

Glendale Unified School District Custom PPO 350 90/70

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

Blue Shield of California

Effective: October 1, 2017 through September 30, 2018

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
Plan Year Medical Deductible (all providers combined)	\$350 per individual / \$700 per family	
Plan Year Out-of-Pocket Maximum (includes the Plan Year medical deductible. Copayments or coinsurance for covered services from participating providers accrue to both the participating and non-participating provider Plan Year out-of-pocket maximum amount)	\$1,500 per individual / \$3,000 per family	\$4,500 per individual / \$9,000 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%	30%
Teladoc consultation	\$5 per consultation (not subject to the Plan Year medical deductible)	Not Covered
Outpatient diagnostic x-ray, imaging, pathology, laboratory and other testing services	10%	30%
Radiological and nuclear imaging (CT scans, MRIs, MRAs, PET scans and cardiac diagnostic procedures utilizing nuclear medicine)	10%	30%
Allergy Testing and Treatment Benefits		
Allergy testing, treatment and serum injections (separate office visit copayment may apply)	10%	30%
Preventive Health Benefits ⁴		
Preventive health services (as required by applicable Federal and California law)	No Charge (not subject to the Plan Year medical deductible)	30%
OUTPATIENT FACILITY SERVICES		
Outpatient surgery performed at a free-standing ambulatory surgery center	10%	30%
Outpatient surgery performed in a hospital or a hospital affiliated ambulatory surgery center	10%	30%
Outpatient services for treatment of illness or injury and necessary supplies (except as described under "Rehabilitation Benefits" and "Speech Therapy Benefits")	10%	30%
Outpatient diagnostic x-ray, imaging, pathology, laboratory and other testing services	10%	30%
Radiological and nuclear imaging (CT scans, MRIs, MRAs, PET scans and cardiac diagnostic procedures utilizing nuclear medicine)	10%	30%
Bariatric surgery ³ (prior authorization is required; medically necessary surgery for weight loss, for morbid obesity only)	10%	30%
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%
Bariatric surgery ³ (prior authorization is required; medically necessary surgery for weight loss is for morbid obesity only)	10%	30%
Inpatient Skilled Nursing Benefits ⁶		
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% ⁵
Skilled nursing unit of a hospital	10%	30%

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 + 10% (not subject to the Plan Year medical deductible)	\$100 per visit + 10% (not subject to the Plan 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	Administered by Medimpact 1-844-863-0356	
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 Plan Year medical deductible)	Not Covered
Other durable medical equipment	10%	30%
MENTAL HEALTH AND SUBSTANCE USE DISORDER SERVICES ^{7, 8}		
	MHSA Participating Providers ¹	MHSA Non-Participating Providers ²
Inpatient hospital services	10%	30%
Residential care	10%	30%
Inpatient physician services	10%	30%
Routine outpatient mental health and substance use disorder services (includes professional/physician visits)	10%	30%
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)	10%	30%
HOME HEALTH SERVICES		
	Participating Providers ¹	Non-Participating Providers ²
Home health care agency services ⁵ Coverage limited to 100 visits per member per Plan Year.	10%	Not Covered ⁹
Home infusion/home injectable therapy and infusion nursing visits provided by a home infusion agency	10%	Not Covered ⁹
HOSPICE PROGRAM BENEFITS		
Routine home care	No Charge (not subject to the Plan Year medical deductible)	Not Covered ⁹
Inpatient respite care	No Charge (not subject to the Plan Year medical deductible)	Not Covered ⁹
24-hour continuous home care	10%	Not Covered ⁹
Short-term inpatient care for pain and symptom management	10%	Not Covered ⁹
CHIROPRACTIC BENEFITS ⁵		
Chiropractic spinal manipulation Coverage limited to 20 visits per Plan Year.	10%	30%
ACUPUNCTURE BENEFITS ⁵		
Acupuncture services Coverage limited to 20 visits per Plan Year.	\$25 per visit (not subject to the Plan Year medical deductible)	\$25 per visit (not subject to the Plan Year medical deductible)
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%	30%
SPEECH THERAPY BENEFITS		
Office location (an additional facility copayment may apply when services are rendered in a hospital or skilled nursing facility)	10%	30%
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%	30%
Abortion services (an additional facility copayment may apply when services are rendered in a hospital or outpatient surgery center)	10%	30%
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 Plan Year medical deductible)	30%
Contraceptive drugs and devices	No Charge ¹⁰ (not subject to the Plan Year medical deductible)	Not Covered
Tubal ligation	No Charge (not subject to the Plan Year medical deductible)	30%
Vasectomy (an additional facility copayment may apply when services are rendered in a hospital or outpatient surgery center)	10%	30%

