

# JACL Health Benefits Trust

## Custom PPO 100 – 80/50

### Ages 30 and under

Group # 0P1900-0100, 0P1900-169, 0P1900-170, 0P1901-0100

Benefit Summary (For groups of 300 and above)

(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

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	\$100 per individual/\$200 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 (pre-authorization required; medically necessary surgery for weight loss, only for morbid obesity) <sup>4</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	\$250/day (up to \$1,250 maximum) + 20%	\$250/day (up to \$1,250 maximum) + 50%
• Bariatric surgery (pre-authorization required; medically necessary surgery for weight loss, only for morbid obesity) <sup>4</sup>	\$250/day (up to \$1,250 maximum) + 20%	\$250/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%
<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)	\$250/day (up to \$1,250 maximum) + 20%	\$250/day (up to \$1,250 maximum) + 20%

An Independent Member of the Blue Shield Association

A18125 RDB(1/09)101408

# JACL Health Benefits Trust

Custom PPO 200 – 80/50

Ages 30 - 39

Group # 0P1900-0200, 0P1901-0200, 0P1905-0175

Benefit Summary (For groups of 300 and above)

(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

Effective January 1, 2009

DEDUCTIBLES <sup>1</sup> (All providers combined)	Preferred Providers <sup>2</sup>	Non-Preferred Providers <sup>2</sup>
<b>Calendar-year medical deductible</b>	\$200 per individual / \$400 per family	
<b>Calendar-year Copayment Maximum<sup>1</sup></b>	\$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%
OUTPATIENT SERVICES		
• 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 (pre-authorization required; medically necessary surgery for weight loss, only for morbid obesity) <sup>4</sup>	\$25/surgery + 20%	\$25/surgery + 50%
HOSPITALIZATION SERVICES		
<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	\$250/day (up to \$1,250 maximum) + 20%	\$250/day (up to \$1,250 maximum) + 50%
• Bariatric surgery (pre-authorization required; medically necessary surgery for weight loss, only for morbid obesity) <sup>4</sup>	\$250/day (up to \$1,250 maximum) + 20%	\$250/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%
EMERGENCY HEALTH COVERAGE		
• 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)	\$250/day (up to \$1,250 maximum) + 20%	\$250/day (up to \$1,250 maximum) + 20%

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A18125 RDB(1/09)101408

JACL Health Benefits Trust  
 Custom PPO 400 – 80/50  
 Ages 40 - 49 Group # 0P1900-0400, 0P1901-0400  
 Benefit Summary (For groups of 300 and above)  
 (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

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	\$400 per individual / \$800 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	
<b>Covered Services</b>	<b>Member Copayment</b>	
<b>PROFESSIONAL SERVICES</b>	<b>Preferred Providers<sup>2</sup></b>	<b>Non-Preferred Providers<sup>2</sup></b>
<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 (pre-authorization required; medically necessary surgery for weight loss, only for morbid obesity) <sup>4</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	\$250/day (up to \$1,250 maximum) + 20%	\$250/day (up to \$1,250 maximum) + 50%
• Bariatric surgery (pre-authorization required; medically necessary surgery for weight loss, only for morbid obesity) <sup>4</sup>	\$250/day (up to \$1,250 maximum) + 20%	\$250/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%
<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)	\$250/day (up to \$1,250 maximum) + 20%	\$250/day (up to \$1,250 maximum) + 20%
• Emergency room physician visits	20%	20%

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A18125 ME(1/09)

JACL Health Benefits Trust  
 Custom PPO 500 – 80/50  
 Ages 50 - 54 Group # 0P1900-0500, 0P1901-0500  
 Benefit Summary (For groups of 300 and above)  
 (Uniform Health Plan Benefits and Coverage Matrix)

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**Blue Shield of California**

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	\$500 per individual / \$1,000 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%
OUTPATIENT SERVICES		
• 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 (pre-authorization required; medically necessary surgery for weight loss, only for morbid obesity) <sup>4</sup>	\$25/surgery + 20%	\$25/surgery + 50%
HOSPITALIZATION SERVICES		
<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	\$250/day (up to \$1,250 maximum) + 20%	\$250/day (up to \$1,250 maximum) + 50%
• Bariatric surgery (pre-authorization required; medically necessary surgery for weight loss, only for morbid obesity) <sup>4</sup>	\$250/day (up to \$1,250 maximum) + 20%	\$250/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%
EMERGENCY HEALTH COVERAGE		
• 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)	\$250/day (up to \$1,250 maximum) + 20%	\$250/day (up to \$1,250 maximum) + 20%
• Emergency room physician visits	20%	20%

