

Choose Blue Shield

Value, quality, access – all from a name you can trust

City of San Jose's 2009 Enrollment Guide:

- Access+ HMO plan
- Shield Spectrum PPO plan
- Added Advantage POS plan

Hello, City of San Jose employees and retirees!

Blue Shield is proud to offer you our Access+ HMO, Shield Spectrum PPO, and Added Advantage POS plans.

There's more to Blue Shield health plans than comprehensive healthcare benefits. Blue Shield brings the City of San Jose one of the largest statewide networks of doctors, specialists, and hospitals, as well as a wide variety of health tools and resources to help make it easier to manage your family's benefits and health.

Competitive rates and comprehensive benefits

Compare for yourself and discover the value Blue Shield offers City employees. With Access+ HMO,[®] eligible employees will have no annual deductibles or claim forms, with affordable copayments each time you see a physician. Our Shield Spectrum PPOSM offers eligible employees comprehensive benefits and one of the largest networks of providers in California. The Added Advantage POSSM plan offers you the best of both worlds – you decide whether to visit your HMO Personal Physician or a PPO physician or a non-network physician each time you access care.

Large provider networks

Blue Shield networks are among the largest in California with more than 31,000 physicians and 280 hospitals in our HMO network, and 63,000 physicians and 351 hospitals in our PPO network.

NurseHelp 24/7SM

Talk to a registered nurse, day or night, for information and support on issues affecting your health. Or chat online with a registered nurse anytime through the *Health & Wellness* section of **blueshieldca.com**. It's completely confidential, and comes at no additional cost when you enroll with Blue Shield.

Dedicated Member Services team

We're here to help. City of San Jose members can now access their dedicated team of Member Services representatives from 7 a.m. to 7 p.m., Monday through Friday, at **(800) 642-6155**.

Discounts on chiropractic, acupuncture, and massage therapy

We offer you access to alternative health and wellness services at a generous reduction in cost – at least 25% off published fees for chiropractic, acupuncture, and massage therapy from participating practitioners.*

Blueshieldca.com

Our award-winning Web site provides round-the-clock tools, resources, and wellness information at your fingertips. Look up your plan benefits, learn about copayments, find a provider, check claims, download forms, and more.



what's new
for 2009

Be healthy and save

Your wellness is important to us. To make it easier for you to take better care of yourself, we offer a wide range of member discounts on popular programs¹ that can help you save money and get healthier:

24 Hour Fitness

Waived/discounted fees make it easier to get in shape and stay fit:

- Waived enrollment and processing fees
- Discounted initiation fees and monthly dues – as low as \$29.99 a month

Drugstore.com

Pay less when you shop for health and wellness products at Drugstore.com:

- 5% off non-prescription drugs
- 15% off herbal vitamins and natural supplements
- 15% off contact lenses for first-time customers: 5% off subsequent orders
- 5% back on eligible purchases with Drugstore.com dollars

Alternative care

Relax and save on alternative healthcare services from participating practitioners:

- Acupuncture services – 25% or more off usual and customary fees
- Chiropractic services – 25% or more off usual and customary fees
- Massage therapy – 25% or more off usual and customary fees
- Health and wellness products – Discounts on vitamins, herbal supplements, fitness equipment, and more; free shipping on most items

Vision services

See better and spend less:

Vision care – Get 20% off the published retail prices when you use a participating California provider in the Discount Vision Program network for:

- Routine eye exams
- Frames and lenses (including photochromic)
- Tints and coatings
- Extra pair of glasses
- Non-prescription sunglasses

LASIK – Get a 15% discount on LASIK laser vision correction surgery through the TLCVision provider network.²

Learn more

For details, go to [blueshieldca.com/wellnessdiscounts](https://www.blueshieldca.com/wellnessdiscounts).

New benefits for 2009!

