West Valley Mission Community College
Custom PPO 250 100/80

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

	Participating Providers [1]	**Non-Participating Providers [2]**
Calendar Year Medical Deductible (all providers combined)	$250 per individual / $750 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)	$250 per individual / $750 per family	$1,250 per individual / $3,750 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)	20%
Teladoc consultation	$5 per consultation	Not Covered
Outpatient diagnostic x-ray, imaging, pathology, laboratory and other testing services	No Charge (not subject to the calendar year medical deductible)	20%
Radiological and nuclear imaging (CT scans, MRIs, MRAs, PET scans and cardiac diagnostic procedures utilizing nuclear medicine)	No Charge	20%
Allergy Testing and Treatment Benefits		
Allergy testing, treatment and serum injections (separate office visit copayment may apply)	$10 per visit	20%
Preventive Health Benefits [3]		
Preventive health services (as required by applicable Federal and California law)	No Charge (not subject to the calendar year medical deductible)	20%
OUTPATIENT FACILITY SERVICES		
Outpatient surgery performed at a free-standing ambulatory surgery center	No Charge	20% up to $350 per day [4]
Outpatient surgery performed in a hospital or a hospital affiliated ambulatory surgery center	No Charge	20% up to $350 per day [4]
Outpatient services for treatment of illness or injury and necessary supplies (except as described under "Rehabilitation Benefits" and "Speech Therapy Benefits")	No Charge	20% up to $350 per day [4]
Outpatient diagnostic x-ray, imaging, pathology, laboratory and other testing services	No Charge (not subject to the calendar year medical deductible)	20% up to $350 per day [4]
Radiological and nuclear imaging (CT scans, MRIs, MRAs, PET scans and cardiac diagnostic procedures utilizing nuclear medicine)	No Charge	20% up to $350 per day [4]
Bariatric surgery [5] (prior authorization is required; medically necessary surgery for weight loss, for morbid obesity only)	No Charge	20% up to $350 per day [4]
HOSPITALIZATION SERVICES		
Hospital Benefits (Facility Services)		
Inpatient physician services	No Charge	20%
Inpatient non-emergency facility services (semi-private room and board, and medically necessary services and supplies, including subacute care)	$150 per admission	20% up to $600 per day [6]
Bariatric surgery [5] (prior authorization is required; medically necessary surgery for weight loss is for morbid obesity only)	$150 per admission	20% up to $600 per day [6]

Inpatient Skilled Nursing Benefits [7] **Coverage limited to 100 days per member per benefit period combined with hospital/free-standing skilled nursing facility.**		
Free-standing skilled nursing facility	No Charge	No Charge [8]
Skilled nursing unit of a hospital	$150 per admission	20% up to $600 per day [6]
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)	$50 per visit (not subject to the calendar year medical deductible)	$50 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)	$150 per admission	$150 per admission
Emergency room physician services	No Charge	No Charge
AMBULANCE SERVICES		
Emergency or authorized transport (ground or air)	No Charge	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 Customer Service number on your identification card.		
PROSTHETICS/ORTHOTICS		
Prosthetic equipment and devices (separate office visit copayment may apply)	No Charge	20%
Orthotic equipment and devices (separate office visit copayment may apply)	No Charge	20%
DURABLE MEDICAL EQUIPMENT		
Breast pump	No Charge (not subject to the calendar year medical deductible)	Not Covered
Other durable medical equipment	No Charge	20%
MENTAL HEALTH AND SUBSTANCE USE DISORDER SERVICES [9, 10]	**MHSA Participating Providers** [1]	**MHSA Non-Participating Providers** [2]
Inpatient hospital services	$150 per admission	20% up to $600 per day [6]
Residential care	$150 per admission	20% up to $600 per day [6]
Inpatient physician services	No Charge	20%
Routine outpatient mental health and substance use disorder services (includes professional/physician visits)	$10 per visit (not subject to the calendar year medical deductible)	20%
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	20%
HOME HEALTH SERVICES	**Participating Providers** [1]	**Non-Participating Providers** [2]
Home health care agency services [7] Coverage limited to 100 visits per member per calendar year.	No Charge	Not Covered [11]
Home infusion/home injectable therapy and infusion nursing visits provided by a home infusion agency	No Charge	Not Covered [11]
HOSPICE PROGRAM BENEFITS		
Routine home care	No Charge (not subject to the calendar year medical deductible)	Not Covered [11]
Inpatient respite care	No Charge (not subject to the calendar year medical deductible)	Not Covered [11]
24-hour continuous home care	No Charge (not subject to the calendar year medical deductible)	Not Covered [11]
Short-term inpatient care for pain and symptom management	No Charge (not subject to the calendar year medical deductible)	Not Covered [11]
CHIROPRACTIC BENEFITS [7]		
Chiropractic spinal manipulation	No Charge	20%
ACUPUNCTURE BENEFITS [7]		
Acupuncture services	No Charge	20%
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)	$10 per visit	20%
SPEECH THERAPY BENEFITS		
Office location (an additional facility copayment may apply when services are rendered in a hospital or skilled nursing facility)	$10 per visit	20%
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)	$10 per visit	20%
Abortion services (an additional facility copayment may apply when services are rendered in a hospital or outpatient surgery center)	No Charge	20%

