

benefit summary

POS Plan

High Desert & Inland Employee-Employer Trust

High Desert & Inland Trust
Victor Valley Union High School District
Custom POSSM 1
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

Effective July 1, 2010

DEDUCTIBLES ¹	LEVEL I: HMO Plan Providers ²	LEVEL II: Preferred Providers ²	LEVEL III: Non-Preferred Providers ²
Calendar year medical deductible	None	\$100 per individual/\$300 per family	
Calendar year copayment maximum ¹ (For many covered services)	\$500 per individual/ \$1,500 per family	\$1,000 per individual/ \$3,000 per family	\$2,000 per individual/ \$6,000 per family
LIFETIME MAXIMUMS	None	\$2,000,000	
Covered Services	Member Copayment		
PROFESSIONAL SERVICES	LEVEL I: HMO Plan Providers²	LEVEL II: Preferred Providers²	LEVEL III: Non-Preferred Providers²
Professional (physician) benefits			
<ul style="list-style-type: none"> Physician and specialist office visits <small>Note: For network benefits provider level, 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 per visit	10%	30%
<ul style="list-style-type: none"> Outpatient X-ray, pathology and laboratory 	No charge	10%	30%
Allergy testing and treatment benefits			
<ul style="list-style-type: none"> Office visits (includes visits for allergy serum injections) 	\$5 per visit	10%	30%
Preventive care			
<ul style="list-style-type: none"> 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 annual gynecological exams.</small>	No charge	10%	30%
<ul style="list-style-type: none"> Vision and hearing screening (through the age of 18) Medically necessary immunizations (according to age schedule) 	No charge	10%	30%
OUTPATIENT SERVICES			
Hospital benefits (facility services)			
<ul style="list-style-type: none"> Outpatient surgery performed in a Participating Ambulatory Surgery Center (ASC) Outpatient surgery in a hospital Outpatient services for treatment of illness or injury and necessary supplies (Except as described under "Rehabilitation services") Bariatric Surgery (preauthorization required; medically necessary surgery for weight loss, only for morbid obesity) 	No charge	10%	30% ³
	No charge	10%	30% ³
	No charge	10%	30% ³
	No charge	10% ⁵	30% ^{3, 5}
HOSPITALIZATION SERVICES			
Hospital benefits (facility services)			
<ul style="list-style-type: none"> Inpatient physician benefits Semi-private room and board, medically necessary services and supplies Bariatric Surgery (preauthorization required; medically necessary surgery for weight loss, only for morbid obesity) Inpatient medically necessary skilled nursing facility services including subacute care⁶ 	No charge	10%	30%
	No charge	10%	30% ⁴
	No charge	10% ⁵	30% ^{4, 5}
	No charge	10%	30% ⁴
EMERGENCY HEALTH COVERAGE			
<ul style="list-style-type: none"> Emergency room services not resulting in admission (ER facility copay does not apply if the member is directly admitted to the hospital for inpatient services) Emergency room physician services 	\$100 per visit	\$100 per visit	\$100 per visit
	No charge	10%	10%
AMBULANCE SERVICES			
<ul style="list-style-type: none"> Emergency or authorized transport 	No charge	10%	10%

An Independent Member of the Blue Shield Association

PRESCRIPTION DRUG COVERAGE
Outpatient prescription drug benefits¹

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)	No charge	10%	30%
• Orthotic equipment and devices (Separate office visit copay may apply)	No charge	10%	30%

DURABLE MEDICAL EQUIPMENT

• Durable medical equipment services (Plan payment up to \$2,000 maximum per calendar-year)	No charge	10%	30%
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MENTAL HEALTH SERVICES (PSYCHIATRIC)⁷

	Level I: MHSA Participating Providers²	Level II: except medical acute detoxification	Level III: MHSA Non-participating Providers²
• Inpatient hospital facility services	No charge	N/A	30% ⁴
• Outpatient mental health services	\$5 per visit	N/A	30%

CHEMICAL DEPENDENCY SERVICES (SUBSTANCE ABUSE)⁹; Please see footnote 8

• Chemical dependency and substance abuse services	Not covered	Not covered	Not covered
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HEARING AID BENEFIT

