

JACL Health Benefits Trust
 Custom HMO
 Benefit Summary

(Uniform Health Plan Benefits and Coverage Matrix)

Blue Shield of California

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

Effective January 1, 2009

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.

DEDUCTIBLES	
Calendar-year medical deductible	None
Calendar-year copayment maximum¹ (For many covered services)	\$2,500 per individual/ \$5,000 per family
LIFETIME MAXIMUM	
	None
Covered Services	Member Copayment
PROFESSIONAL SERVICES	
Physician services – outpatient	
<ul style="list-style-type: none"> Physician and authorized specialist office visits <small>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.</small> 	\$15/visit
<ul style="list-style-type: none"> Allergy testing or treatment 	\$15/visit
Access+ SpecialistSM (Self-referred office visits and consultations only) ^{1, 2}	\$30/visit
Laboratory, X-ray and diagnostic tests	No charge
Preventive care	
<ul style="list-style-type: none"> Routine physical exam, eye/ear screenings and immunizations according to age schedule <small>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.</small> 	\$5/visit
OUTPATIENT SERVICES	
Non-emergency	
<ul style="list-style-type: none"> Outpatient surgery performed in a Participating Ambulatory Surgery Center³(ASC) 	\$100/surgery
<ul style="list-style-type: none"> Outpatient surgery in hospital/facility 	\$100/surgery
<ul style="list-style-type: none"> Outpatient treatment (Except as described under "Rehabilitative therapy services"), and necessary supplies 	No charge
HOSPITALIZATION SERVICES	
<ul style="list-style-type: none"> Inpatient physician services, including pregnancy and maternity care 	No charge
<ul style="list-style-type: none"> Semi-private room and board, medically necessary services and supplies 	\$250/day (\$1,250 maximum)
<ul style="list-style-type: none"> Skilled nursing facility (SNF) services⁴ 	\$25/day
EMERGENCY HEALTH COVERAGE	
<ul style="list-style-type: none"> Emergency room facility services (Waived if the member is directly admitted to the hospital for inpatient services) 	\$50/visit
<ul style="list-style-type: none"> Emergency room physician visits 	No charge
AMBULANCE SERVICES	
	\$50
PRESCRIPTION DRUG COVERAGE¹	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 Member Services..
PROSTHETICS/ORTHOTICS (Equipment and devices only)	
	No charge
DURABLE MEDICAL EQUIPMENT¹	
	50% of allowed charges (Plan payment up to \$2000 maximum per calendar year)
MENTAL HEALTH SERVICES (PSYCHIATRIC)⁵	
<ul style="list-style-type: none"> Inpatient hospital facility services 	\$250/day (\$1,250 maximum)
<ul style="list-style-type: none"> Outpatient visits for severe mental health conditions 	\$15/visit
<ul style="list-style-type: none"> Outpatient visits for non-severe mental health conditions¹ <small>(Up to 20 visits per calendar year combined with outpatient chemical dependency visits)</small> 	\$25/visit

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CHEMICAL DEPENDENCY SERVICES (SUBSTANCE ABUSE)⁵**Please see footnote 6**

- Inpatient services for medical acute detoxification See "Hospitalization Services"
 - Outpatient visits¹ \$25/visit
(Up to 20 visits per calendar year combined with outpatient non-severe mental health visits)
-

HOME HEALTH SERVICES

- Agency visits (Up to 100 visits per calendar year) \$15/visit
 - Medical supplies/IV solutions No charge
(For home self-administered injectable medications, see "Prescription Drug Coverage.")
-

OTHER**Hospice**

- Routine home care No charge
 - Inpatient respite care No charge
 - 24 hour continuous home care \$25/day
 - General inpatient care \$25/day
-

Pregnancy and maternity care

- Prenatal and postnatal professional (physician) services No charge
(For all necessary inpatient hospital services, see "Hospitalization Services.")
-

Family planning and infertility services

- Family planning counseling \$15/visit
 - Diagnosis and treatment of causes of infertility 50% of allowed charges
(Excludes in vitro fertilization, injectables for infertility, artificial insemination and GIFT)
 - Tubal ligation^{7, 8} and elective abortion⁸ \$100
 - Vasectomy⁸ \$75
-

Rehabilitative therapy services

- Outpatient visits \$15/visit
(Copayment applies to all place of services, including professional and facility settings)
-

Diabetes care

- Equipment, devices and non-testing supplies 50% of allowed charges
(For testing supplies, see "Prescription Drug Coverage.")
 - Self-management training and education \$15/visit
-

Urgent care outside service area (BlueCard[®] Program)

\$50/visit

Optional benefits¹ Optional dental, vision, chiropractic, chiropractic and acupuncture or infertility benefits are available. If your employer purchased any of these benefits, a description of the benefit is provided separately.