DIABETES CARE BENEFITS

Devices, equipment, and non-testing supplies (for testing supplies see Outpatient Prescription Drug Benefits)	10%	30%
Diabetes self-management training	10%	30%

HEARING AID BENEFITS

Hearing aid and ancillary equipment	10%	10%
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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 Plan 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 Plan Year deductible or out-of-pocket maximum.
- 3 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.
- 4 Preventive Health Services, including an annual preventive care or well-baby care office visit, are not subject to the Plan 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 Plan Year medical deductible and applicable member copayment/coinsurance.
- 5 For plans with a Plan Year medical deductible amount, services with a day or visit limit accrue to the Plan Year day or visit limit maximum regardless of whether the plan Plan Year medical deductible has been met.
- 6 Services may require prior authorization. When services are prior authorized, members pay the participating provider amount.
- 7 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.
- 8 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.
- 9 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.
10. Coverage for contraceptive drugs and devices may be provided under your employer's separate prescription drug plan. To obtain contraceptive drugs and devices through the Blue Shield medical Plan, you must first pay all charges for the prescription and submit a completed Subscriber's Statement of Claim Form for reimbursement at 100%.

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

A17266 (1/17) 19592 DC020217; 041217; MS071017

Notice of the Availability of Language Assistance Services

Blue Shield of California

IMPORTANT: Can you read this letter? If not, we can have somebody help you read it. You may also be able to get this letter written in your language. For help at no cost, please call right away at the Member/Customer Service telephone number on the back of your Blue Shield ID card, or (866) 346-7198.

IMPORTANTE: ¿Puede leer esta carta? Si no, podemos hacer que alguien le ayude a leerla. También puede recibir esta carta en su idioma. Para ayuda sin cargo, por favor llame inmediatamente al teléfono de Servicios al miembro/cliente que se encuentra al reverso de su tarjeta de identificación de Blue Shield o al (866) 346-7198. (Spanish)

重要通知: 您能讀懂這封信嗎? 如果不能, 我們可以請人幫您閱讀。這封信也可以用您所講的語言書寫。如需免費幫助, 請立即撥打登列在您的 Blue Shield ID 卡背面上的會員/客戶服務部的電話, 或者撥打電話 (866) 346-7198。(Chinese)

QUAN TRỌNG: Quý vị có thể đọc lá thư này không? Nếu không, chúng tôi có thể nhờ người giúp quý vị đọc thư. Quý vị cũng có thể nhận lá thư này được viết bằng ngôn ngữ của quý vị. Để được hỗ trợ miễn phí, vui lòng gọi ngay đến Ban Dịch vụ Hội viên/Khách hàng theo số ở mặt sau thẻ ID Blue Shield của quý vị hoặc theo số (866) 346-7198. (Vietnamese)

MAHALAGA: Nababasa mo ba ang sulat na ito? Kung hindi, maari kaming kumuha ng isang tao upang matulungan ka upang mabasa ito. Maari ka ring makakuha ng sulat na ito na nakasulat sa iyong wika. Para sa libreng tulong, mangyaring tumawag kaagad sa numerong telepono ng Miyembro/Customer Service sa likod ng iyong Blue Shield ID kard, o (866) 346-7198. (Tagalog)

Baa' ákohwiindzindooígí: Díí naaltsoosish yíiniłta'go bíniñhah? Doo bíniñhahgóó éí, naaltsoos nich'í' yíidóółtahígíí ta' niheé hóló. Díí naaltsoos áldó' t'áá Diné k'ehjí ádooníł nínízingo bíghah. Doo bąąh ílinígó shíká' adoowoł nínízingó nihich'í' béésh bee hodílnih dóó námbóo éí díí Blue Shield bee néího'dílninígí bine'déé' bikáá' éí doodagó éí (866) 346-7198 jí' hodílnih. (Navajo)

