High Desert & Inland Trust
Custom PPO 1

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

	Participating Providers[1]	Non-Participating Providers[2]
Calendar Year Medical Deductible (All providers combined)	$200 per individual / $400 per family	$1,000 per individual / $2,000 per family
Calendar Year Out-of-Pocket Maximum (Includes the calendar year medical deductible. Copayments or coinsurance for covered services from participating providers accrue to both the participating and non-participating provider calendar year out-of-pocket maximum amount.)	$1,500 per individual / $2,500 per family	$2,000 per individual / $4,000 per family
Lifetime Benefit Maximum	None	

Covered Services	**Member Copayment**	
OUTPATIENT PROFESSIONAL SERVICES	**Participating Providers[1]**	**Non-Participating Providers[2]**
Professional (Physician) Benefits		
Physician and specialist office visits	$10 per visit (not subject to the calendar year medical deductible)	30%
Outpatient diagnostic x-ray, imaging, pathology, laboratory and other testing services	$10 per visit (not subject to the calendar year medical deductible)	30%
Radiological and nuclear imaging (CT scans, MRIs, MRAs, PET scans and cardiac diagnostic procedures utilizing nuclear medicine)	$10 per visit (not subject to the calendar year medical deductible)	30%
Allergy Testing and Treatment Benefits		
Allergy testing, treatment and serum injections (separate office visit copayment may apply)	$10 per visit (not subject to the calendar year medical deductible)	30%
Allergy serum purchased separately for treatment	No Charge (not subject to the calendar year medical deductible)	30%
Preventive Health Benefits[11]		
Preventive health services (as required by applicable Federal and California law)	No Charge (not subject to the calendar year medical deductible)	Not Covered
OUTPATIENT FACILITY SERVICES		
Outpatient surgery performed at a free-standing ambulatory surgery center	10%	30% up to $350 per day[3]
Outpatient surgery performed in a hospital or a hospital affiliated ambulatory surgery center	10%	30% up to $350 per day[3]
Outpatient services for treatment of illness or injury and necessary supplies (except as described under "Rehabilitation Benefits" and "Speech Therapy Benefits")	10%	30% up to $350 per day[3]
Outpatient diagnostic x-ray, imaging, pathology, laboratory and other testing services	$10 per visit (not subject to the calendar year medical deductible)	30% up to $350 per day[3]
Radiological and nuclear imaging (CT scans, MRIs, MRAs, PET scans and cardiac diagnostic procedures utilizing nuclear medicine)	$10 per visit (not subject to the calendar year medical deductible)	30% up to $350 per day[3]
Bariatric surgery[4] (prior authorization is required; medically necessary surgery for weight loss, for morbid obesity only)	10%	30% up to $350 per day[3]

HOSPITALIZATION SERVICES		
Hospital Benefits (Facility Services)		
Inpatient physician services	10%	30%
Inpatient non-emergency facility services (semi-private room and board, and medically necessary services and supplies, including subacute care)	10%	30% up to $600 per day[5]
Bariatric surgery[4] (prior authorization is required; medically necessary surgery for weight loss, for morbid obesity only)	10%	30% up to $600 per day[5]
Inpatient Skilled Nursing Benefits[6,7] (Coverage limited to 100 days per member per benefit period combined with hospital/free-standing skilled nursing facility)		
Free-standing skilled nursing facility	10%	10%[7]
Skilled nursing unit of a hospital	10%	30% up to $600 per day[5]
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 (not subject to the calendar year medical deductible)	$100 per visit (not subject to the calendar year medical deductible)
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 (ground or air)	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 the Customer Service number on your identification card.		
PROSTHETICS/ORTHOTICS		
Prosthetic equipment and devices (separate office visit copayment may apply)	10%	30%
Orthotic equipment and devices (separate office visit copayment may apply)	10%	30%
DURABLE MEDICAL EQUIPMENT		
Breast pump	No Charge (not subject to the calendar year medical deductible)	Not Covered
Other durable medical equipment	10%	30%
MENTAL HEALTH AND SUBSTANCE ABUSE SERVICES[8,9]	**MHSA Participating Providers[1]**	**MHSA Non-Participating Providers[2]**
Inpatient hospital services	10%	30% up to $600 per day[5]
Residential care	10%	30% up to $600 per day[5]
Inpatient physician services	10%	30%
Routine outpatient mental health and substance abuse services (includes professional/physician visits)	$10 per visit (not subject to the calendar year medical deductible)	30%
Non-routine outpatient mental health and substance abuse services (includes behavioral health treatment, electroconvulsive therapy, intensive outpatient programs, office-based opioid treatment, partial hospitalization program, psychological testing and transcranial magnetic stimulation)	No Charge	30%
HOME HEALTH SERVICES[10]	**Participating Providers[1]**	**Non-Participating Providers[2]**
Home health care agency services[6] (Coverage limited to 100 visits per member per calendar year. Non-participating home health care and home infusion are not covered unless pre-authorized. When these services are pre-authorized, you pay the participating provider member cost share)	10%	Not Covered[10]
Home infusion/home injectable therapy and infusion nursing visits provided by a home infusion agency	10%	Not Covered[10]
HOSPICE PROGRAM BENEFITS[10]		
Routine home care	No Charge	Not Covered[10]
Inpatient respite care	No Charge	Not Covered[10]
24-hour continuous home care	10%	Not Covered[10]
Short-term inpatient care for pain and symptom management	10%	Not Covered[10]

