West Valley Mission Community College
Custom Access+ HMO Zero Admit

Benefit Summary (For groups of 101 and above)
(Uniform Health Plan Benefits and Coverage Matrix)

Blue Shield of California

Effective: July 1, 2017

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

Calendar Year Medical Deductible	None
Calendar Year Out-of-Pocket Maximum	$1,000 per individual / $2,000 per family
Lifetime Benefit Maximum	None

Covered Services	**Member Copayment**
OUTPATIENT PROFESSIONAL SERVICES	
Professional (Physician) Benefits	
Physician and specialist office visits (note: 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
Teladoc consultation	$5 per consultation
Outpatient diagnostic x-ray, imaging, pathology, laboratory and other testing services	No Charge
Radiological and nuclear imaging (CT scans, MRIs, MRAs, PET scans and cardiac diagnostic procedures utilizing nuclear medicine)	No Charge
Allergy Testing and Treatment Benefits	
Allergy testing, treatment and serum injections	$5 per visit
Access+ *Specialist*^{SM} Benefits [1]	
Office visit, examination or other consultation (self-referred office visits and consultations only)	$30 per visit
Preventive Health Benefits	
Preventive health services (as required by applicable Federal and California law)	No Charge
OUTPATIENT FACILITY SERVICES	
Outpatient surgery performed at a free-standing ambulatory surgery center	No Charge
Outpatient surgery performed in a hospital or a hospital affiliated ambulatory surgery center	No Charge
Outpatient services for treatment of illness or injury and necessary supplies (except as described under "Rehabilitation Benefits" and "Speech Therapy Benefits")	No Charge
Outpatient diagnostic x-ray, imaging, pathology, laboratory and other testing services	No Charge
Radiological and nuclear imaging (CT scans, MRIs, MRAs, PET scans and cardiac diagnostic procedures utilizing nuclear medicine)	No Charge
HOSPITALIZATION SERVICES	
Hospital Benefits (Facility Services)	
Inpatient physician services	No Charge
Inpatient non-emergency facility services (semi-private room and board, and medically necessary services and supplies, including subacute care)	No Charge
Inpatient Skilled Nursing Benefits [2, 3] (combined maximum of up to 100 days per benefit period; prior authorization is required; semi-private accommodations)	
Free-standing skilled nursing facility	No Charge
Skilled nursing unit of a hospital	No Charge
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)	$25 per visit
Emergency room physician services	No Charge
AMBULANCE SERVICES	
Emergency or authorized transport (ground or air)	No Charge
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 Member Services number on your identification card.	

PROSTHETICS/ORTHOTICS	
Prosthetic equipment and devices (separate office visit copayment may apply)	No Charge
Orthotic equipment and devices (separate office visit copayment may apply)	No Charge
DURABLE MEDICAL EQUIPMENT	
Breast pump	No Charge
Other durable medical equipment (member share is based on allowed charges)	20%
MENTAL HEALTH AND SUBSTANCE USE DISORDER SERVICES [4, 5]	
Inpatient hospital services	No Charge
Residential care	No Charge
Inpatient physician services	No Charge
Routine outpatient mental health and substance use disorder services (includes professional/physician visits)	$5 per visit
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 programs, psychological testing and transcranial magnetic stimulation)	No Charge
HOME HEALTH SERVICES	
Home health care agency services [2] Coverage limited to 100 visits per member per calendar year.	$5 per visit
Home infusion/home injectable therapy and infusion nursing visits provided by a home infusion agency	No Charge
HOSPICE PROGRAM BENEFITS	
Routine home care	No Charge
Inpatient respite care	No Charge
24-hour continuous home care	No Charge
Short-term inpatient care for pain and symptom management	No Charge
PREGNANCY AND MATERNITY CARE BENEFITS	
Prenatal and postnatal physician office visits (may be billed as part of global maternity fee including hospital inpatient delivery services)	No Charge
Abortion services (an additional facility copayment may apply when services are rendered in a hospital or outpatient surgery center)	No Charge
FAMILY PLANNING AND INFERTILITY BENEFITS	
Counseling, consulting, and education (Includes insertion of IUD, as well as injectable and implantable contraceptives for women)	No Charge
Infertility services (member cost share is based upon allowed charges) (diagnosis and treatment of cause of infertility. Excludes in vitro fertilization, injectables for infertility, artificial insemination and GIFT)	50%
Tubal ligation	No Charge
Vasectomy (an additional facility copayment may apply when services are rendered in a hospital or outpatient surgery center)	$75 per surgery
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
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
DIABETES CARE BENEFITS	
Devices, equipment, and non-testing supplies (member share is based upon allowed charges; for testing supplies see Outpatient Prescription Drug Benefits)	20%
Diabetes self-management training	$5 per visit
URGENT CARE BENEFITS	
Urgent care services outside your personal physician service area within California	$5 per visit
Urgent care services outside of California (BlueCard® Program)	$5 per visit

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 To use this option, members must select a personal physician who is affiliated with a medical group or IPA that is an Access+ provider group, which offers the Access+ Specialist feature. Members should then select a specialist within that medical group or IPA.