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A18125 RDB(1/09) 101408

JACL Health Benefits Trust  
 Custom PPO 500 – 80/50  
 Ages 55 - 64 Group # 0P1900-0600, 0P1901-0600  
 Benefit Summary (For groups of 300 and above)  
 (Uniform Health Plan Benefits and Coverage Matrix)

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## Blue Shield of California

Effective January 1, 2009

DEDUCTIBLES <sup>1</sup> (All providers combined)	Preferred Providers <sup>2</sup>	Non-Preferred Providers <sup>2</sup>
<b>Calendar-year medical deductible</b>	\$500 per individual / \$1,000 per family	
<b>Calendar-year Copayment Maximum<sup>1</sup></b>	\$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%
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• 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%
OUTPATIENT SERVICES		
• 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 (pre-authorization required; medically necessary surgery for weight loss, only for morbid obesity) <sup>4</sup>	\$25/surgery + 20%	\$25/surgery + 50%
HOSPITALIZATION SERVICES		
<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	\$250/day (up to \$1,250 maximum) + 20%	\$250/day (up to \$1,250 maximum) + 50%
• Bariatric surgery (pre-authorization required; medically necessary surgery for weight loss, only for morbid obesity) <sup>4</sup>	\$250/day (up to \$1,250 maximum) + 20%	\$250/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%
EMERGENCY HEALTH COVERAGE		
• 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)	\$250/day (up to \$1,250 maximum) + 20%	\$250/day (up to \$1,250 maximum) + 20%
• Emergency room physician visits	20%	20%

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A18125 ME(1/09)

<b>AMBULANCE SERVICES</b>	20%	20%
<b>PRESCRIPTION DRUG COVERAGE</b> (\$250 calendar year deductible applies)	20%	20%
<b>PROSTHETICS/ORTHOTICS</b> (Equipment and devices only)	20%	50%
<b>DURABLE MEDICAL EQUIPMENT</b>	20%	50%
<b>(Plan payment up to \$2000 maximum per calendar year)</b>		
<b>MENTAL HEALTH SERVICES (PSYCHIATRIC)<sup>6</sup></b>	<b>MHSA Participating Providers<sup>2</sup></b>	<b>MHSA Non-Participating Providers<sup>2</sup></b>
• Inpatient hospital facility services	\$250/day (up to \$1,250 maximum) + 20%	\$250/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>6</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	20%	20% with prior authorization <sup>9</sup>
<b>OTHER</b>		
<b>Hospice<sup>9</sup></b>		
• Routine home care	20%	20% with prior authorization <sup>9</sup>
• Inpatient respite care	20%	20% with prior authorization <sup>9</sup>
• 24 hour continuous home care	20%	20% with prior authorization <sup>9</sup>
• General inpatient care	20%	20% with prior authorization <sup>9</sup>
<b>Alternative care<sup>7</sup></b>		
• Chiropractic services (Up to 20 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	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.	20%	50%
<b>Optional Benefits</b>	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.	

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.

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- 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 the mental health services administrator (MHSA) - U.S. Behavioral Health Plan, California (USBHPC) - using MHSA participating and non-participating providers. MHSA non-participating providers are not administered by USBHPC. 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

# JACL Health Benefits Administrators

## 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](http://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 <sup>1</sup> )	50%	50%
Orthodontics	Not Covered	Not Covered

<sup>1</sup> 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.*

# JACL Health Benefits Administrators

## 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
<b>Annual Examination</b> (one per 12 consecutive months)		
Ophthalmologic Exam	100%	\$60
Optometric Exam	100%	\$50
Follow-up Exam	100%	\$30
<b>Standard Lenses<sup>1</sup></b> (one pair per 24 consecutive months OR one pair per 12-month period if required by prescription change <sup>2</sup> )		
Single Vision	100%	\$43
Bifocal	100%	\$60
Trifocal	100%	\$75
Aphakic Monofocal	100%	\$120
Aphakic Multifocal	100%	\$200
Standard Frame <sup>3</sup> (per 24 consecutive months)	Up to \$75	\$40
<b>Contact Lenses<sup>4</sup></b> (one pair per 24 consecutive months OR one pair per 12-month period if required by prescription change)		
Medically Necessary <sup>5</sup>		
Hard	100%	\$200
Soft	100%	\$250
Cosmetic or Convenience <sup>6</sup>	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](http://www.mesvision.com)

<sup>1</sup> Fit any frame with an eye size less than 61 mm.

<sup>2</sup> 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.

<sup>3</sup> Any frame with a maximum retail cost of \$75.

<sup>4</sup> In lieu of lenses and frame.

<sup>5</sup> 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.

<sup>6</sup> 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.