
 Custom PPOSM 2
 Outpatient Prescription Drug Coverage
 (For groups of 300 and above)

Blue Shield of California

Highlight: 3-Tier/Incentive Formulary
 No Calendar-Year Brand-Name Drug Deductible
 \$8 Formulary Generic/\$30 Formulary Brand-Name/\$45 Non-Formulary Brand-Name Drugs - Retail Pharmacy
 \$8 Formulary Generic/\$45 Formulary Brand-Name/\$60 Non-Formulary Brand-Name Drugs - Mail Service

July 1, 2010

THIS DRUG SUMMARY IS INTENDED TO BE USED WITH THE SHIELD SPECTRUM 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.

Covered Services	Member Copayment	
DEDUCTIBLES (Prescription drug coverage benefits are not subject to the medical plan deductible.)	None	
Calendar-year brand-name drug deductible	None	
PRESCRIPTION DRUG COVERAGE ^{1, 2, 3, 4, 5} (Includes oral contraceptives, diaphragms, and covered diabetic drugs and testing supplies)	Participating Pharmacy	Non-Participating Pharmacy Member pays 25% of allowable amount plus a copayment of:
Retail prescriptions (For up to a 30-day supply)		
• Formulary generic drugs	\$8 per prescription	\$8 per prescription
• Formulary brand name drugs	\$30 per prescription	\$30 per prescription
• Non-formulary brand name drugs	\$45 per prescription	\$45 per prescription
Mail service prescriptions (For up to a 90-day supply)		
• Formulary generic drugs	\$8 per prescription	Not covered
• Formulary brand name drugs	\$45 per prescription	Not covered
• Non-formulary brand name drugs	\$60 per prescription	Not covered
Specialty Pharmacies		
• Specialty drugs	30%	Not covered
	(Up to \$150 copayment maximum per prescription)	

1 Copayments and charges for these covered services are not included in the calculation of the member's medical calendar-year copayment maximum and continue to be the member's responsibility after the calendar-year copayment maximum is reached. Please refer to the Evidence of Coverage and the Plan Contract for exact terms and conditions of coverage. Please note that if you switch from another plan, your prescription drug deductible credit from the previous plan during the calendar year, if applicable, will not carry forward to the new plan.

2 If the member requests a brand-name drug and a generic drug equivalent is available, the member is responsible for paying the difference between the cost to Blue Shield of California of the brand-name drug and its generic drug equivalent, as well as the applicable generic drug copayment.

3 Specialty drugs are covered only when dispensed by select pharmacies in the Specialty Pharmacy Network unless Medically Necessary for a covered emergency.

4 Selected formulary and non-formulary drugs require prior authorization for Medical Necessity, and when effective, lower cost alternatives are available.

5 Specialty Drugs are specific Drugs used to treat complex or chronic conditions which usually require close monitoring such as multiple sclerosis, hepatitis, rheumatoid arthritis, cancers, and other conditions that are difficult to treat with traditional therapies. Specialty Drugs are listed in the Blue Shield Outpatient Drug Formulary. Specialty Drugs may be self-administered in the home by injection by the patient or family member (subcutaneously or intramuscularly), by inhalation, orally or topically. Infused or Intravenous (IV) medications are not included as Specialty Drugs. These Drugs may also require special handling, special manufacturing processes, and may have limited prescribing or limited pharmacy availability. Specialty Drugs must be considered safe for self-administration by Blue Shield's Pharmacy & Therapeutics Committee, be obtained from a Blue Shield Specialty Pharmacy and may require prior authorization for Medical Necessity by Blue Shield

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). Since this plan's prescription drug coverage is creditable, you do not have to enroll in Medicare Part D while you maintain this coverage; however, you should be aware that if you have a subsequent break in this coverage of 63 days or more before enrolling in Medicare Part D you could be subject to payment of higher Part D premiums.

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Important Prescription Drug Information

You can find details about your drug coverage three ways:

1. Check your *Evidence of Coverage*.
2. Go to **blueshieldca.com** 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 **blueshieldca.com** 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 drugs with generic equivalents;
- Look up drugs that require prior authorization;
- Find specifics about your prescription copayments;
- Find local network pharmacies to fill your prescriptions.

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 866-346-7197.

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

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Substance Abuse Treatment Benefits

Attachment to Benefit Summary (Uniform Benefits and Coverage Matrix)

For Shield Spectrum PPOSM Plans, Shield Spectrum PPO Savings Plus Plans, Core Flex Plans

How the Plan Works

In addition to the benefits listed in the Benefit Summary, your health plan also covers inpatient hospital and professional (physician) services for substance abuse treatment and rehabilitation provided via hospitalization or partial hospitalization/day treatment.¹ All services must be medically necessary. Blue Shield of California has contracted with a Mental Health Service Administrator (MHSA), a licensed specialized health care service plan, to administer and deliver these services from MHSA participating providers. The MHSA is only the administrator for participating providers, and does not administer non-participating providers.

Coverage Details

Residential care is not covered. Out of pocket costs are lowest when you receive care from an MHSA participating provider.

Covered Services	Member Copayment ³	
	MHSA Participating Provider*	MHSA Non-Participating Provider ²
Inpatient Hospital	Inpatient Hospitalization Copay Applies	Inpatient Hospitalization Copay Applies
Professional (Physician) Services - Inpatient and Outpatient Physician Visit	Physician Visit Copay Applies	Physician Visit Copay Applies

1. Except for emergencies, benefits are covered only when pre-authorized by the MHSA.
2. Member is responsible for a copayment in addition to any charges above allowable amounts from non-participating providers. MHSA participating providers accept Blue Shield's allowable amount as full payment for covered services. Non-participating providers can charge more than these amounts. When members use non-participating providers, they must pay the applicable copayment plus any amount that exceeds Blue Shield's allowable amount.
3. Please refer to the Medical Benefit Summary for applicable copayment responsibility.

* Copayments are calculated based on the negotiated rate with participating providers.

This is only a summary of the additional substance abuse treatment benefits not described in the Uniform Benefits and Coverage Matrix. It is not a contract. Please refer to the *Plan Contract* and *Evidence of Coverage* for a detailed description of covered benefits and limitations.

Notice on the availability of language assistance services to accompany vital documents issued in English

IMPORTANT: Can you read this letter? If not, we can have somebody help you read it.

You may also be able to get this letter written in your language. For free help, please call right away at the Member/Customer Service telephone number on the back of your Blue Shield ID card, or (866) 346-7198.

IMPORTANTE: ¿Puede leer esta carta? Si no, podemos hacer que alguien le ayude a leerla. También puede recibir esta carta en su idioma. Para ayuda gratuita, por favor llame inmediatamente al teléfono de Servicios al miembro/cliente que se encuentra al reverso de su tarjeta de identificación de Blue Shield o al (866) 346-7198.

(Spanish)

重要通知： 您能讀懂這封信嗎？ 如果不能，我們可以請人幫您閱讀。

這封信也可以用您所講的語言書寫。 如需幫助，請立即撥打登列在您的Blue Shield ID卡背面上的會員/客戶服務部的電話，或者撥打電話866-346-7198。

(Chinese)

QUAN TRỌNG: Quý vị có thể đọc lá thư này không? Nếu không, chúng tôi có thể nhờ người giúp quý vị đọc thư. Quý vị cũng có thể nhận lá thư này được viết bằng ngôn ngữ của quý vị. Để được hỗ trợ miễn phí, vui lòng gọi ngay đến Ban Dịch vụ Hội viên/Khách hàng theo số ở mặt sau thẻ ID Blue Shield của quý vị hoặc theo số 866-346-7198.

(Vietnamese)