2 For Plans with a facility deductible amount, services with a day or visit limit accrue to the calendar year day or visit limit maximum regardless of whether the plan deductible has been met.

3 Inpatient skilled nursing services are limited to 100 preauthorized days during a benefit period except when received through a hospice program provided by a participating hospice agency. This 100 preauthorized day maximum on inpatient skilled nursing services is a combined maximum between skilled nursing services provided in a hospital unit and skilled nursing services provided in a skilled nursing facility (SNF).

4 Mental health and substance use disorder services are accessed through Blue Shield's Mental Health Service Administrator (MHSA) - using MHSA participating providers.

5 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.

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

Blue Shield of California Life & Health Insurance Company
Vision Plan

Custom Eye Exam Only

Exam copayment $5

West Valley Mission Community College Custom Benefit Summary
HMO Plan
Effective July 1, 2017

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Using your vision plan

With this vision plan, you have access to an extensive network of vision providers in California and nationwide[1]. Many of the providers are conveniently located in optical centers at retail stores[2] such as LensCrafters, Sears, Target Optical, Wal-Mart, and Costco (membership required). When you use a network provider for your eye exam, there's no additional charge.

Covered services	Coverage when provided by network providers (after applicable copayment)	Maximum payment when provided by non-network provider
Comprehensive Examination - every 12 months		
Ophthalmologic	100%	up to a maximum of $60
Optometric	100%	up to a maximum of $50

Accessing your vision benefits is easy, just follow these steps:

1. Prior to receiving a service, review your benefit information for coverage details outlined in the chart above.
2. Call and make an appointment with a network provider.

Or:

If you use a non-network provider, you're required to pay the provider's bill at the time of service. You can get your reimbursement by obtaining a claim form from your employer or by logging on to **blueshieldca.com.** Select *Members,* then *Forms* and then select the *Vision Benefit Claim Form (C-4669-61)* link. Complete and submit the claim form with the itemized receipt and a copy of your prescription to:

Blue Shield of California Life & Health Insurance Company
P.O. Box 25208
Santa Ana, CA 92799-5208

You will be reimbursed for your expenses up to the maximum payment allowed (see table above). Note that when your dependents submit a claim form for reimbursement, payment will be made to you. Be sure to use your Blue Shield member identification number when filling out the form.

Your vision coverage is underwritten by Blue Shield of California Life & Health Insurance Company (Blue Shield Life) and administered by a contracted vision plan administrator.

Find a network provider nearest you by going to the *Find a Provider* section on **blueshieldca.com,** or calling Member Services at **(877) 601-9083.** You'll find a complete listing of ophthalmologists, optometrists, and opticians.

1 Nationwide vision providers are available by arrangement through a contracted vision plan administrator.

2 Availability of retail store locations varies by state. Refer to blueshieldcavision.com for out-of-state retail locations.

West Valley Mission Community College Custom HMO Plan

Outpatient Prescription Drug Coverage
(For groups of 101 and above)

Blue Shield of California

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.

Highlight: $0 Calendar Year Pharmacy Deductible
$6 Tier 1 / $6 Tier 2 - Retail Pharmacy
$6 Tier 1 / $6 Tier 2 - Mail Service

Covered Services	Member Copayment
DEDUCTIBLES (Prescription drug coverage benefits are not subject to the medical plan deductible.)	
Calendar Year Pharmacy Deductible	None
PRESCRIPTION DRUG COVERAGE[1,2,4,5]	**Participating Pharmacy**
Retail Prescriptions (up to a 30-day supply)	
• Contraceptive drugs and devices[3]	$0 per prescription
• Tier 1 drugs	$6 per prescription
• Tier 2 drugs	$6 per prescription
• Tier 3 drugs	Not Covered[4]
• Tier 4 drugs (excluding Specialty drugs)	$30 per prescription
Mail Service Prescriptions (up to a 90-day supply)	
• Contraceptive drugs and devices[3]	$0 per prescription
• Tier 1 drugs	$6 per prescription
• Tier 2 drugs	$6 per prescription
• Tier 3 drugs	Not Covered[4]
• Tier 4 drugs (excluding Specialty drugs)	$30 per prescription
Specialty Pharmacies (up to a 30-day supply)[6]	
• Tier 4 - Specialty drugs[7]	$30 per prescription

1 Amounts paid through copayments and any applicable pharmacy 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 pharmacy 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 brand contraceptives may need prior authorization to be covered without a copayment.

4 Select and all Tier 3 drugs require prior authorization by Blue Shield for medical necessity, or when effective, lower cost alternatives are available. If prior authorization is approved for a Tier 3 drug, then the Tier 2 copay will apply.

5 If the member requests a brand drug and a generic drug equivalent is available, the member is responsible for paying the Tier 1 drug copayment plus the difference in cost to Blue Shield between the brand drug and its generic drug equivalent.

6 Network Specialty Pharmacies dispense Specialty drugs which require coordination of care, close monitoring, or extensive patient training that generally cannot be met by a retail pharmacy. Network Specialty Pharmacies also dispense Specialty drugs requiring special handling or manufacturing processes, 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.

A16148-d (01/17) DC030201