High Desert & Inland Trust
Victor 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, 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 BENEFIT AND LIMITATIONS.

	LEVEL I: HMO Plan Providers[1]	**LEVEL II: Participating Providers[1]**	**LEVEL III: Non-Participating Providers[2]**
Calendar Year Medical Deductible	None	$100 per Individual/ $300 per Family	
Calendar Year Out-of-Pocket Maximum (Includes the calendar year medical deductible)	$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	None
Covered Services		**Member Copayment**	
OUTPATIENT PROFESSIONAL SERVICES	**LEVEL I: HMO Plan Providers[1]**	**LEVEL II: Participating Providers[1]**	**LEVEL III: Non-Participating Providers[2]**
Professional (Physician) Benefits			
• Physician and specialist office visits (note: for level I 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 diagnostic x-ray, imaging, pathology, laboratory and other testing services	No Charge	10%	30%
• Radiological and nuclear imaging (CT scans, MRIs, MRAs, PET scans and cardiac diagnostic procedures utilizing nuclear medicine)	No Charge	10%	30%
Allergy Testing and Treatment Benefits			
• Allergy testing, treatment and serum injections	$5 per visit	10%	30%
• Allergy serum purchased separately for treatment	No Charge	50%	50%
Preventive Health Benefits			
• Preventive health services (as required by applicable Federal and California law.)	No Charge	10%	30%
OUTPATIENT FACILITY SERVICES			
• Outpatient surgery performed at a free-standing ambulatory surgery center	No Charge	10%	30% up to $350 per day[3]
• Outpatient surgery in a hospital or a hospital affiliated ambulatory surgery center	No Charge	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")	No Charge	10%	30% up to $350 per day[3]
• Outpatient diagnostic x-ray, imaging, pathology, laboratory and other testing services	No Charge	10%	30% up to $350 per day[3]
• Radiological and nuclear imaging (CT scans, MRIs, MRAs, PET scans and cardiac diagnostic procedures utilizing nuclear medicine)	No Charge	10%	30% up to $350 per day[3]
• Bariatric surgery (prior authorization is required; medically necessary surgery for weight loss, for morbid obesity only)	No Charge	10%[4]	30% up to $350 per day[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, and medically-necessary services and supplies, including subacute care)	No Charge	10%	30% up to $600 per day[5]
• Bariatric surgery (prior authorization is required; medically necessary surgery for weight loss, for morbid obesity only)	No Charge	10%[4]	30% up to $600 per day[4,5]
Inpatient Skilled Nursing Benefits[6,7] (combined maximum of up to100 prior authorized days per benefit period; prior authorization required ; semi-private accommodations)			
• Free-standing skilled nursing facility	No Charge	10%	10%[7]
• Skilled nursing unit of a hospital	No Charge	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	$100 per visit (not subject to the calendar year deductible)	$100 per visit (not subject to the calendar year deductible)
• Emergency room physician services	No Charge	No Charge (not subject to the calendar year deductible)	No Charge (not subject to the calendar year deductible)
AMBULANCE SERVICES			
• Emergency or authorized transport (ground or air) (emergency transports are paid under the HMO benefit level)	No Charge	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)	No Charge	10%	30%
• Orthotic equipment and devices (separate office visit copayment may apply)	No Charge	10%	30%
DURABLE MEDICAL EQUIPMENT			
• Breast pump	No Charge	No Charge (not subject to the calendar year deductible)	30%
• Other durable medical equipment (member cost share is based upon allowed charges, Level I only)	No Charge	10%	10%
MENTAL HEALTH AND SUBSTANCE USE DISORDER SERVICES[8,12]	**LEVEL I: MHSA Participating Providers**[1]	**LEVEL II: N/A**	**LEVEL III: MHSA Non-Participating Providers**[2]
• Inpatient hospital services	No Charge	N/A	30% up to $600 per day[5]
• Residential care	No Charge	N/A	30% up to $600 per day[5]
• Inpatient physician services	No Charge	N/A	30%
• Routine outpatient mental health and substance use disorder services (includes professional/physician visits)	$5 per visit	N/A	30%
• Non-routine outpatient mental health and substance use disorder 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	N/A	30%