Lower copayments for asthma and diabetes drugs

As an added benefit for City of San Jose members, certain drugs for the treatment of asthma and diabetes will be covered at a lower copayment. Copayments for these formulary drugs will be \$5 for brand-name drugs and \$0 for generic drugs. For additional details, please refer to the printed formulary, Summary of Benefits, and EOC. You can also call Customer Service at the number on your Blue Shield of California ID card for additional information. This benefit does not apply to those Medicare members enrolled in the Part D drug plan.

New and improved Wellness programs

Incentive program for maternity through Health Advocate

In our goal to assist expectant mothers in obtaining prenatal care early on in their pregnancy, Blue Shield provides educational information specific to the member's trimester and any identified risks.

Earn a \$50 gift certificate to Babies-R-Us while you are in your first trimester by participating in your Health Advocate program. Complete a specialized assessment and create an education action plan for a healthy pregnancy by calling your Health Advocate at **(866) 596-7557** or e-mail healthadvocate@blueshieldca.com.

New and improved Wellness programs

Healthy Lifestyle Rewards

**You and your dependents can each receive \$175!
Log in for the \$175, log out feeling great.**

We're making it easier for you and your dependents to adopt a healthier lifestyle in 2009. Healthy Lifestyle Rewards is an online, interactive, and completely confidential program available to all Blue Shield members ages 18 and older. Healthy Lifestyle Rewards provides valuable tools to help you get in shape, eat right, reduce stress, or quit smoking. Go to blueshieldca.com/hlr and register. Complete the Wellness Assessment to help guide your wellness activities and goals. Dependents must be over the age of 18 to be eligible for rewards.



Weight Watchers

Starting January 1, 2009! To show our commitment to helping you achieve your weight-loss goals and improve your overall health, Blue Shield of California is offering City of San Jose members a \$50 reimbursement for either Weight Watchers local meetings, at-home kits, or online subscriptions.

Additional program benefits include:

- Meeting vouchers – Discounts on local meetings (prices depend on the location; at participating locations only)
- Premium extras – Complimentary walking kits and exercise DVDs
- Earn rewards with Healthy Lifestyle Rewards – Members are eligible for discounts and reimbursement

Log on to blueshieldca.com/hlr and start to work toward a healthier you!

Save while you lose those extra pounds and keep them off:

	With special price, you pay	Potential reward	If you meet the reward criteria, your final cost is
13-week local meeting vouchers ³	\$119.86	\$50.00	\$69.86
18-week local meeting vouchers ⁴	\$165.96	\$50.00	\$115.96
At-home kit ⁵	\$179.00	\$50.00	\$129.00
3-month online subscription ⁶	\$55.00	\$50.00	\$5.00
12-month online subscription ⁶	\$166.70	\$50.00	\$116.70

Wellness tools and resources

As a Blue Shield member, you'll receive access to health and wellness resources, and extra services and support that help make it easier to manage your family's health.

Health management programs

We've designed a suite of health management programs to help members get practical resources and support at no additional charge. Participation does not affect coverage in any way, and all information is kept confidential. Our health management services include:

- Diabetes Management Program
- Heart Monitoring Program
- Asthma Self-Management Program
- Coronary Artery Disease Program
- Chronic Obstructive Pulmonary Disease (COPD) Self-Management Program
- Prenatal Education Program
- Depression Management Program

Health advocate program

Support for your overall health and well-being. This comprehensive, quality health plan is just the start of what you can expect from Blue Shield of California. Health advocates are registered nurses who provide sound clinical advice and support to help you get the most out of your health-care experience.

Dedicated Health Advocates. Our dedicated team of Health Advocates is available to provide support with:

- Questions about treatment options, hospitalization, or dealing with a chronic illness diagnosis
- Identification of potential healthcare needs, such as education on Blue Shield's health and wellness programs

As a coordinated, comprehensive healthcare plan provider, Blue Shield integrates all wellness programs with the services your Health Advocate provides. All information given through your calls to our NurseHelp 24/7SM will be confidentially transitioned to your Health Advocate, helping ensure that the care you need is seamlessly coordinated your Blue Shield health plan. Contact healthadvocate@blueshieldca.com for more information, or call directly at (866) 596-7557.

