

# benefit summary

Access+ HMO 2 Plan

High Desert & Inland Employee-Employer Trust

High Desert & Inland Trust  
 Custom Access+ HMO<sup>®</sup> 2  
 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 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, 2010

<b>DEDUCTIBLES</b>	
<b>Calendar year medical deductible</b>	None
<b>Calendar year copayment maximum<sup>1</sup></b> (For many covered services)	\$1,000 per individual/ \$2,000 per family
<b>LIFETIME MAXIMUM</b>	
	None
<b>Covered Services</b>	<b>Member Copayment</b>
<b>PROFESSIONAL SERVICES</b>	
<b>Professional (physician) benefits</b>	
<ul style="list-style-type: none"> <li>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></li> <li>Outpatient X-ray, pathology and laboratory</li> </ul>	\$10 per visit No charge
<b>Allergy testing and treatment benefits</b>	
<ul style="list-style-type: none"> <li>Office visits (includes visits for allergy serum injections)</li> </ul>	\$10 per visit
<b>Access+ Specialist<sup>SM</sup> benefits</b> (Self-referred office visits and consultations only) <sup>1, 2</sup>	
<ul style="list-style-type: none"> <li>Office visit, examination or other consultation</li> </ul>	\$30 per visit
<b>Preventive care benefits</b>	
<ul style="list-style-type: none"> <li>Routine physical exams  <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></li> <li>Vision and hearing screening (through the age of 18)</li> <li>Medically necessary immunizations (according to age schedule)</li> </ul>	No charge No charge No charge
<b>OUTPATIENT SERVICES</b>	
<b>Hospital benefits (facility services)</b>	
<ul style="list-style-type: none"> <li>Outpatient surgery performed in a Participating Ambulatory Surgery Center (ASC)<sup>3</sup></li> <li>Outpatient surgery in a hospital</li> <li>Outpatient services for treatment of illness or injury and necessary supplies (Except as described under "Rehabilitation services")</li> </ul>	No charge No charge No charge
<b>HOSPITALIZATION SERVICES</b>	
<b>Hospital benefits (facility services)</b>	
<ul style="list-style-type: none"> <li>Inpatient physician benefits</li> <li>Semi-private room and board, medically necessary services and supplies</li> <li>Inpatient medically necessary skilled nursing services including subacute care<sup>4</sup></li> </ul>	No charge No charge No charge
<b>EMERGENCY HEALTH COVERAGE</b>	
<ul style="list-style-type: none"> <li>Emergency room services not resulting in admission (Copayment does not apply if the member is directly admitted to the hospital for inpatient services)</li> <li>Emergency room physician services</li> </ul>	\$100 per visit No charge
<b>AMBULANCE SERVICES</b>	
<ul style="list-style-type: none"> <li>Emergency or authorized transport</li> </ul>	No charge for ground transport \$50 for emergency air transport
<b>PRESCRIPTION DRUG COVERAGE</b>	
<b>Outpatient prescription drug benefits<sup>1</sup></b>	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 Member Services at <b>(800) 642-6155</b> .
<b>PROSTHETICS/ORTHOTICS</b>	
<ul style="list-style-type: none"> <li>Prosthetic equipment and devices (Separate office visit copay may apply)</li> <li>Orthotic equipment and devices (Separate office visit copay may apply)</li> </ul>	No charge No charge
<b>DURABLE MEDICAL EQUIPMENT</b>	
<ul style="list-style-type: none"> <li>Durable medical equipment services<sup>1</sup></li> </ul>	No charge