중요: 이 서신을 읽을 수 있으세요? 읽으실 수 경우, 도움을 드릴 수 있는 사람이 있습니다. 또한 다른 언어로 작성된 이 서신을 받으실 수도 있습니다. 무료로 도움을 받으시려면 Blue Shield ID 카드 뒷면의 회원/고객 서비스 전화번호 또는 (866) 346-7198로 지금 전환하세요. (Korean)

ԿԱՐԵՎՈՐ Է: Կարողանո՞ւմ ե՞ք կարդալ այս նամակը: Եթե ոչ, ապա մենք կօգնենք ձեզ: Դուք պետք է նաև կարողանաք ստանալ այս նամակը ձեր լեզվով: Օտարալեզուներին անվճար է: Խնդրում ենք անմիջապես զանգահարել Հաճախորդների սպասարկման բաժնի հեռախոսահամարով, որը նշված է ձեր Blue Shield ID քարտի ետևի մասում, կամ (866) 346-7198 համարով: (Armenian)

ВАЖНО: Не можете прочесть данное письмо? Мы поможем вам, если необходимо. Вы также можете получить это письмо написанное на вашем родном языке. Позвоните в Службу клиентской/членской поддержки прямо сейчас по телефону, указанному сзади идентификационной карты Blue Shield, или по телефону (866) 346-7198, и вам помогут совершенно бесплатно. (Russian)

重要: お客様は、この手紙を読むことができますか? もし読むことができない場合、弊社が、お客様をサポートする人物を手配いたします。また、お客様の母国語で書かれた手紙をお送りすることも可能です。無料のサポートを希望される場合は、Blue Shield IDカードの裏面に記載されている会員/お客様サービスの電話番号、または、(866)346-7198 にお電話をおかけください。(Japanese)

مهم: آیا می‌توانید این نامه را بخوانید؟ اگر پاسختان منفی است، می‌توانیم کسی را برای کمک به شما در اختیارتان قرار دهیم. حتی می‌توانید نسخه مکتوب این نامه را به زبان خودتان دریافت کنید. برای دریافت کمک رایگان، لطفاً بدون فوت وقت از طریق شماره تلفنی که در پشت کارت شناسی Blue Shield تان درج شده است و یا از طریق شماره تلفن (866) 346-7198 با خدمات اعضا/مشتری تماس بگیرید. (Persian)

ਮਹੱਤਵਪੂਰਨ: ਕੀ ਤੁਸੀਂ ਇਸ ਪੱਤਰ ਨੂੰ ਪੜ੍ਹ ਸਕਦੇ ਹੋ? ਜੇ ਨਹੀਂ ਤਾਂ ਇਸ ਨੂੰ ਪੜ੍ਹਨ ਵਿਚ ਮਦਦ ਲਈ ਅਸੀਂ ਕਿਸੇ ਵਿਅਕਤੀ ਦਾ ਪ੍ਰਬੰਧ ਕਰ ਸਕਦੇ ਹਾਂ। ਤੁਸੀਂ ਇਹ ਪੱਤਰ ਆਪਣੀ ਭਾਸ਼ਾ ਵਿਚ ਲਿਖਿਆ ਹੋਇਆ ਵੀ ਪ੍ਰਾਪਤ ਕਰ ਸਕਦੇ ਹੋ। ਮੁਫਤ ਵਿਚ ਮਦਦ ਪ੍ਰਾਪਤ ਕਰਨ ਲਈ ਤੁਹਾਡੇ Blue Shield ID ਕਾਰਡ ਦੇ ਪਿੱਛੇ ਦਿੱਤੇ ਮੈਂਬਰ/ਕਸਟਮਰ ਸਰਵਿਸ ਟੈਲੀਫੋਨ ਨੰਬਰ ਤੇ, ਜਾਂ (866) 346-7198 ਤੇ ਕਾਲ ਕਰੋ। (Punjabi)

