

# JACL Health Benefits Trust Custom PPO – 2500 80/50

Group # 0P1912 and 0P1913 Ages 65+  
Benefit Summary

(Uniform Health Plan Benefits and Coverage Matrix)

**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.**

## Blue Shield of California

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

Effective January 1, 2009

DEDUCTIBLES <sup>1</sup> (All providers combined)	Preferred Providers <sup>2</sup>	Non-Preferred Providers <sup>2</sup>
Calendar-year medical deductible	\$2,500 per individual/\$5,000 per family	
Calendar-year Copayment Maximum <sup>1</sup>	\$5,000 per individual/ \$10,000 per family	\$10,000 per individual/ \$20,000 per family
<b>LIFETIME MAXIMUM</b>	\$6,000,000	
Covered Services	Member Copayment	
PROFESSIONAL SERVICES	Preferred Providers <sup>2</sup>	Non-Preferred Providers <sup>2</sup>
<b>Physician services</b>		
• Physician and specialist office visits	20%	50%
• Laboratory and X-rays	20%	50%
• Allergy testing or treatment	20%	50%
• Diagnostic testing	20%	50%
<b>Preventive care</b>		
• Annual routine physical exam, eye/ear screenings and immunizations	20%	50%
• Laboratory, including mammogram and Pap test screening or other FDA-approved cervical cancer screening tests (One per calendar year)	20%	50%
<b>Well-baby care</b>		
• Office visits and consultations Includes: eye/ear screenings, immunizations, vaccinations	20%	50%
• Laboratory	20%	50%
<b>OUTPATIENT SERVICES</b>		
• Outpatient surgery performed in a Participating Ambulatory Surgery Center <sup>3</sup> (ASC)	\$25/surgery + 20%	\$25/surgery + 50%
• Outpatient surgery in hospital/facility	\$25/surgery + 20%	\$25/surgery + 50%
• Outpatient treatment and necessary supplies	20%	50%
• Bariatric surgery <sup>4</sup> (pre-authorization required; medically necessary surgery for weight loss, only for morbid obesity) <sup>5</sup>	\$25/surgery + 20%	\$25/surgery + 50%
<b>HOSPITALIZATION SERVICES</b>		
<b>Inpatient services – non-emergency</b>		
• Inpatient physician services (Including pregnancy and maternity care)	20%	50%
• Semi-private room and board, medically necessary services and supplies	\$100/day (up to \$1,250 maximum) + 20%	\$100/day (up to \$1,250 maximum) + 50%
• Bariatric surgery <sup>4</sup> (pre-authorization required; medically necessary surgery for weight loss, only for morbid obesity)	\$100/day (up to \$1,250 maximum) + 20%	\$100/day (up to \$1,250 maximum) + 50%
<b>Skilled nursing facility (SNF) services<sup>5</sup></b> (Combined maximum of up to 100 preauthorized days per calendar year; semi-private accommodations)		
• Freestanding SNF	20%	20% with prior authorization <sup>5</sup>
• Hospital SNF unit	20%	50%

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<b>EMERGENCY HEALTH COVERAGE</b>		
• ER facility services (Deductible waived on services not resulting in a direct admission)	20%	20%
• Inpatient facility services (when the member is admitted directly from the ER)	\$100/day (up to \$1,250 maximum) + 20%	\$100/day (up to \$1,250 maximum) + 50%
• Emergency room physician visits	20%	20%
<b>AMBULANCE SERVICES</b>	20%	20%
<b>PRESCRIPTION DRUG COVERAGE</b>	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 Service.	
<b>PROSTHETICS/ORTHOTICS</b> (Equipment and devices only)	20%	50%
<b>DURABLE MEDICAL EQUIPMENT</b>	20%	50%
(Plan payment up to \$2000 maximum per calendar year.)		
<b>MENTAL HEALTH SERVICES (PSYCHIATRIC)<sup>7</sup></b>	<b>MHSA Participating Providers<sup>2</sup></b>	<b>MHSA Non-Participating Providers<sup>2</sup></b>
• Inpatient hospital facility services	\$100/day (up to \$1,250 maximum) + 20%	\$100/day (up to \$1,250 maximum) + 50%
• Outpatient visits for severe mental health conditions	20%	50%
• Outpatient visits for non-severe mental health conditions (Up to 20 visits per calendar year combined with outpatient chemical dependency visits) <sup>7</sup>	50%	50%
<b>CHEMICAL DEPENDENCY SERVICES (SUBSTANCE ABUSE)<sup>7</sup></b>		
<b>Please see footnote 8</b>		
• Inpatient services for medical acute detoxification	See "Hospitalization Services"	See "Hospitalization Services"
• Inpatient services (other than acute detox) limited to 30 days per calendar year	20%	50%
• Outpatient visits (Up to 20 visits per calendar year combined with outpatient non-severe mental health visits) <sup>7</sup>	50%	50%
<b>HOME HEALTH SERVICES<sup>9</sup></b> (Combined maximum of 100 prior authorized visits per calendar year)	<b>Preferred Providers<sup>2</sup></b>	<b>Non-Preferred Providers<sup>2</sup></b>
• Home health and home infusion care (See "Prescription Drug Coverage" for home self-administered injectables.)	20%	Not covered <sup>9</sup>
<b>OTHER</b>		
<b>Hospice<sup>9</sup></b>		
• Routine home care	20%	Not covered <sup>9</sup>
• Inpatient respite care	20%	Not covered <sup>9</sup>
• 24 hour continuous home care	20%	Not covered <sup>9</sup>
• General inpatient care	20%	Not covered <sup>9</sup>
<b>Alternative care<sup>7</sup></b>		
• Chiropractic services (Up to 12 visits per calendar year)	20%	50%
• Acupuncture services (Up to 15 visits per calendar year; maximum payment of \$35 /visit)	20%	20%
<b>Rehabilitative therapy services</b>		
• Outpatient visits	20%	50%
<b>Pregnancy and maternity care</b>		
• Prenatal and postnatal professional (physician) services (For all necessary inpatient hospital services, see "Hospitalization Services.")	20%	50%
<b>Family planning</b>		
• Family planning counseling	20%	50%
• Elective abortion, tubal ligation, vasectomy <sup>10</sup>	20%	50%
<b>Diabetes care</b>		
• Equipment, devices and non-testing supplies (For testing supplies, see "Prescription Drug Coverage.")	20%	50%
• Self-management training and education (If billed by your provider, you will also be responsible for the office visit copayment)	20%	50%
<b>Covered out-of-state benefits</b> Benefits provided through BlueCard <sup>®</sup> 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.	See Applicable Benefit	See Applicable Benefit

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**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.

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- 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 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.
- 5 Services may require prior authorization by Blue Shield. When these services are prior authorized, members pay the preferred or participating provider amount.
- 6 Mental health and chemical dependency services, other than medical acute detoxification, are accessed through Blue Shield's Mental Health Services Administrator (MHSA) - using Blue Shield MHSA participating and non-participating providers. Only Blue Shield MHSA contracted providers are administered by the Blue Shield MHSA. Behavioral health services rendered by non participating providers are administered by Blue Shield. 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.
- 7 All outpatient non-severe mental health, outpatient substance abuse and chiropractic visits accrue to the calendar-year visit maximum regardless of whether the plan deductible has been met.
- 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.

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