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<b>MENTAL HEALTH SERVICES (PSYCHIATRIC)<sup>5</sup></b>	
<ul style="list-style-type: none"> <li>Inpatient hospital facility services</li> <li>Outpatient mental health services</li> </ul>	No charge \$10 per visit
<b>CHEMICAL DEPENDENCY SERVICES (SUBSTANCE ABUSE)<sup>7</sup></b>	
<b>Please see footnote 6</b>	
<ul style="list-style-type: none"> <li>Chemical dependency and substance abuse services</li> </ul>	Not covered
<b>HOME HEALTH SERVICES</b>	
<ul style="list-style-type: none"> <li>Home health care agency services (Up to 100 visits per calendar year)</li> <li>Medical supplies</li> </ul> (For home self-administered injectable medications, see "Prescription Drug Coverage.")	\$10 per visit No charge
<b>OTHER</b>	
<b>Hospice program benefits</b>	
<ul style="list-style-type: none"> <li>Routine home care</li> <li>Inpatient respite care</li> <li>24- hour continuous home care</li> <li>General inpatient care</li> </ul>	No charge No charge No charge No charge
<b>Pregnancy and maternity care benefits</b>	
<ul style="list-style-type: none"> <li>Prenatal and postnatal physician office visits</li> </ul> (For inpatient hospital services, see "Hospitalization Services.")	No charge
<b>Family planning and infertility benefits</b>	
<ul style="list-style-type: none"> <li>Counseling and consulting</li> <li>Infertility services (Diagnosis and treatment of causes of infertility. Excludes in vitro fertilization, injectables for infertility, artificial insemination and GIFT)</li> <li>Tubal ligation<sup>8,9</sup></li> <li>Elective abortion<sup>9</sup></li> <li>Vasectomy<sup>9</sup></li> </ul>	\$10 per visit 50% of allowed charges \$100 per surgery \$100 per surgery \$75 per surgery
<b>Rehabilitation services (physical, occupational and respiratory therapy)</b>	
<ul style="list-style-type: none"> <li>In an office location</li> </ul> (Copayment applies to all place of services, including professional and facility settings)	\$10 per visit
<b>Speech therapy benefits</b>	
<ul style="list-style-type: none"> <li>In an office location</li> </ul>	\$10 per visit
<b>Diabetes care benefits</b>	
<ul style="list-style-type: none"> <li>Devices, equipment and non-testing supplies</li> </ul> (For testing supplies, see "Outpatient Prescription Drug Coverage Summary.")	No charge
<ul style="list-style-type: none"> <li>Diabetes self-management training</li> </ul>	\$10 per visit
<b>Urgent services benefits (BlueCard<sup>®</sup> Program)</b>	
<ul style="list-style-type: none"> <li>Urgent services outside your personal physician service area</li> </ul>	\$25 per visit
<b>Optional benefits<sup>1</sup></b>	Optional dental, vision, infertility, substance abuse, chiropractic or chiropractic and acupuncture 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, 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 services must be provided by a MHA network participating provider.

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 services are accessed through Blue Shield's Mental Health Service Administrator (MHSA) using Blue Shield's MHSA participating 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 substance abuse treatment benefits are available. If your employer purchased these benefits, a description of the benefit is attached hereto as "Substance Abuse Treatment Benefits."**

7 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 HMO providers.

8 Copayment does not apply when procedure is performed in conjunction with delivery or abdominal surgery.

9 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

High Desert & Inland Trust  
 Custom Access+ HMO® 2  
 Outpatient Prescription Drug Coverage  
 (For groups of 300 and above)

**THIS DRUG SUMMARY IS INTENDED TO BE USED WITH THE ACCESS+ HMO OR ADDED ADVANTAGE POS 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.**

**Blue Shield of California**

**Highlight:** 3-Tier/Incentive Formulary  
 No Calendar-Year Brand-Name Drug Deductible  
 \$8 Formulary Generic/\$25 Formulary Brand-Name/\$40 Non-Formulary Brand-Name Drugs - Retail Pharmacy  
 \$16 Formulary Generic/\$50 Formulary Brand-Name/\$80 Non-Formulary Brand-Name Drugs - Mail Service

July 1, 2010

**Covered Services** **Member Copayment**

**DEDUCTIBLES** (Prescription drug coverage benefits are not subject to the medical plan deductible.)

**Calendar-year brand-name drug deductible**

None

**PRESCRIPTION DRUG COVERAGE**<sup>1, 2, 3, 4, 5</sup>

(Includes oral contraceptives, diaphragms, and covered diabetic drugs and testing supplies)

**Participating Pharmacy**

**Non-Participating Pharmacy**

Retail prescriptions (For up to a 30-day supply)

- Formulary generic drugs
- Formulary brand name drugs
- Non-formulary brand name drugs

\$8 per prescription  
 \$25 per prescription  
 \$40 per prescription

Not covered  
 Not covered  
 Not covered

Mail service prescriptions (For up to a 90-day supply)

- Formulary generic drugs
- Formulary brand name drugs
- Non-formulary brand name drugs

\$16 per prescription  
 \$50 per prescription  
 \$80 per prescription

Not covered  
 Not covered  
 Not covered

Specialty Pharmacies

- Specialty drugs

20%  
 (Up to \$100 copayment maximum per prescription)

Not covered

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 Access+ HMO® Plans and Core Flex HMO 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.<sup>1</sup> 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. Blue Shield of California does not provide benefits for services provided by non-participating providers.

### Coverage Details

Residential care is not covered.

Covered Services	Member Copayment <sup>2</sup>
MHSA Participating Provider	
Inpatient Hospitalization	Inpatient Hospitalization Copay Applies
Professional (Physician) Services - Inpatient and Outpatient Physician Visit	Physician Visit Copay Applies
Partial Hospitalization/Day Treatment	Ambulatory Surgery Copay Applies

1. Except for emergencies, benefits are covered only when pre-authorized by the MHSA.
2. Please refer to the Medical Benefit Summary for applicable copayment responsibility.

This document is only a summary for informational purposes. It is not a contract. Please refer to the *Plan Contract* and *Evidence of Coverage* for the exact terms and conditions of coverage.

## **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)

