POS Plan benefit summary

We're here to help

If you have any questions, simply contact your dedicated Blue Shield Member Services team at **(800) 642-6155** for personal assistance. They are available from 7 a.m. to 7 p.m., Monday through Friday. You can also visit the Blue Shield custom website for the High Desert & Inland Employee-Employer Trust at **blueshieldca.com/hdieet**.

Blue Shield of California is an Independent Member of the Blue Shield Association

A36785-HDIEET (7/11)

blue of california

HIGH DESERT & INLAND EMPLOYEE-EMPLOYER TRUST

High Desert & Inland Employee-Employer Trust
Victory Valley Union High School District

Custom POS℠ 1

Benefit Summary (For groups of 300 and above)

(Uniform Health Plan Benefits and Coverage Matrix)

Blue Shield of California

Effective July 1, 2011

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.

	LEVEL I: HMO Plan Providers[1]	**LEVEL II: Preferred Providers[1]**	**LEVEL III: Non-Preferred Providers[1]**
Calendar Year Medical Deductible	None	$100 per Individual/ $300 per Family	
Calendar year copayment maximum[2] (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 BENEFIT MAXIMUM	None	None	

Covered Services	**Member Copayment**		
PROFESSIONAL SERVICES	**LEVEL I: HMO Plan Providers[1]**	**LEVEL II: Preferred Providers[1]**	**LEVEL III: Non-Preferred Providers[1]**
Professional (Physician) Benefits			
• Physician and specialist office visits 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.	$5 per visit	10%	30%
• Outpatient X-ray, pathology and laboratory	No Charge	10%	30%
Allergy Testing and Treatment Benefits			
• Office visits (includes visits for allergy serum injections)	$5 per visit	10%	30%
Preventive Health Benefits			
• Preventive Health Services (see the description of Preventive Health Services in the definitions section of the Evidence of Coverage for more information)	No Charge	10%	30%
OUTPATIENT SERVICES			
Hospital Benefits (Facility Services)			
• Outpatient surgery performed at an Ambulatory Surgery Center	No Charge	10%	30%[3]
• Outpatient surgery in a hospital	No Charge	10%	30%[3]
• Outpatient Services for treatment of illness or injury and necessary supplies (Except as described under "Rehabilitation benefits" and "Speech therapy benefits")	No Charge	10%	30%[3]
• Bariatric Surgery (preauthorization required; medically necessary surgery for weight loss, only for morbid obesity)	No Charge	10%[4]	30%[3, 4]
HOSPITALIZATION SERVICES			
Hospital Benefits (Facility Services)			
• Inpatient Physician Services	No Charge	10%	30%
• Inpatient Non-emergency Facility Services (semi-private room and board, medically necessary services and supplies)	No Charge	10%	30%[5]
• Bariatric Surgery (preauthorization required; medically necessary surgery for weight loss, only for morbid obesity)	No Charge	10%[4]	30%[4, 5]
• Inpatient Medically Necessary skilled nursing Services including Subacute Care[6]	No Charge	10%	30%[5]

EMERGENCY HEALTH COVERAGE			
• 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)	$100 per visit	$100 per visit	$100 per visit
• Emergency room Physician Services	No Charge	10%	10%
AMBULANCE SERVICES			
• Emergency or authorized transport	No Charge	10%	10%
PRESCRIPTION DRUG COVERAGE			
Outpatient Prescription Drug Benefits[2]	Please see a description of your outpatient prescription drug coverage in this booklet.		
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 (member share is based upon allowed charges, Level I only)	No Charge	10%	30%
MENTAL HEALTH SERVICES (PSYCHIATRIC)[7]	**LEVEL I: MHSA Participating Providers**[1]	**LEVEL II: N/A, except for medical acute detoxification**	**LEVEL III: MHSA Non-Participating Providers**[1]
• Inpatient Hospital Services	No Charge	N/A	30%[5]
• Outpatient Mental Health Services	$5 per visit	N/A	30%
CHEMICAL DEPENDENCY SERVICES (SUBSTANCE ABUSE)[13]**, Please see footnote 14**			
• Chemical dependency and substance abuse services	Not Covered	Not Covered	Not Covered
HEARIING AID SERVICES			
Hearing aid benefit (maximum plan payment $3,000 per lifetime)	No Charge	No Charge	No Charge
HOME HEALTH SERVICES	**LEVEL I: HMO Plan Providers**[1]	**LEVEL II: Preferred Providers**[1]	**LEVEL III: Non-Preferred Providers**[1]
• Home health care agency Services (up to 100 visits per calendar year)	No charge	10%	Not Covered[8]
• Medical supplies and laboratory Services (See "Prescription Drug Coverage" for specialty drugs)	No Charge	10%	Not Covered[8]
OTHER			
Hospice Program Benefits			
• Routine home care	No Charge	Not Covered[9]	Not Covered[9]
• Inpatient Respite Care	No Charge	Not Covered[9]	Not Covered[9]
• 24-hour Continuous Home Care	No Charge	Not Covered[9]	Not Covered[9]
• General Inpatient care	No Charge	Not Covered[9]	Not Covered[9]
Pregnancy and Maternity Care Benefits			
• Prenatal and Postnatal Physician Office Visits (For inpatient hospital services, see "Hospitalization Services.")	No Charge	10%	30%
Family Planning and Infertility Benefits			
• Counseling and consulting	No Charge	Not Covered	Not Covered
• Infertility Services (member share is based upon allowed charges, Level I only) (Diagnosis and treatment of cause of infertility. Excludes in vitro fertilization, injectables for infertility, artificial insemination and GIFT)	50%	Not Covered	Not Covered
• Tubal ligation[10, 11]	$100 per surgery	50%	50%
• Elective abortion[10]	$100 per surgery	50%	50%
• Vasectomy[10]	$75 per surgery	50%	50%
Rehabilitation Benefits (Physical, Occupational and Respiratory Therapy)			
• Office location Copayment applies to all places of service including professional and facility settings. (Up to 12 visits per calendar year combined for Levels II & III for physical therapy and chiropractic services)	$5 per visit (Copayment applies to all places of service including professional and facility settings)	10%	30%

