# 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] |

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|---|---|---|
| **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] |