1 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. Please refer to the Evidence of Coverage, the Disclosure Form and the plan contract for exact terms and conditions of coverage.

2 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. Access+ Specialist visits for mental health or substance abuse services must be provided by a MHSA network participating provider. Access+ Specialist visits for mental health services for non-severe mental illness, or non-serious emotional disturbances of a child or substance abuse will accrue toward the 20 visit per calendar-year 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 Skilled nursing services are limited to 100 preauthorized days during a calendar-year except when received through a hospice program provided by a participating hospice agency. This 100 preauthorized day maximum on skilled nursing services is a combined maximum between SNF in a hospital unit and skilled nursing facilities.

5 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 providers. Services for medical acute detoxification are accessed through Blue Shield using Blue Shield HMO 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.

6 **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."**

7 Copayment waived when procedure is performed in conjunction with delivery or abdominal surgery.

8 Physician services copayment in the office or outpatient hospital facility only. If procedure is performed in a hospital facility setting, additional hospital services copayment may apply.

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

JACL Health Benefits Trust
 Access+ HMO®/Added Advantage POSSM Plans
 Outpatient Prescription Drug Coverage
 (For groups of 300 and above)
Blue Shield of California

THIS DRUG SUMMARY IS INTENDED TO BE USED WITH THE ACCESS+ HMO OR ADDED ADVANTAGE POS PLANS UNIFORM HEALTH PLAN BENEFITS AND COVERAGE MATRIX. THE EVIDENCE OF COVERAGE, DISCLOSURE FORM AND PLAN CONTRACT SHOULD BE CONSULTED FOR A DETAILED DESCRIPTION OF COVERAGE BENEFITS AND LIMITATIONS.

Highlight: 2-Tier/Closed Formulary
 No Calendar-Year Brand-Name Drug Deductible
 \$15 Generic/\$25 Formulary Brand-Name - Retail Pharmacy
 \$30 Generic/\$50 Formulary Brand-Name - Mail Service

Covered Services	Member Copayment	
DEDUCTIBLES (Prescription drug coverage benefits are not subject to the medical plan deductible.)	None	
Calendar-year brand-name drug deductible		
PRESCRIPTION DRUG COVERAGE^{1,2} (Includes oral contraceptives, diaphragms, and covered diabetic drugs and testing supplies)	Participating Pharmacy	Mail Service Prescriptions
	(For up to a 30-day supply)	(For up to a 90-day supply)
	\$15/prescription	\$30/prescription
	\$25/prescription	\$50/prescription
	20%	Not covered
	(Up to \$100 copayment maximum per prescription) ²	

1 Copayments and charges for these covered services are not included in the calculation of the member's medical calendar-year copayment maximum and continue to be the member's responsibility after the calendar-year copayment maximum is reached. Please refer to the Evidence of Coverage and the Plan Contract for exact terms and conditions of coverage.

2 Only drugs on the Blue Shield Drug Formulary are covered unless prior authorized by Blue Shield Pharmacy Services. If the member requests a brand-name drug and a generic drug equivalent is available, the member is responsible for paying the difference between the cost to Blue Shield of California of the brand-name drug and its generic drug equivalent, as well as the applicable generic drug copayment. Home self-administered injectable drugs are covered only when dispensed by select participating pharmacies in the Specialty Pharmacy Network. Drugs obtained at a Non-Participating Pharmacy are not covered, unless Medically Necessary for a covered emergency.

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). Since this plan's prescription drug coverage is creditable, you do not have to enroll in Medicare Part D 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 before enrolling in Medicare Part D you could be subject to payment of higher Part D premiums.

Important Prescription Drug Information

You can find details about your drug coverage three ways:

1. Check your *Evidence of Coverage*.
2. Go to **blueshieldca.com** 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 **blueshieldca.com** 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 generic equivalents;
- Look up drugs that require 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.

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Blue Shield Dental PPO Plan



Blue Shield of California's Dental PPO plan allows you to select any licensed dentist in California. When you use a Participating Dentist in Blue Shield's dental network, you are responsible only for paying applicable deductibles and copayments. Participating Dentists accept Blue Shield's Allowable Amount as full payment for covered services, and you do not have to file claims forms.

