

High Desert & Inland Trust-Premier PPO Custom PPOSM 200-90/70

Benefit Summary (For groups of 300 and above)

Blue Shield of California

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

Effective July 1, 2008

THIS MATRIX IS INTENDED TO BE USED TO HELP YOU COMPARE COVERAGE BENEFITS AND IS A SUMMARY ONLY. THE EVIDENCE OF COVERAGE, DISCLOSURE FORM AND PLAN CONTRACT SHOULD BE CONSULTED FOR A DETAILED DESCRIPTION OF COVERAGE BENEFITS AND LIMITATIONS.

	Preferred Providers ²	Non-Preferred Providers ²
DEDUCTIBLES¹ (All providers combined)		
Calendar-year medical deductible	\$200 per individual/ \$400 per family	
Calendar-year Copayment Maximum¹	\$1,500 per individual/ \$2,500 per family	\$2,000 per individual/ \$4,000 per family
LIFETIME MAXIMUM	\$6,000,000	
Covered Services	Member Copayment	
PROFESSIONAL SERVICES	Preferred Providers ²	Non-Preferred Providers ²
Physician services		
• Physician and specialist office visits	\$10/visit (Deductible waived)	30%
• Laboratory and X-rays	\$10/visit (Deductible waived)	30%
• Allergy testing or treatment	\$10/visit (Deductible waived)	30%
• Diagnostic testing	\$10/visit (Deductible waived)	30%
Preventive care		
• Annual routine physical exam, eye/ear screenings and immunizations	\$10/visit (Deductible waived)	Not covered
• Laboratory, including mammogram and Pap test screening or other FDA-approved cervical cancer screening tests (One per calendar year)	\$10/visit (Deductible waived)	Not covered
Well-baby care		
• Office visits and consultations Includes: eye/ear screenings, immunizations, vaccinations	\$10/visit (Deductible waived)	Not covered
• Laboratory	\$10/visit (Deductible waived)	Not covered
OUTPATIENT SERVICES		
The maximum allowed charges for non-emergency surgery and services performed in a non-participating Ambulatory Surgery Center or outpatient unit of a non-preferred hospital is \$350 per day. Members are responsible for 30% of this \$350 per day, plus all charges in excess of \$350.		
• Outpatient surgery performed in a Participating Ambulatory Surgery Center ³ (ASC)	10%	30%
• Outpatient surgery in hospital/facility	10%	30%
• Outpatient treatment and necessary supplies	10%	30%
HOSPITALIZATION SERVICES		
Inpatient services – non-emergency		
• Inpatient physician services (Including pregnancy and maternity care)	10%	30%
• Semi-private room and board, medically necessary services and supplies	10%	30% ⁴
• Bariatric surgery (pre-authorization required; medically necessary surgery for weight loss, only for morbid obesity) ⁵	10%	30% ⁴
Skilled nursing facility (SNF) services⁶ (Combined maximum of up to 100 preauthorized days per calendar year; semi-private accommodations)		
• Freestanding SNF	10%	10% with prior authorization ⁶
• Hospital SNF unit	10%	30% ⁴
EMERGENCY HEALTH COVERAGE		
• ER facility services (Deductible and copay waived if the member is admitted directly from the ER for inpatient services)	\$100	\$100
• Inpatient facility services (when the member is admitted directly from the ER)	10%	10%
• Emergency room physician visits	10%	10%
AMBULANCE SERVICES	10%	10%

