Classified PPO Plan Summary

High Desert & Inland Trust
Custom PPO 2

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 THE *PLAN CONTRACT* SHOULD BE CONSULTED FOR A DETAILED DESCRIPTION OF COVERAGE BENEFITS AND LIMITATIONS.

Blue Shield of California

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

Effective: July 1, 2015

	Participating Providers[1]	Non-Participating Providers[1]
Calendar Year Medical Deductible (All providers combined)	$500 per individual / $1,000 per family	$1,000 per individual / $2,000 per family
Calendar Year Copayment Maximum (Includes the plan deductible) (Copayments/Coinsurance for participating providers accrue to both participating and non-participating provider Calendar Year Out-of-Pocket Maximum amounts.)	$1,500 per individual / $2,500 per family	$2,000 per individual / $4,000 per family
LIFETIME BENEFIT MAXIMUM	None	

Covered Services	Member Copayment	
PROFESSIONAL SERVICES	**Participating Providers[1]**	**Non-Participating Providers[1]**
Professional (Physician) Benefits		
• Physician and specialist office visits	$20 per visit (Not subject to the Calendar Year Deductible)	30%
• CT scans, MRIs, MRAs, PET scans, and cardiac diagnostic procedures utilizing nuclear medicine (prior authorization is required)[2]	$20 per visit (Not subject to the Calendar Year Deductible)	30%
• Other outpatient X-ray, pathology and laboratory (Diagnostic testing by providers other than outpatient laboratory, pathology, and imaging departments of hospitals/facilities)[2]	$20 per visit (Not subject to the Calendar Year Deductible)	30%
Allergy Testing and Treatment Benefits		
• Office visits (includes visits for allergy serum injections)	$20 per visit (Not subject to the Calendar Year Deductible)	30%
• Allergy serum purchased separately for treatment	No Charge (Not subject to the Calendar Year Deductible)	30%
Preventive Health Benefits		
• Preventive Health Services (As required by applicable federal and California law.)	No Charge (Not subject to the Calendar Year Deductible)	Not Covered
OUTPATIENT SERVICES		
Hospital Benefits (Facility Services)		
• Outpatient surgery performed at an Ambulatory Surgery Center[3]	10%	30%[4]
• Outpatient surgery in a hospital	10%	30%[4]
• Outpatient Services for treatment of illness or injury and necessary supplies (Except as described under "Rehabilitation Benefits")	10%	30%[4]
• CT scans, MRIs, MRAs, PET scans, and cardiac diagnostic procedures utilizing nuclear medicine performed in a hospital (prior authorization is required)[2]	$20 per visit (Not subject to the Calendar Year Deductible)	30%[4]
• Other outpatient X-ray, pathology and laboratory performed in a hospital[2]	$20 per visit (Not subject to the Calendar Year Deductible)	30%[4]
• Bariatric Surgery (prior authorization required by the Plan; medically necessary surgery for weight loss, for morbid obesity only)[5]	10%	30%[4]
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%[6]
• Bariatric Surgery (prior authorization required by the Plan; medically necessary surgery for weight loss, for morbid obesity only)[5]	10%	30%[6]

Skilled Nursing Facility Benefits[7] (Combined maximum of up to 100 prior authorized days per Calendar Year; semi-private accommodations)		
• Services by a free-standing Skilled Nursing Facility	10%	10%[8]
• Skilled Nursing Unit of a Hospital	10%	30%[6]
EMERGENCY HEALTH COVERAGE		
• Emergency room Services not resulting in admission (The ER 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 Deductible)	$100 per visit (Not subject to the Calendar Year 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	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 copay may apply)	10%	30%
• Orthotic equipment and devices (Separate office visit copay may apply)	10%	30%
DURABLE MEDICAL EQUIPMENT		
• Breast pump	No Charge (Not subject to the Calendar Year Deductible)	Not Covered
• Other Durable Medical Equipment	10%	30%
MENTAL HEALTH AND SUBSTANCE ABUSE SERVICES[9, 10]	**MHSA Participating Providers**[1]	**MHSA Non-Participating Providers**[1]
• Inpatient Hospital Services	10%	30%[6]
• Residential Care	10%	30%[6]
• Inpatient Physician Services	10%	30%
• Routine Outpatient Mental Health and Substance Abuse Services (includes professional/physician visits)	$20 per visit (Not subject to the Calendar Year 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 programs, and transcranial magnetic stimulation. For partial hospitalization programs, a higher copayment and facility charges may apply per episode of care)	No Charge	30%
HOME HEALTH SERVICES	**Participating Providers**[1]	**Non-Participating Providers**[1]
• Home health care agency Services (up to 100 prior authorized visits per Calendar Year)[7]	10%	Not Covered[11]
• Home infusion/home intravenous injectable therapy and infusion nursing visits provided by a Home Infusion Agency	10%	Not Covered[11]
OTHER		
Hospice Program Benefits		
• Routine home care	No Charge	Not Covered[11]
• Inpatient Respite Care	No Charge	Not Covered[11]
• 24-hour Continuous Home Care	10%	Not Covered[11]
• General Inpatient care	10%	Not Covered[11]
Chiropractic Benefits[7]		
• Chiropractic Services (up to 20 visits per Calendar Year)	10% (Not subject to the Calendar Year Deductible)	30%
Acupuncture Benefits[7]		
• Acupuncture Services (up to 20 visits per Calendar Year)	$25 per visit	30%
Rehabilitation Benefits (Physical, Occupational and Respiratory Therapy)		
• Office location	$20 per visit (Not subject to the Calendar Year Deductible)	30%
Speech Therapy Benefits		
• Office Visit	$20 per visit (Not subject to the Calendar Year Deductible)	30%