Benefit			
Speech Therapy Benefits			
• Office location (Copayment applies to all places of service including professional and facility settings)	$5 per visit	10%	30%
Diabetes Care Benefits			
• Devices, equipment, and non-testing supplies (member share is based upon allowed charges, Level I only) (For testing supplies, please see "Outpatient Prescription Drug Coverage Summary.")	No Charge	10%	30%
• Diabetes self-management training	$5 per visit	10%	30%
Urgent Care Benefits			
• Urgent Services outside your Personal Physician Service Area	$25 per visit[12]	See Applicable Benefit	See Applicable Benefit

Optional Benefits[2] 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.

1 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.

2 Deductible and copayments marked with a (2) 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.

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 the Allowable Amount. Members are responsible for 30 percent of this $350 per day, plus all charges in excess of $350.

4 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.

5 The maximum allowed charges for non-emergency hospital services received from a Non-Preferred Hospital are $600 per day. Members are responsible for 30 percent of this $600 per day, plus all charges in excess of $600.

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 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.

9 Out of network hospice is not covered unless pre-authorized. When these services are pre-authorized, the member pays the Level I copayment.

10 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.

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

12 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.

13 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).

14 **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."**

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

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Blue Shield believes this plan/policy is a “grandfathered health plan” under the Patient Protection and Affordable Care Act (the Affordable Care Act). As permitted by the Affordable Care Act, a grandfathered health plan can preserve certain basic health coverage that was already in effect when that law was enacted. Being a grandfathered health plan means that your plan or policy is not required to include certain consumer protections of the Affordable Care Act that apply to other plans, for example, the requirement for the provision of preventive health services without any cost sharing. However, grandfathered health plans must comply with certain other consumer protections in the Affordable Care Act, for example, the elimination of lifetime limits on benefits. Note, even though they are not required to be included, many of the protections of the Affordable Care Act are included in your current plan/policy.

Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to Blue Shield at the telephone number on your identification card. If you obtain this plan/policy through your employer and your plan is subject to ERISA, you may also contact the Employee Benefits Security Administration, U.S. Department of Labor at 1-866-444-3272 or www.dol.gov/ebsa/healthreform. This website has a table summarizing which protections do and do not apply to grandfathered health plans. If you obtain your coverage through a nonfederal governmental employer, you may also contact the U.S. Department of Health and Human Services at www.healthreform.gov.

High Desert & Inland Employee-Employer Trust
Custom POS℠ 1
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
July 1, 2011

Highlight: 2-Tier/Closed Formulary
No Calendar Year Brand-Name Drug Deductible
$2 Formulary Generic/$5 Formulary Brand Name - Retail Pharmacy
$2 Formulary Generic/$5 Formulary Brand Name - Mail Service

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[1, 2, 3, 4, 5] (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	$2 per prescription	Not Covered
• Formulary brand name drugs	$5 per prescription	Not Covered
Mail service prescriptions (For up to a 90-day supply)		
• Formulary generic drugs	$2 per prescription	Not Covered
• Formulary brand name drugs	$5 per prescription	Not Covered
Specialty Pharmacies		
• Specialty drugs	20% (Up to $100 copayment maximum per prescription)	Not Covered

1 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.

2 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.

3 Only drugs on the Blue Shield Drug Formulary are covered unless prior authorized by Blue Shield Pharmacy Services. 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.

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

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

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.

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.

Substance Abuse Treatment Benefits
For Added Advantage POS℠ Plan

Attachment to Benefit Summary (Uniform Benefits and Coverage Matrix)

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 a 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
Partial Hospitalization/Day Treatment	Ambulatory Surgery Copay Applies	Ambulatory Surgery 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.

A17278 (07/11)

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