High Desert & Inland Trust
Custom HMO 3

Benefit Summary (For groups of 300 and above)
(Uniform Health Plan Benefits and Coverage Matrix)

Blue Shield of California

Effective: July 1, 2016

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.

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

Calendar Year Medical Deductible	None
Calendar Year Out-of-Pocket Maximum	$1,000 per individual / $2,000 per family
Lifetime Benefit Maximum	None
Covered Services	**Member Copayment**
OUTPATIENT PROFESSIONAL SERVICES	
Professional (Physician) Benefits	
Physician and specialist office visits (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)	$20 per visit
Outpatient diagnostic x-ray, imaging, pathology, laboratory and other testing services	No Charge
Radiological and nuclear imaging (CT scans, MRIs, MRAs, PET scans and cardiac diagnostic procedures utilizing nuclear medicine)	No Charge
Allergy Testing and Treatment Benefits	
Allergy testing, treatment and serum injections	$20 per visit
Allergy serum purchased separately for treatment	No Charge
Access+ *Specialist*[SM] Benefits[1]	
Office visit, examination or other consultation (self-referred office visits and consultations only)	$30 per visit
Preventive Health Benefits	
Preventive health services (as required by applicable Federal and California law)	No Charge
OUTPATIENT FACILITY SERVICES	
Outpatient surgery performed at a free-standing ambulatory surgery center	No Charge
Outpatient surgery performed in a hospital or a hospital affiliated ambulatory surgery center	No Charge
Outpatient services for treatment of illness or injury and necessary supplies (except as described under "Rehabilitation Benefits" and "Speech Therapy Benefits")	No Charge
Outpatient diagnostic x-ray, imaging, pathology, laboratory and other testing services	No Charge
Radiological and nuclear imaging (CT scans, MRIs, MRAs, PET scans and cardiac diagnostic procedures utilizing nuclear medicine)	No Charge
HOSPITALIZATION SERVICES	
Hospital Benefits (Facility Services)	
Inpatient physician services	No Charge
Inpatient non-emergency facility services (semi-private room and board, and medically necessary services and supplies, including subacute care)	No Charge
INPATIENT SKILLED NURSING BENEFITS[2,3] (combined maximum of up to 100 days per benefit period; prior authorization is required; semi-private accommodations)	
Free-standing skilled nursing facility	No Charge
Skilled nursing unit of a hospital	No Charge

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EMERGENCY HEALTH COVERAGE	
Emergency room services not resulting in admission (copayment does not apply if the member is directly admitted to the hospital for inpatient services)	$100 per visit
Emergency room physician services	No Charge
AMBULANCE SERVICES	
Emergency or authorized transport	No Charge for ground transport $50 for emergency air transport
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 the Member Services number on your identification card.	
PROSTHETICS/ORTHOTICS	
Prosthetic equipment and devices (separate office visit copayment may apply)	No Charge
Orthotic equipment and devices (separate office visit copayment may apply)	No Charge
DURABLE MEDICAL EQUIPMENT	
Breast pump	No Charge
Other durable medical equipment (member share is based upon allowed charges)	No Charge
MENTAL HEALTH AND SUBSTANCE ABUSE SERVICES[4, 5]	
Inpatient hospital services	No Charge
Residential care	No Charge
Inpatient physician services	No Charge
Routine outpatient mental health and substance abuse services (includes professional/physician visits)	$20 per visit
Non-routine outpatient mental health and substance abuse services (includes behavioral health treatment, electroconvulsive therapy, intensive outpatient programs, office-based opioid treatment, partial hospitalization programs, psychological testing and transcranial magnetic stimulation)	No Charge
HOME HEALTH SERVICES	
Home health care agency services[2] (Coverage limited to 100 visits per member per calendar year)	$20 per visit
Home infusion/home injectable therapy and infusion nursing visits provided by a home infusion agency	No Charge
HOSPICE PROGRAM BENEFITS	
Routine home care	No Charge
Inpatient respite care	No Charge
24-hour continuous home care	No Charge
Short-term inpatient care for pain and symptom management	No Charge
PREGNANCY AND MATERNITY CARE BENEFITS	
Prenatal and postnatal physician office visits (when billed as part of global maternity fee including hospital inpatient delivery services)	No Charge
Abortion services (an additional facility copayment may apply when services are rendered in a hospital or outpatient surgery center)	No Charge
FAMILY PLANNING AND INFERTILITY BENEFITS	
Counseling and consulting (Includes insertion of IUD, as well as injectable and implantable contraceptives for women)	No Charge
Infertility services (member cost share is based upon allowed charges) (diagnosis and treatment of cause of infertility. Excludes in vitro fertilization, injectables for infertility, artificial insemination and GIFT)	50%
Tubal ligation	No Charge
Vasectomy (an additional facility copayment may apply when services are rendered in a hospital or outpatient surgery center)	$75 per surgery
REHABILITATION AND HABILITATION BENEFITS (Physical, Occupational and Respiratory Therapy)	
Office location (an additional facility copayment may apply when services are rendered in a hospital or skilled nursing facility)	$20 per visit
SPEECH THERAPY BENEFITS	
Office location (an additional facility copayment may apply when services are rendered in a hospital or skilled nursing facility)	$20 per visit