Online tools and features to help with care decisions

We make it easier to manage your health online with blueshieldca.com. Our Web site gives you easy access to resources that can help improve and better manage your health.

- **Ask the Pharmacist** allows you to submit a question to a pharmacist and receive a personal, confidential response.
- **Nurse Chat** offers confidential online chats with a registered nurse, any time, day or night.
- **Drug Formulary** is a comprehensive list of drugs that are medically appropriate and cost-effective.
- **Drug Interaction Checker** provides information on interactions among prescription drugs, over-the-counter medications, dietary supplements, and herbal products.
- **Hospital Comparison Tool** rates selected hospitals on procedure volume, complication and mortality rates, length of stay, and relative cost.
- **Treatment Options Tool** searches a database of information on treatment options along with issues that you may want to discuss with your physician.

Your health plan options

Your Blue Shield health plan options for 2009 include the Access+ HMO, Shield Spectrum PPO, and the Added Advantage POS plan.

Access+ HMO

With Access+ HMO, you'll have no annual deductibles or claim forms, with only affordable copayments each time you see a physician. You'll need to select your Personal Physician, who is responsible for the overall coordination of your care. As an Access+ HMO member, you also have the option to visit a specialist within your Personal Physician's medical group or IPA without a referral for a higher copayment.**

Plan features

- No deductibles for services
- Self-referral to specialists, using the Access+ *Specialist* referral feature**
- Get generic prescription drugs for a \$5 copayment, formulary brand-name drugs for a \$10 copayment, and non-formulary brand-name drugs for a \$15 copayment
- No copayment for inpatient hospitalization
- \$5 copayment for physician office visits

Shield Spectrum PPO

Your Blue Shield PPO plan lets you choose, each time you need care, between network providers who offer their services at negotiated rates and non-network providers who are not in Blue Shield's network. You pay less when you see a network provider. You are responsible for paying a certain amount of covered expenses (deductible) before the plan pays most benefits, and you also can seek services from a specialist without a referral.

Plan features

- Choice of providers every time you seek covered services with lower out-of-pocket costs when you choose from preferred providers
- \$10 copayments for preferred physician office visits and preventive care (deductible does not apply)
- Get generic prescription drugs for a \$5 copayment, formulary brand-name drugs for a \$10 copayment, and non-formulary brand-name drugs for a \$25 copayment
- Access to a mail-service pharmacy benefit

Added Advantage POS plan

With Blue Shield's Added Advantage POS plan, you have the choice of seeing any doctor you like. You choose whether to visit your HMO Personal Physician for the most savings, a PPO provider, or a non-network provider at a greater out-of-pocket cost.

The cost advantages of using your HMO option

When you use your HMO option, you maximize your POS plan benefits because you're covered for more services, and your out-of-pocket payments are predictable and set at the lowest amounts.

Plan features

- There are no copayments for covered preventive care services and a \$5 copayment for routine immunizations, vision, and hearing screenings
- Other non-emergency physician visits are available for a fixed copayment
- Your calendar-year copayment maximum is set at its lowest level
- You'll never need to deal with claim forms
- You won't need to satisfy a deductible

The flexibility of using your PPO option

With your Added Advantage plan, you can use your PPO option anytime. You can go to one of Blue Shield's preferred providers or hospitals – more than 63,000 doctors and 350 hospitals ready to serve you. Or you can see a non-preferred (non-network)

provider. The benefit coverage you receive and the amount you pay is outlined in the benefit grids (on the following page).

Plan features

- Choice of providers every time you seek covered services, with lower out-of-pocket costs when you choose from preferred providers
- \$10 copayments for physician office visits with preferred providers
- Access to a mail-service pharmacy benefit

Choose your doctor

You can select your physician at blueshieldca.com. For help selecting one or to get a printed directory of network providers, contact Member Services. It's always best to phone the physician's office and ask about becoming a new patient.