ប្រការសំខាន់៖ តើអ្នកអាចលិខិតនេះបានដែរឬទេ? បើមិនអាចទេ យើងអាចឲ្យកេរដ្ឋអ្នកក្នុងការអានលិខិតនេះ។ អ្នកក៏អាចទទួលបានលិខិតនេះជាភាសារបស់អ្នកផងដែរ។ សម្រាប់ជំនួយដោយឥតគិតថ្លៃ សូមហៅទូរស័ព្ទក្លាយទៅកាន់លេខទូរស័ព្ទសេវាសមាជិក/អតិថិជនដែលមាននៅលើខ្នងប័ណ្ណសម្គាល់ Blue Shield របស់អ្នក ឬក៏អាសយ:លេខ (866) 346-7198។ (Khmer)

المهم: هل تستطيع قراءة هذا الخطاب؟ أن لم تستطع قراءته، يمكننا إحضار شخص ما ليساعدك في قراءته. قد تحتاج أيضاً إلى الحصول على هذا الخطاب مكتوباً بلغتك. للحصول على المساعدة بدون تكلفة، يرجى الاتصال الآن على رقم هاتف خدمة العملاء/أحد الأعضاء المدون على الجانب الخلفي من بطاقة الهوية Blue Shield أو على الرقم (866) 346-7198. (Arabic)

TSEEM CEEB: Koj pos tuaj yeem nyeem tau tsab ntawv no? Yog hais tias nyeem tsis tau, peb tuaj yeem nrhiav ib tug neeg los pab nyeem nws rau koj. Tej zaum koj kuj yuav tau txais muab tsab ntawv no sau ua koj hom lus. Rau kev pab txhais dawb, thov hu kias rau tus xov tooj Kev Pab Cuam Tub Koom Xeeb/Tub Lag Luam uas nyob rau sab nraum nrob qaum ntawm koj daim npav Blue Shield ID, los yog hu rau tus xov tooj (866) 346-7198. (Hmong)

สำคัญ: คุณอ่านจดหมายฉบับนี้ได้หรือไม่ หากไม่ได้ โปรดขอความช่วยเหลือจากผู้อ่านได้ คุณอาจได้รับจดหมายฉบับนี้เป็นภาษาของคุณ หากต้องการความช่วยเหลือโดยไม่มีค่าใช้จ่าย โปรดติดต่อฝ่ายบริการลูกค้า/สมาชิกทางเบอร์โทรศัพท์ในบัตรประจำตัว Blue Shield ของคุณ หรือโทร (866) 346-7198 (Thai)

महत्वपूर्ण: क्या आप इस पत्र को पढ़ सकते हैं? यदि नहीं, तो हम इसे पढ़ने में आपकी मदद के लिए किसी व्यक्ति का प्रबंध कर सकते हैं। आप इस पत्र को अपनी भाषा में भी प्राप्त कर सकते हैं। निःशुल्क मदद प्राप्त करने के लिए अपने Blue Shield ID कार्ड के पीछे दिए गये मंबर/कस्टमर सर्विस टेलीफोन नंबर, या (866) 346-7198 पर कॉल करें। (Hindi)

Blue Shield of California is an independent member of the Blue Shield Association A49726-LANG (1/17)

Notice Informing Individuals about Nondiscrimination and Accessibility Requirements

Discrimination is against the law

Blue Shield of California complies with applicable federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability or sex. Blue Shield of California does not exclude people or treat them differently because of race, color, national origin, age, disability or sex.

Blue Shield of California:

- Provides aids and services at no cost to people with disabilities to communicate effectively with us such as:
 - Qualified sign language interpreters
 - Written information in other formats (including large print, audio, accessible electronic formats and other formats)
- Provides language services at no cost to people whose primary language is not English such as:
 - Qualified interpreters
 - Information written in other languages

If you need these services, contact the Blue Shield of California Civil Rights Coordinator.

If you believe that Blue Shield of California has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability or sex, you can file a grievance with:

Blue Shield of California Civil Rights
Coordinator
P.O. Box 629007
El Dorado Hills, CA 95762-9007

Phone: (844) 831-4133 (TTY: 711)

Fax: (916) 350-7405

Email: BlueShieldCivilRightsCoordinator@blueshieldca.com

You can file a grievance in person or by mail, fax or email. If you need help filing a grievance, our Civil Rights Coordinator is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue SW.
Room 509F, HHH Building Washington,
DC 20201
(800) 368-1019; TTY: (800) 537-7697

Complaint forms are available at www.hhs.gov/ocr/office/file/index.html.