If you choose a Non-Participating Dentist, you are responsible for paying the dentist for the entire cost of your care, then filing a claim form with Blue Shield for reimbursement. Non-Participating Dentists can charge more than Blue Shield's Allowable Amount. So if you use Non-Participating Dentists, you must pay the applicable deductibles and copayments plus any amount that exceeds Blue Shield's Allowable Amount. It will be your responsibility to pay any difference between the amount Blue Shield allows and the amount billed.

What the Plan Covers

- **\$50 Deductible (\$100 Family)** – does not apply to Diagnostic and Preventive Services by Participating Dentists. Applies to all other combined services of Participating and Non-Participating Dentists.
- **\$1,500 Annual Maximum**

Plan Highlights

- Participating Dentists accept payment in full for specified diagnostic and preventive services
- Statewide network of over 8,850 Participating Dentists
- You may use any licensed dentist in California
- Dental PPO Dental Center Directory is available on-line at www.mylifepath.com
- Toll-free customer service number

DENTAL PPO PLAN	% MAX. ALLOWABLE CHARGE	
	Participating Dentist	Non-Participating Dentist
Diagnostic & Preventive Care (not subject to plan deductibles with Participating Dentists; includes routine oral exams & x-rays, cleanings)	100%	100%
Basic Services (includes anesthesia, crowns, inlays, onlays, emergency treatment to relieve pain, oral surgery, restorative dentistry, sealants, space maintainers)	80%	80%
Endodontics & Peridontics	80%	80%
Major Services (includes prosthetics ¹)	50%	50%
Orthodontics	Not Covered	Not Covered

¹ Covered after 12 continuous months of coverage under this plan.

How the Plans Work

Your Plan covers your dental care when you select any licensed dentist in California. When you choose a Participating Dentist, you'll know that the dentist has met Blue Shield's credentialing standards and you'll have the lowest out-of-pocket costs. You won't have to bother with claim forms; you'll be responsible only for paying applicable deductibles and copayments. All participating providers agree to accept the Blue Shield allowable amount as payment in full.

When you choose a Non-Participating Dentist, you'll pay the dentist for the entire cost of your care, then file a claim form with Blue Shield. You will be responsible for paying applicable deductibles and copayments plus the difference between the amount Blue Shield allows and the amount billed.

Exclusions and Limitations

Benefits are not provided for:

- Crowns, inlays or onlays, laminate veneers, or other cast or laboratory prepared restorations if the tooth can be restored with a filling material (e.g., amalgam, composite resin or silicate cement).
- Implants (artificial materials, including synthetic bone grafting materials which are implanted into, onto or under bone or soft tissue) or the removal of implants (surgically or otherwise).
- General anesthesia except as administered by a licensed dentist in connection with a covered oral surgical procedure. (Intravenous sedation is not general anesthesia and is not covered).
- Charges for services in connection with any treatment to the gums for tumors, cysts and neoplasms.
- Services or supplies provided in connection with a congenital anomaly or development malformation.
- Charges for vestibuloplasty and for any procedure, services or supply including office visits, examination and diagnosis provided directly or indirectly to treat a muscular, neural or skeletal disorder, dysfunction or disease of the temporomandibular joint and its associated structures including but not limited to myofascial pain dysfunction syndrome.
- Charges for services performed by a close relative or by a person who ordinarily resides in the Subscriber's or Dependent's home.
- Prescribed drugs, premedication, analgesia, local anesthetics, sedatives or intravenous sedation.
- Services, procedures or supplies which are not reasonably necessary for the care of the person's dental condition according to broadly accepted standards of professional care or which are investigative in nature or which do not have uniform professional endorsement.
- Appliances, restorations or services, including but not limited to equilibration, required solely to change, maintain or restore vertical dimension or occlusion or solely for the purpose of splinting.
- Services, procedures or supplies that are purely cosmetic in nature.
- The replacement of an appliance that has been either lost or stolen.
- Myofunctional therapy; biofeedback procedures; athletic mouthguards; precision or semi-precision attachments; denture duplication; oral hygiene instruction; treatment of jaw fractures; sealants; charges for acidetching.
- Orthognathic surgery; including but not limited to osteotomy; ostectomy and other services or supplies to augment or reduce the upper or lower jaw.
- Charges for services in connection with orthodontia.
- Temporary dental services.
- Extra-oral grafts.
- Hospital costs and any additional fees charged by the dentist for hospital treatment.
- Any service, procedure or supply for which the prognosis for long-term success is not reasonably favorable as determined by Blue Shield and its dental consultants.
- Any service, procedure or supply that is received or started prior to the patient's effective date of coverage.