For Access+ HMO and Added Advantage POS plans, you'll need to choose a Personal Physician and let us know which doctor you've selected. You can do this by calling Member Services at **(800) 642-6155**.

We're here to help

If you have any questions, visit blueshieldca.com or call your dedicated Member Services team at **(800) 642-6155** from 7 a.m. to 7 p.m., Monday through Friday.

* The Alternative Care Discount Program is an exclusive offer to Blue Shield members, made available through an arrangement with American Specialty Health Networks of California Inc. (ASH Networks), and is not a covered service of any Blue Shield health plan. ASH Networks credentials and manages the program's practitioners. None of the terms and conditions of Blue Shield health plans apply. Blue Shield of California and ASH Networks do not review the program's practitioner services and products for medical necessity or efficacy, and make no representations, claims, or guarantees regarding their services or products. Members who use the discount program are responsible for the payment of services provided by participating network practitioners, including payment for cancelled or missed appointments. Members who are not satisfied with services received from the program's practitioners may use the Blue Shield grievance process. Blue Shield reserves the right to terminate this program without notice.

** If you are an Access+ HMO member and your Personal Physician participates in our Access+ *Specialist* feature, you may go directly to a specialist in your Personal Physician's medical group or IPA without a referral for a slightly higher copayment. Medical groups and IPAs that participate in the Access+ *Specialist* program are designated with an A+ in our online and printed directories, and on your Blue Shield member ID card.

1 These discount program services are not a covered benefit of Blue Shield health plans, and none of the terms or conditions of Blue Shield health plans apply.

The network of practitioners and facilities in the discount programs are managed by the external program administrators identified below, including any screening and credentialing of providers. Blue Shield does not review the services provided by discount program providers for medical necessity or efficacy, nor does Blue Shield make any recommendations representations, claims, or guarantees regarding the practitioners, their availability, fees, services, or products.

Some services offered through the discount program may already be included as part of the Blue Shield health plan covered benefits. Members should access those covered services prior to using the discount program.

Members who are not satisfied with products or services received from the discount program may use Blue Shield's grievance process described in the Grievance Process section of the *Evidence of Coverage* or Certificate of Insurance. Blue Shield reserves the right to terminate this program at any time without notice.

Discount programs administered by or arranged through:

- Alternative Health Services Discount Program – American Specialty Health Networks of California Inc. (ASH Networks)
- Vision program – MESVision
- Weight control – Weight Watchers North America
- Fitness facilities – 24 hour Fitness
- Health products (excluding prescription drugs) – Drugstore.com Inc.
- LASIK – Laser Eye Care of California LLC

2 Prior to January 1, 2009, this discount program is available to Blue Shield of California vision plan members only. Effective January 1, 2009, this discount program is available to all Blue Shield members. Available in California only.

3 Available only in participating areas in the United States. Total cost must be paid in advance. Missed week fees must be paid in order to keep your membership current. You will need to re-enroll after four consecutive absences. Sales tax applicable in Connecticut.

4 Available only in participating areas in the U.S. Minimum enrollment required. Total cost At Work meeting series must be paid in advance. Sales tax applicable in Connecticut.

5 Available only in participating areas in the U.S.

6 Your subscription will be automatically renewed at the end of your plan period at the standard monthly rate (currently \$16.95) unless you cancel. You can cancel your subscription on the Weight Watchers site, by e-mail, or by U.S. mail; please see www.weightwatchers.com/cancel for details. Void where prohibited. This offer cannot be transferred, combined with other current offers, or redeemed for cash.

City of San Jose Custom Access+ HMO® Plan 5 Groups H11186 and H11365

For groups of 300 or more.

Blue Shield of California

This matrix is intended to be used to help you compare coverage benefits, and is a summary only. The *Evidence of Coverage and Disclosure Form* and plan contract should be consulted for a detailed description of coverage benefits and limitations.