HOME HEALTH SERVICES[9]	LEVEL I: HMO Plan Providers[1]	LEVEL II: Participating Providers[1]	LEVEL III: Non-Participating Providers[2]
• Home health care agency services[6] (up to 100 visits per calendar year)	No Charge	10%	Not Covered[9]
• Home infusion/home injectable therapy and infusion nursing visits provided by a home infusion agency	No Charge	10%	Not Covered[9]
HOSPICE PROGRAM BENEFITS			
• Routine home care	No Charge	Not Covered[10]	Not Covered[10]
• Inpatient respite care	No Charge	Not Covered[10]	Not Covered[10]
• 24-hour continuous home care	No Charge	Not Covered[10]	Not Covered[10]
• Short-term inpatient care for pain and symptom management	No Charge	Not Covered[10]	Not Covered[10]
PREGNANCY AND MATERNITY CARE BENEFITS			
• Prenatal and postnatal physician office visits (when billed as part of global maternity fee including hospital inpatient delivery service)	No Charge	10%	30%
• Abortion services (an additional facility copayment may apply when services are rendered in a hospital or outpatient surgery center)	$100 per surgery	50%	50%
FAMILY PLANNING AND INFERTILITY BENEFITS			
• Counseling and consulting (Includes insertion of IUD, as well as injectable and implantable contraceptives for women)	No Charge	10%	30%
• Infertility services 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	No Charge	10%	30%
• Vasectomy (an additional facility copayment may apply when services are rendered in a hospital or outpatient surgery center)	$75 per surgery	50%	50%
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)	$5 per visit	10%	30%
SPEECH THERAPY BENEFITS			
• Office location (an additional facility copayment may apply when services are rendered in a hospital or skilled nursing facility)	$5 per visit	10%	30%
DIABETES CARE BENEFITS			
• Devices, equipment, and non-testing supplies (member cost share is based upon allowed charges, Level I only; for testing supplies see Outpatient Prescription Drug Benefits.)	No Charge	10%	30%
• Diabetes self-management training	$5 per visit	10%	30%
URGENT CARE BENEFITS			
• Urgent care services outside your personal physician service area, within California	$5 per visit[11]	N/A	N/A
• Urgent care services outside of California (BlueCard® Program)	$5 per visit[11]	See Applicable Benefit	See Applicable Benefit

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 Unless otherwise specified, copayments/coinsurance are calculated based on allowable amounts. After the calendar year medical deductible is met, the member is responsible for a copayment or coinsurance from participating providers. Participating providers accept Blue Shield's allowable amounts 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 medical deductible or out-of-pocket maximum. Calendar year deductible applies to services of non-participating providers only.

3 The allowable amount 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.

4	For levels II and III, 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.
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 from non-participating providers require prior authorization by the Blue Shield. When services are prior authorized, members pay the participating provider amount.
8	Mental health and substance use disorder services are accessed through Blue Shield's Mental Health Service Administrator (MHSA) - using Blue Shield's MHSA participating (Level I) and non-participating (Level III) providers. Only mental health and substance use disorder services rendered by Blue Shield MHSA participating providers are administered by the Blue Shield MHSA. Mental health and substance use disorder services rendered by non- participating providers are administered by Blue Shield. There are no Level II providers for mental health and substance use disorder services.
9	Services from non-participating providers for health care 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.
10	Out of network hospice is not covered unless prior authorized. When these services are prior authorized, the member pays the Level I copayment.
11	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 participating provider. To receive Level I services, Blue Shield HMO may direct the patient to receive follow-up services from the personal physician.
12	Inpatient services for acute detoxification are covered under the medical benefits; see the Hospital Benefits (Facility Services) section of the Evidence of Coverage for details. Services for acute medical detoxification are accessed through Blue Shield using Blue Shield's HMO plan providers (Level I), participating providers (Level II), or non-participating providers (Level III).

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

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.

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 POS 1 RX

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.

Blue Shield of California

Highlight: 2-Tier/Closed Formulary
$0 Calendar Year Brand Drug Deductible
$2 Formulary Generic/$5 Formulary Brand - Retail Pharmacy
$2 Formulary Generic/$5 Formulary Brand - 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	$2 per prescription
• Formulary Brand Drugs[4, 5]	$5 per prescription
Mail Service Prescriptions (up to a 90-day supply)	
• Contraceptive Drugs and Devices[3]	$0 per prescription
• Formulary Generic Drugs	$2 per prescription
• Formulary Brand Drugs[4, 5]	$5 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 pick up.

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 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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