DIABETES CARE BENEFITS	
Devices, equipment, and non-testing supplies (member share is based upon allowed charges; for testing supplies see Outpatient Prescription Drug Benefits)	No Charge
Diabetes self-management training	$20 per visit
URGENT CARE BENEFITS	
Urgent care services outside your personal physician service area within California	$20 per visit
Urgent care services outside of California (BlueCard® Program)	$20 per visit

OPTIONAL BENEFITS

Optional dental, vision, hearing aid, infertility, chiropractic or acupuncture benefits are available. If your employer purchased any of these benefits, a description of the benefit is provided separately.

1 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.

2 For Plans with a facility deductible amount, services with a day or visit limit accrue to the calendar year day or visit limit maximum regardless of whether the plan deductible has been met.

3 Inpatient skilled nursing services are limited to 100 preauthorized days during a benefit period except when received through a hospice program provided by a participating hospice agency. This 100 preauthorized day maximum on inpatient skilled nursing services is a combined maximum between skilled nursing services provided in a hospital unit and skilled nursing services provided in a skilled nursing facility (SNF).

4 Mental Health and Substance Abuse services are accessed through Blue Shield's Mental Health Service Administrator (MHSA) using MHSA participating providers.

5 Inpatient services for acute detoxification are covered under the medical benefit; see the Hospital Benefits (Facility Services) section of the Evidence of Coverage for benefit details. Services for acute medical detoxification are accessed through Blue Shield using Blue Shield participating providers.

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

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High Desert & Inland Trust Chiropractic Benefits

Additional coverage for your HMO and POS Plans

Blue Shield Chiropractic Care coverage lets you self-refer to a network of more than 4,000 licensed chiropractors. Benefits are provided through a contract with American Specialty Health Plans of California, Inc. (ASH Plans).

How the Program Works

You can visit any participating chiropractor from the ASH Plans network *without* a referral from your HMO or POS Personal Physician. Simply call a participating provider to schedule an initial exam.

At the time of your first visit, you'll present your Blue Shield identification card and pay only your copayment. Because participating chiropractors bill ASH Plans directly, you'll never have to file claim forms.

If you need further treatment, the participating chiropractor will submit a proposed treatment plan to ASH Plans and obtain the necessary authorization from ASH Plans to continue treatment up to the calendar year maximum of 30 visits.

What's Covered

The plan covers medically necessary chiropractic services including:

- Initial and subsequent examinations
- Office visits and adjustments (subject to annual limits)
- Adjunctive therapies
- X-rays (chiropractic only)

Benefit Plan Design

Calendar year Maximum	30 Visits
Calendar year Deductible	None
Calendar year Chiropractic Appliances Benefit[1,2]	$50
Covered Services	**Member Copayment**
Chiropractic Services	$10
Out-of-network Coverage	None

1. Chiropractic appliances are covered up to a maximum of $50 in a calendar year as authorized by ASH Plans.
2. As authorized by ASH Plans, this allowance is applied toward the purchase of items determined necessary, such as supports, collars, pillows, heel lifts, ice packs, cushions, orthotics, rib belts and home traction units.

Friendly Customer Service

Helpful ASH Plans Member Services representatives are available at (800) 678-9133 Monday through Friday from 6 a.m. to 5 p.m. to answer questions, assist with problems, or help locate a participating chiropractor.

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

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High Desert & Inland Trust Additional Hearing Aid and Ancillary Equipment Benefit

Attachment to Benefit Summary (Uniform Benefits and Coverage Matrix)

Additional coverage for HMO and POS Plans

How the Plan Works

In addition to the benefits set forth in the Benefit Summary (Uniform Benefits and Coverage Matrix), your group has added hearing aid benefits to your benefit plan. Coverage includes hearing aid services, subject to the conditions and limitations listed below. This rider provides a $2,000 allowance every 24 months towards the purchase of hearing aids and ancillary equipment. The calendar year deductible does not apply to the services provided in this hearing aid services benefit and hearing aid expenses in excess of the maximum allowance are not included in the calendar year out-of-pocket maximum amount.