CHIROPRACTIC BENEFITS[6]		
Chiropractic spinal manipulation (Coverage for chiropractic services is limited to 20 visits per calendar year)	10% (not subject to the calendar year medical deductible)	30%
ACUPUNCTURE BENEFITS[6]		
Acupuncture services (Coverage for acupuncture services is limited to 20 visits per calendar year)	$25 per visit	30%
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)	$10 per visit (not subject to the calendar year medical deductible)	30%
SPEECH THERAPY BENEFITS		
Office location (an additional facility copayment may apply when services are rendered in a hospital or skilled nursing facility)	$10 per visit (not subject to the calendar year medical deductible)	30%
PREGNANCY AND MATERNITY CARE BENEFITS		
Prenatal and postnatal physician office visits (when billed as part of global maternity fee including hospital inpatient delivery services)	10%	30%
Abortion services (an additional facility copayment may apply when services are rendered in a hospital or outpatient surgery center)	10%	30%
FAMILY PLANNING BENEFITS		
Counseling and consulting (includes insertion of IUD, as well as injectable and implantable contraceptives for women)	No Charge (not subject to the calendar year medical deductible)	Not Covered
Tubal ligation	No Charge (not subject to the calendar year medical deductible)	Not Covered
Vasectomy (an additional facility copayment may apply when services are rendered in a hospital or outpatient surgery center)	10%	Not Covered
DIABETES CARE BENEFITS		
Devices, equipment, and non-testing supplies (for testing supplies see Outpatient Prescription Drug Benefits)	10%	30%
Diabetes self-management training	$10 per visit (not subject to the calendar year medical deductible)	30%
CARE OUTSIDE OF PLAN SERVICE AREA Benefits provided through the BlueCard® Program are paid at the participating level. Member's cost share will be either a copayment or coinsurance based on the lower of billed charges or the negotiated allowable amount for participating providers as agreed upon with the local Blue's Plan.		
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, infertility and hearing aid benefits are available. If your employer purchased any of these benefits, a description of the benefit is provided separately.		

1 Unless otherwise specified, copayments/coinsurance are calculated based on allowable amounts. After the calendar year medical deductible is met, the member is responsible for copayments/coinsurance for covered services from participating providers. Participating providers agree to accept Blue Shield's allowable amount plus any applicable member copayment or coinsurance as full payment for covered services.

2 Non-participating providers can charge more than Blue Shield's allowable amounts. When members use non-participating providers, they must pay the applicable deductibles, copayments or coinsurance plus any amount that exceeds Blue Shield's allowable amount. Charges above the allowable amount do not count toward the calendar year deductible or out-of-pocket maximum.

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-participating hospital is $350 per day. Members are responsible for 30% of this $350 per day, and all charges in excess of $350 per day. Amounts that exceed the benefit maximums do not count toward the calendar year out-of-pocket maximum and continue to be the member's financial responsibility after the calendar year maximums are reached.

4 Bariatric surgery is covered when prior 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 participating provider and there is no coverage for bariatric services from non-participating providers. In addition, if prior authorized by Blue Shield, 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 details.