FAMILY PLANNING BENEFITS		
Counseling, consulting, and education (includes insertion of IUD, as well as injectable and implantable contraceptives for women)	No Charge (not subject to the calendar year medical deductible)	20%
Tubal ligation	No Charge (not subject to the calendar year medical deductible)	20%
Vasectomy (an additional facility copayment may apply when services are rendered in a hospital or outpatient surgery center)	No Charge	20%
DIABETES CARE BENEFITS		
Devices, equipment, and non-testing supplies (for testing supplies see Outpatient Prescription Drug Benefits)	No Charge	20%
Diabetes self-management training	No Charge (not subject to the calendar year medical deductible)	20%
CARE OUTSIDE OF CALIFORNIA		
Benefits provided through the BlueCard® Program are paid at the participating level. Member's cost share will be either a copayment or coinsurance based on the lower of billed charges or the negotiated allowable amount for participating providers as agreed upon with the local Blue's Plan.		
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. After the calendar year medical deductible is met, the member is responsible for copayments/coinsurance for covered services from participating providers. Participating providers agree to accept Blue Shield's allowable amount plus any applicable member copayment or coinsurance 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 deductible or out-of-pocket maximum.

3 Preventive Health Services, including an annual preventive care or well-baby care office visit, are not subject to the calendar year medical deductible. Other covered non-preventive services received during, or in connection with, the preventive care or well-baby care office visit are subject to the calendar year medical deductible and applicable member copayment/coinsurance.

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 20% of this $350 per day, and all charges in excess of $350 per day. Amounts that exceed the benefit maximums do not count toward the calendar year out-of-pocket maximum and continue to be the member's financial responsibility after the calendar year maximums are reached.

5 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.

6 The maximum allowed charges for non-emergency hospital services received from a non-participating hospital is $600 per day. Members are responsible for 20% of this $600 per day, and all charges in excess of $600 per day. Amounts that exceed the benefit maximum do not count toward the calendar year out-of-pocket maximum and continue to be the member's responsibility after the calendar year maximums are reached.

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 calendar year medical deductible has been met.

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

9 Mental health and substance use disorder services are accessed through Blue Shield's Mental Health Service Administrator (MHSA) - using MHSA participating and MHSA non-participating providers. Only mental health and substance use disorder services rendered by MHSA participating providers are administered by the MHSA. Mental health and substance use disorder services rendered by non-MHSA 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 Services from non-participating providers for home health care and hospice 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.

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

A17266 (1/17) 19999 DC032017

Blue Shield of California Life & Health Insurance Company
Vision Plan

Custom Eye Exam Only

Exam copayment $10

West Valley Mission Community College Custom Benefit Summary
PPO Group 975723
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.