Benefit	Participating Providers	Non-Participating Providers
Pregnancy and Maternity Care Benefits		
• Prenatal and postnatal Physician office visits (For inpatient hospital services, see "Hospitalization Services.")	10%	30%
• Abortion Services (Facility charges may apply – see "Hospital Benefits (Facility Services)")	10%	30%
Family Planning Benefits		
• Counseling and consulting[12]	No Charge (Not subject to the Calendar Year Deductible)	Not Covered
• Tubal ligation	No Charge (Not subject to the Calendar Year Deductible)	Not Covered
• Vasectomy[13]	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	$20 per visit (Not subject to the Calendar Year Deductible)	30%
Care Outside of Plan Service Area (Benefits provided through the BlueCard® Program for out-of-state emergency and non-emergency care are provided at the participating level of the local Blue Plan allowable amount when you use a Blue Cross/Blue Shield provider)		
• 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. Participating providers agree to accept Blue Shield's allowable amount plus the plan's and any applicable member's payment 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 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.

2 Participating non Hospital based ("freestanding") laboratory or radiology centers may not be available in all areas. Laboratory and radiology Services may also be obtained from a Hospital or from a laboratory and radiology center that is affiliated with a Hospital, and paid according to the benefit under your health plan's Hospital Benefits.

3 Participating Ambulatory Surgery Centers may not be available in all areas. Outpatient surgery Services may also be obtained from a Hospital or from an ambulatory surgery center that is affiliated with a Hospital, and paid according to the benefit under your health plan's Hospital Benefits.

4 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, plus all charges in excess of $350.

5 Bariatric surgery is covered when pre-authorized by the Plan. 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 the Plan, 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 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, plus all charges in excess of $600.

7 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 plan medical deductible has been met.

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

9 Mental Health and Substance Abuse services are accessed through Blue Shield's Mental Health Service Administrator (MHSA) – using Blue Shield's MHSA participating and non-participating providers. Only Mental Health and Substance Abuse services rendered by Blue Shield MHSA participating providers are administered by the Blue Shield MHSA. Mental Health and Substance Abuse services rendered by non-participating providers are administered by Blue Shield.

10 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.

11 Out of network home health care, home infusion and hospice services are not covered unless pre-authorized. When these services are pre-authorized, the member pays the participating provider copayment.

12 Includes insertion of IUD as well as injectable and implantable contraceptives for women.

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. Services from non-participating providers and non-participating facilities are not covered under this benefit.

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

A17266 (1/15) VR041415

High Desert & Inland Trust
Custom RX PPO 2

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

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-Name Drug Deductible
$8 Formulary Generic/$30 Formulary Brand Name/$45 Non-Formulary Brand Name Drug - Retail Pharmacy
$8 Formulary Generic/$45 Formulary Brand Name/$60 Non-Formulary Brand-Name Drug - 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]	**Participating Pharmacy**	**Non-Participating Pharmacy** 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	Not Covered
• Formulary Generic Drugs	$8 per prescription	$8 per prescription
• Formulary Brand Name Drugs[3, 4]	$30 per prescription	$30 per prescription
• Non-Formulary Brand Name Drugs[3, 4]	$45 per prescription	$45 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 Name Drugs[3, 4]	$45 per prescription	Not Covered
• Non-Formulary Brand Name Drugs[3, 4]	$60 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-name drug deductible accrue 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-name drug deductible. If a brand-name 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-name 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-name 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-name drug and its generic drug equivalent.

5 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. Specialty 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. Infused or Intravenous (IV) medications are not included as Specialty Drugs.

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

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 **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 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.

A16154-d (1/15) VR042015

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 aid Services Benefit and hearing aid expenses in excess of the maximum allowance are not included in the calculation of the Subscriber's Maximum Calendar Year Out-of-Pocket Responsibility.

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*.

An independent member of the Blue Shield Association A19528 (01/15) VR042015