5 The maximum allowed charges for non-emergency hospital services received from a non-participating hospital is $600 per day. Members are responsible for 30% of this $600 per day, and all charges in excess of $600 per day. Amounts that exceed the benefit maximum do not count toward the calendar year out-of-pocket maximum and continue to be the member's responsibility after the calendar year maximums are reached.

6 For plans with a calendar year medical deductible amount, services with a day or visit limit accrue to the calendar year day or visit limit maximum regardless of whether the calendar year medical deductible has been met.

7 Services may require prior authorization. When services are prior authorized, members pay the participating provider amount.

8 Mental health and substance abuse services are accessed through Blue Shield's Mental Health Service Administrator (MHSA) - using MHSA participating and MHSA non-participating providers. Only mental health and substance abuse services rendered by MHSA participating providers are administered by the MHSA. Mental health and substance abuse services rendered by non-MHSA participating providers are administered by Blue Shield.

9 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's participating providers or non-participating providers.

10 Services from non-participating providers for home health care and hospice services are not covered unless prior authorized. When these services are prior authorized, the member's copayment or coinsurance will be calculated at the participating provider level, based upon the agreed upon rate between Blue Shield and the agency.

11 Preventive Health Services, including an annual preventive care or well-baby care office visit, are not subject to the calendar year medical deductible. Other covered non-preventive services received during, or in connection with, the preventive care or well-baby care office visit are subject to the calendar year medical deductible and applicable member copayment/coinsurance

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

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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 PPO 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 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
PPO 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*.

High Desert & Inland Trust
Custom RX PPO 1

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

THIS DRUG COVERAGE SUMMARY IS ADDED TO BE COMBINED WITH 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.

Highlight: 3-Tier/Incentive Formulary
0 Calendar year Brand Drug Deductible
$8 Formulary Generic/$20 Formulary Brand/$35 Non-Formulary Brand Drug - Retail Pharmacy
$8 Formulary Generic/$30 Formulary Brand/$50 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]	**Participating Pharmacy**	**Non-Participating Pharmacy**[7,8] Member pays 25% of billed amount plus a copayment of:
Retail Prescriptions (up to a 30-day supply)		
• Contraceptive Drugs and Devices[2]	$0 per prescription	Applicable Generic, Brand or Non-Formulary Copayment[9]
• Formulary Generic Drugs	$8 per prescription	$8 per prescription
• Formulary Brand Drugs[3, 4]	$20 per prescription	$20 per prescription
• Non-Formulary Brand Drugs[3, 4]	$35 per prescription	$35 per prescription
Mail Service Prescriptions (up to a 90-day supply)		
• Contraceptive Drugs and Devices[2]	$0 per prescription	Not Covered
• Formulary Generic Drugs	$8 per prescription	Not Covered
• Formulary Brand Drugs[3, 4]	$30 per prescription	Not Covered
• Non-Formulary Brand Drugs[3, 4]	$50 per prescription	Not Covered
Specialty Pharmacies (up to a 30-day supply)[5]		
• Specialty Drugs[6]	30% (Up to $150 copayment maximum per prescription)	Not Covered

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 Contraceptive Drugs and Devices covered under the outpatient prescription drug benefits will not be subject to the applicable calendar year brand drug deductible when obtained from a participating pharmacy. 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.

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

4 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.

5 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.

6 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.

7 To obtain prescription drugs at a non-participating pharmacy, the member must first pay all charges for the prescription and submit a completed Prescription Drug Claim Form for reimbursement. The member will be reimbursed the price paid for the drug less any applicable deductible, copayment or coinsurance (Generic, Formulary Brand, or Non-Formulary Brand) and any applicable out of network charge.

8 Outpatient prescription drug copayments for covered drugs obtained from non-participating pharmacies will accrue to the participating provider maximum calendar year out-of-pocket maximum.

9 To obtain contraceptive drugs and devices at a non-participating pharmacy, the member must first pay all charges for the prescription and submit a completed Prescription Drug Claim Form for reimbursement. The member will be reimbursed the price paid for the drug less any applicable deductible, copayment or coinsurance (Generic, Formulary Brand, or Non-Formulary Brand) and any applicable out of network charge.

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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