For the purpose of this limitation, the date on which a procedure shall be considered to have started is defined as follows:

- For full dentures or partial dentures: on the date the final impression is taken.
- For fixed bridges, crowns, inlays, onlays: on the date the teeth are first prepared.
- For root canal therapy: on the later date the pulp chamber opened or the date canals are explored to the apex.
- For all periodontal surgery: on the date the surgery is actually performed.
- **For all other services: on the date the service is performed.**

This is only a summary of the Blue Shield Dental PPO Plan. Please refer to the plan contract and evidence of coverage for a detailed description of covered benefits and limitations.

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Blue Shield Vision Plan



The Blue Shield of California Vision Plan is administered by Medical Eye Services (MES), using The Eye Care Network contracted providers (Participating Ophthalmologists, Optometrists and Opticians).

What the Vision Plan Covers

Service & Eyewear	Coverage when provided by Participating Providers	Maximum payment when provided by Non-Participating Providers
Annual Examination (one per 12 consecutive months)		
Ophthalmologic Exam	100%	\$60
Optometric Exam	100%	\$50
Follow-up Exam	100%	\$30
Standard Lenses¹ (one pair per 24 consecutive months OR one pair per 12-month period if required by prescription change ²)		
Single Vision	100%	\$43
Bifocal	100%	\$60
Trifocal	100%	\$75
Aphakic Monofocal	100%	\$120
Aphakic Multifocal	100%	\$200
Standard Frame ³ (per 24 consecutive months)	Up to \$75	\$40
Contact Lenses⁴ (one pair per 24 consecutive months OR one pair per 12-month period if required by prescription change)		
Medically Necessary ⁵		
Hard	100%	\$200
Soft	100%	\$250
Cosmetic or Convenience ⁶	Up to \$100	\$100

- Largest statewide network of over 5,200 ophthalmologists, optometrists and opticians
- No charge for specified preventive services and eyewear from Participating Providers
- Coverage available for family members
- The *Eye Care Network Directory of Participating Providers* available online at www.mesvision.com

¹ Fit any frame with an eye size less than 61 mm.

² A change in prescription of 0.50 diopter or more in one or both eyes; a shift in axis of astigmatism of 15 degrees; or a difference in vertical prism greater than 1 prism diopter.

³ Any frame with a maximum retail cost of \$75.

⁴ In lieu of lenses and frame.

⁵ Following cataract surgery; when visual acuity cannot be corrected to 20/70 in the better eye except through the use of contacts; when necessitated by anisometropia or certain conditions of keratoconus. Prior authorization from MES is required.

⁶ Any cost over \$100 is your responsibility.

How the Plan Works

Your Vision Plan covers your vision care when you select any licensed ophthalmologist, optometrist or optician. When you choose an Eye Care Network Participating Provider, you'll have the lowest out-of-pocket costs. Just complete Part 1 of your claim form before presenting it to your provider at the time of your visit. Participating Providers will submit the claim form to, and be paid directly by, MES. Be sure to bring your claim form (available from JACL Health Benefits Administrators) to avoid being responsible for the costs associated with the visit.

When you choose a Non-Participating Provider, you'll pay the entire cost of your care, then file a claim form along with an itemized bill and a copy of your prescription to MES. You will be reimbursed according to the Schedule of Allowances in the chart on the front. You will be responsible for the difference between the amount Blue Shield allows and the amount billed by a Non-Participating Provider.

Exclusions

(Contract and Evidence of Coverage exclusions also apply.)

Benefits are not provided for:

- Any covered services provided by another vision plan;
- Covered services for which the Vision Plan member is not legally obligated to pay;
- Covered services performed by a close relative or by an individual who ordinarily resides in the Vision Plan member's home;
- Medical or surgical treatments of the eyes;
- Non-prescription (plano) eyewear;
- Orthoptics, subnormal vision aids or vision training;

Limitations

All benefits are subject to the following limitations:

- Contact lenses and contact lens fitting, except as specifically provided;
- Eyewear for which there is no prescription change, unless benefits are otherwise available;
- Replacement of lenses or frames which are lost, stolen or broken, unless benefits are otherwise available;
- Lenses such as no-line (blended type), coated or oversize exceeding the allowance for covered lenses.

If you have any questions about the Vision Plan, please contact:

JACL Health Benefits Administrators
220 Sansome Street, Suite 1360
San Francisco, CA 94104
(800) 400-6633

This is only a summary of the Vision Plan. Please see the Evidence of Coverage Booklet for exact terms and conditions of coverage.