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PRESCRIPTION DRUG COVERAGE	A description of your outpatient prescription drug coverage is provided separately. If you do not have the separate drug sheet that goes with this benefit summary, please contact your benefits administrator or call Customer Services at (800) 642-6155 .	
PROSTHETICS/ORTHOTICS (Equipment and devices only)	10%	30%
DURABLE MEDICAL EQUIPMENT	10%	30%
(Plan payment up to \$3000 maximum per calendar year.)		
MENTAL HEALTH SERVICES (PSYCHIATRIC)⁷	MHSA Participating Providers²	MHSA Non-Participating Providers²
<ul style="list-style-type: none"> Inpatient hospital facility services Outpatient visits for severe mental health conditions 	10%	30% ⁴
	\$10/visit	30%
	(Deductible waived)	
<ul style="list-style-type: none"> Outpatient visits for non-severe mental health conditions (Up to 20 visits per calendar year combined with outpatient chemical dependency visits)¹¹ 	50% ¹	Not covered
CHEMICAL DEPENDENCY SERVICES (SUBSTANCE ABUSE)⁷		
Please see footnote⁸		
<ul style="list-style-type: none"> Inpatient services for medical acute detoxification 	See "Hospitalization Services"	See "Hospitalization Services"
	50% ¹	Not covered
<ul style="list-style-type: none"> Outpatient visits (Up to 20 visits per calendar year combined with outpatient non-severe mental health visits)¹¹ 		
HOME HEALTH SERVICES⁹ (Combined maximum of 100 prior authorized visits per calendar year)	Preferred Providers²	Non-Preferred Providers²
<ul style="list-style-type: none"> Home health and home infusion care (See "Prescription Drug Coverage" for home self-administered injectables.) 	10%	10% with prior authorization ⁹
OTHER		
Hospice⁹		
<ul style="list-style-type: none"> Routine home care and inpatient respite care 	No charge	No charge with prior authorization ⁹
<ul style="list-style-type: none"> 24 hour continuous home care and general inpatient care 	10%	10% with prior authorization ⁹
Alternative care¹¹		
<ul style="list-style-type: none"> Chiropractic services (Up to 20 visits per calendar year) 	10%	30%
	(Deductible waived)	
<ul style="list-style-type: none"> Acupuncture services (Up to 20 visits per calendar year) 	\$25/visit	\$25/visit
Rehabilitative therapy services		
<ul style="list-style-type: none"> Outpatient visits 	\$10/visit	30%
	(Deductible waived)	
Pregnancy and maternity care		
<ul style="list-style-type: none"> Prenatal and postnatal professional (physician) services (For all necessary inpatient hospital services, see "Hospitalization Services.") 	10%	30%
Family planning		
<ul style="list-style-type: none"> Family planning counseling 	\$10/visit	Not covered
	(Deductible waived)	
<ul style="list-style-type: none"> Elective abortion, tubal ligation, vasectomy¹⁰ 	10%	Not covered
Covered out-of-state benefits Benefits provided through BlueCard [®] Program, for out-of-state emergency and non-emergency care, are provided at the preferred level of the local Blue Plan allowable amount when you use a Blue Cross/Blue Shield provider.	10% or \$10 copay	30%
	(Deductible waived)	
Diabetes care		
<ul style="list-style-type: none"> Equipment, devices and non-testing supplies (For testing supplies, see "Prescription Drug Coverage.") 	10%	30%
<ul style="list-style-type: none"> Self-management training and education (If billed by your provider, you will also be responsible for the office visit copayment) 	\$10/visit	30%
	(Deductible waived)	
Optional Benefits	Optional dental, vision, inpatient substance abuse treatment, infertility and hearing aid benefits are available. If your employer purchased any of these benefits, a description of the benefit is provided separately.	

1 Deductible and copayments marked with a (1) do not accrue to calendar-year copayment maximum. Copayments and charges for services not accruing to the member's calendar-year copayment maximum continue to be the member's responsibility after the calendar-year copayment maximum is reached. Deductible does not apply toward the calendar-year maximum. Please refer to the Evidence of Coverage, the Disclosure Form and the Plan Contract for exact terms and conditions of coverage.

2 Member is responsible for copayment in addition to any charges above allowable amounts. The copayment percentage indicated is a percentage of allowable amounts. Preferred providers accept Blue Shield's allowable amount as full payment for covered services. Non-preferred providers can charge more than these amounts. When members use non-preferred providers, they must pay the applicable copayment plus any amount that exceeds Blue Shield's allowable amount. Charges above the allowable amount do not count toward the calendar-year deductible or copayment maximum.

3 Participating ambulatory surgery centers may not be available in all areas. Regardless of their availability, you can obtain outpatient surgery services from a hospital or an ambulatory surgery center affiliated with a hospital; with payment according to your health plan's hospital services benefits.

4 The maximum allowed charge for non-emergency hospital services received from a Non-Preferred Hospital is \$600 per day. Members are responsible for 30 percent of this \$600 per day, plus all charges in excess of \$600.

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- 5 Bariatric surgery is covered when pre-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 preferred provider and there is no coverage for bariatric services from non-preferred Providers. In addition, if prior authorized by Blue Shield of California, 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 Services may require prior authorization by Blue Shield. When these services are prior authorized, members pay the preferred or participating provider amount.
- 7 Mental health and chemical dependency services, other than medical acute detoxification, are accessed through the mental health services administrator (MHSA) - U.S. Behavioral Health Plan, California (USBHPC) - using MHSA participating and non-participating providers. MHSA non-participating providers are not administered by USBHPC. Services for medical acute detoxification are accessed through Blue Shield using Blue Shield's preferred providers or non-preferred providers. For a listing of severe mental illnesses, including serious emotional disturbances of a child, and other benefit details, please refer to the Evidence of Coverage or plan contract.
- 8 **Optional inpatient substance abuse treatment benefits are available. If your employer purchased these benefits, a description of the benefit is attached hereto as "Additional Substance Abuse Treatment Benefits."**
- 9 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 Preferred Provider copayment.
- 10 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.
- 11 All outpatient non-severe mental health, outpatient substance abuse, acupuncture and chiropractic visits accrue to the calendar-year visit maximum regardless of whether the plan deductible has been met.
- Plan designs may be modified to ensure compliance with state and federal requirements