• Hearing aid benefit (maximum plan payment \$3,000 per lifetime)	No charge	No charge	No charge
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HOME HEALTH SERVICES

	LEVEL I: HMO Plan Providers²	LEVEL II: Preferred Providers²	LEVEL III: Non-Preferred Providers²
• Home health care agency services (up to 100 visits per calendar year)	No charge	10%	Not covered ¹⁰
• Medical supplies (For home self-administered injectable medications, see "Prescription Drug Coverage.")	No charge	10%	Not covered ¹⁰

OTHER

Hospice program benefits

• Routine home care	No charge	Not covered ¹¹	Not covered ¹¹
• Inpatient respite care	No charge	Not covered ¹¹	Not covered ¹¹
• 24 hour continuous home care	No charge	Not covered ¹¹	Not covered ¹¹
• General inpatient care	No charge	Not covered ¹¹	Not covered ¹¹

Pregnancy and maternity care benefits

• Prenatal and Postnatal physician services (For inpatient hospital services, see "Hospitalization Services.")	No charge	10%	30%
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Family planning and infertility benefits

• Counseling and consulting	No charge	Not covered	Not covered
• Infertility services (Diagnosis and treatment of cause of infertility. Excludes in vitro fertilization, injectables for infertility, artificial insemination and GIFT)	50% of allowed charges	Not covered	Not covered
• Tubal ligation ^{12, 13}	\$100 per surgery	50%	50%
• Elective abortion ¹³	\$100 per surgery	50%	50%
• Vasectomy ¹³	\$75 per surgery	50%	50%

Rehabilitation services (physical, occupational and respiratory therapy)

• In an office location	\$5 per visit (Copayment applies to all places of service including professional and facility settings)	10%	30%
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Speech therapy benefits

• In an office location	\$5 per visit	10%	30%
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Diabetes care benefits

• Devices, equipment and non-testing supplies (For testing supplies, please see "Outpatient Prescription Drug Coverage Summary.")	No charge	10%	30%
• Diabetes self-management training	\$5 per visit	10%	30%

Urgent services benefits

• Urgent services outside your personal physician service area	\$25 per visit ¹⁴	See Applicable Benefit	See Applicable Benefit
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Optional benefits¹ Optional dental, vision, infertility, substance abuse, chiropractic, or acupuncture/chiropractic benefits are available. If your employer purchased any of these benefits, a description of the benefit is provided separately.

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- 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.
 - 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. Calendar-year deductible applies to services of Non-Preferred Providers only.
 - 3 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 percent of this \$350 per day, plus all charges in excess of \$350.
 - 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 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.
 - 7 Mental health services are accessed through Blue Shield's Mental Health Service Administrator (MHSA) – utilizing Blue Shield's MHSA Participating (Level I) and Non-Participating (Level III) 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. There are no Level II providers for mental health services, other than for medical acute detoxification. 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 **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."**
 - 9 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 HMO Plan Providers (Level I), Preferred Providers (Level II), or Non-Preferred Providers (Level III).
 - 10 Out of network home health care services are not covered unless pre-authorized. When these services are pre-authorized, the member pays the Preferred Provider copayment.
 - 11 Out of network hospice is not covered unless pre-authorized. When these services are pre-authorized, the member pays the Level I copayment.
 - 12 Copayment does not apply when procedure is performed in conjunction with delivery or abdominal surgery.
 - 13 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.
 - 14 For Level I Services outside of California or the United States, Out-of-Area Follow-up Care is covered through any provider or through the BlueCard® Program participating provider network. However, authorization by Blue Shield HMO is required for more than two Out-of-Area Follow-up Care outpatient visits or for care that involves a surgical or other procedure or inpatient stay. For Level I Services outside your Personal Physician Service Area but within California, Member Services will assist the patient in receiving Out-of-Area Follow-up Care through a Blue Shield Plan Provider. To receive Level I Services, Blue Shield HMO may direct the patient to receive follow-up Services from the Personal Physician.

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

A16536 (07/10) POS1 DD 042110 MH carve-in RDB 042710

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)