Coverage Details

The hearing aid allowance includes:

- A hearing aid instrument, monaural or binaural, including ear mold(s)
- Visit for fitting, counseling, and adjustments
- The initial battery
- Cords
- Other ancillary equipment

Benefit Plan Design

Plan Options	Benefit Allowance
HMO and POS Plans	$2,000 allowance every 24 months

The following services and supplies are not covered:

- Purchase of batteries or other ancillary equipment, except those covered under the terms of the initial hearing aid purchase
- Charges for a hearing aid which exceed specifications prescribed for correction of a hearing loss
- Replacement parts for hearing aids, repair of hearing aid after the covered warranty period and replacement of a hearing aid more than once in any period of 24 months
- Surgically implanted hearing devices

All benefits are subject to the general provisions, limitations and exclusions listed in your *Evidence of Coverage*.

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High Desert & Inland Trust
Custom RX HMO 3

Outpatient Prescription Drug Coverage
(For groups of 300 and above)

THIS DRUG COVERAGE SUMMARY IS ADDED TO BE COMBINED WITH THE HMO OR 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.

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Highlight: 3-Tier/Incentive Formulary
0 Calendar Year Brand Drug Deductible
$10 Formulary Generic/$30 Formulary Brand/$50 Non-Formulary Brand Drug - Retail Pharmacy
$20 Formulary Generic/$60 Formulary Brand/$100 Non-Formulary Brand Drug - Mail Service

Covered Services	Member Copayment
DEDUCTIBLES (Prescription drug coverage benefits are not subject to the medical plan deductible.)	
Calendar Year Brand Drug Deductible	None
PRESCRIPTION DRUG COVERAGE[1,2]	**Participating Pharmacy**
Retail Prescriptions (up to a 30-day supply)	
• Contraceptive Drugs and Devices[3]	$0 per prescription
• Formulary Generic Drugs	$10 per prescription
• Formulary Brand Drugs[4, 5]	$30 per prescription
• Non-Formulary Brand Drugs[4, 5]	$50 per prescription
Mail Service Prescriptions (up to a 90-day supply)	
• Contraceptive Drugs and Devices[3]	$0 per prescription
• Formulary Generic Drugs	$20 per prescription
• Formulary Brand Drugs[4, 5]	$60 per prescription
• Non-Formulary Brand Drugs[4, 5]	$100 per prescription
Specialty Pharmacies (up to a 30-day supply)[6]	
• Specialty Drugs[7]	20% (Up to $100 copayment maximum per prescription)

1 Amounts paid through copayments and any applicable brand drug deductible accrues to the member's medical calendar year out-of-pocket maximum. Please refer to the Evidence of Coverage and Plan Contract for exact terms and conditions of coverage. Please note that if you switch from another plan, your prescription drug deductible credit, if applicable, from the previous plan during the calendar year will not carry forward to your new plan.

2 Drugs obtained at a non-participating pharmacy are not covered, unless Medically Necessary for a covered emergency.

3 Contraceptive Drugs and Devices covered under the outpatient prescription drug benefits will not be subject to the applicable calendar year brand drug deductible. If a brand contraceptive is requested when a generic equivalent is available, the member will be responsible for paying the difference between the cost to Blue Shield for the brand contraceptive and its generic drug equivalent. In addition, select contraceptives may need prior authorization to be covered without a copayment.

4 Select formulary and non-formulary drugs require prior authorization by Blue Shield for Medical Necessity, or when effective, lower cost alternatives are available.

5 If the member requests a brand drug and a generic drug equivalent is available, the member is responsible for paying the generic drug copayment plus the difference in cost to Blue Shield between the brand drug and its generic drug equivalent.

6 Specialty Drugs are Drugs requiring coordination of care, close monitoring, or extensive patient training for self-administration that generally cannot be met by a retail pharmacy and are available at a Network Specialty Pharmacy. Specialty Drugs may also require special handling or manufacturing processes (such as biotechnology), restriction to certain Physicians or pharmacies, or reporting of certain clinical events to the FDA. Specialty Drugs are generally high cost.

7 Specialty drugs are available from a Network Specialty Pharmacy. A Network Specialty Pharmacy provides specialty drugs by mail or upon member request, at an associated retail store for pickup.

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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). Because this plan's prescription drug coverage is creditable, you do not have to enroll in a Medicare prescription drug plan 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 anytime after you were first eligible to enroll in a Medicare prescription drug plan, you could be subject to a late enrollment penalty in addition to your Part D premium.

Important Prescription Drug Information

You can find details about your drug coverage three ways:

1. Check your *Evidence of Coverage.*
2. Go to **https://www.blueshieldca.com/bsca/pharmacy/home.sp** 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 **https://www.blueshieldca.com/bsca/pharmacy/home.sp** 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 non-formulary drugs with formulary or generic equivalents;
- Look up drugs that require step therapy or 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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