Effective January 1, 2009

Deductibles

Calendar-year medical deductible	None
Calendar-year copayment maximum¹ (for many covered services)	\$1,000 per individual/\$2,000 per family
Calendar-year brand-name drug deductible (Prescription drug coverage benefits are not subject to the medical plan deductible.)	None
Lifetime maximum	None

Covered services

Member copayment

Professional services		
Physician services – outpatient		
Physician and authorized specialist office visits 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.	\$5/visit	
Allergy testing or treatment	\$5/visit	
Access+ SpecialistSM (self-referred office visits and consultations only) ¹⁻²	\$30/visit	
Laboratory, X-ray, and diagnostic tests	No charge	
Preventive care		
Routine physical exam 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.	No charge	
Eye/ear screenings and immunizations according to age schedule	No charge	
Outpatient services		
Non-emergency		
Outpatient surgery performed in a participating ambulatory surgery center ³ (ASC)	No charge	
Outpatient surgery in hospital/facility	No charge	
Outpatient treatment (except as described under "Rehabilitative Therapy Services") and necessary supplies	No charge	
Hospitalization services		
Inpatient physician services (including pregnancy and maternity care)	No charge	
Semi-private room and board, medically necessary services, and supplies	No charge	
Skilled nursing facility (SNF) services ⁴	No charge	
Emergency health coverage		
Emergency room facility services (waived if the member is directly admitted to the hospital for inpatient services)	\$50/visit	
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.)	Participating pharmacy (for up to a 30-day supply)	Mail-service prescriptions (for up to a 90-day supply)
Select generics ¹⁵	\$0/prescription	\$0/prescription
Select brand-names ¹⁵	\$5/prescription	\$10/prescription
Generic drugs	\$5/prescription	\$10/prescription
Formulary brand-name drugs	\$10/prescription	\$20/prescription
Non-formulary brand-name drugs	\$15/prescription	\$30/prescription
Home self-administered injectable medications ¹³	\$30/prescription	Not covered

Covered services

Member copayment

Prosthetics and orthotics (equipment and devices only)	No charge
Durable medical equipment¹	No charge
Mental health services (psychiatric)⁵	
Inpatient hospital facility services	No charge
Outpatient visits for severe mental health conditions	\$5/visit
Outpatient visits for non-severe mental health conditions ¹ (up to 20 visits per calendar year combined with outpatient chemical dependency visits)	\$25/visit
Chemical dependency services (substance abuse)⁵	
Inpatient services for medical acute detoxification	See "Hospitalization Services"
Outpatient visits ¹ (up to 20 visits per calendar year combined with outpatient non-severe mental health visits)	\$25/visit
Health services	
Agency visits (up to 100 visits per calendar year)	\$5/visit
Medical supplies/IV solutions (for home self-administered injectable medications, see "Prescription Drug Coverage")	No charge
Other	
Hospice	
Routine home care and inpatient respite care	No charge
Inpatient respite care	No charge
24-hour continuous home care and general inpatient care	No charge
General inpatient care	No charge
Pregnancy and maternity care	
Prenatal and postnatal professional (physician) services (for all necessary inpatient hospital services, see "Hospitalization Services")	No charge
Family planning and infertility services	
Family planning counseling	No charge
Diagnosis and treatment of causes of infertility (excludes in vitro fertilization, injectables for infertility, artificial insemination, and GIFT)	50% of allowed charges
Tubal ligation ^{7,8} and elective abortion ⁸	\$100
Vasectomy ⁸	\$75
Rehabilitative therapy services	
Outpatient visits (copayment applies to all places of services, including professional and facility settings)	\$5/visit
Diabetes care	
Equipment, devices, and non-testing supplies (for testing supplies, see "Prescription Drug Coverage")	No charge
Self-management training and education	\$5/visit
Urgent care outside service area (BlueCard [®] Program)	\$50/visit
Hearing aids	
Audiological evaluations	No charge
Hearing-aid instrument and ancillary equipment (up to a maximum of \$1,000 per member every 36 months for the hearing-aid and ancillary equipment)	No charge
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.	
Chiropractic services	
Calendar-year maximum	30 combined visits
Calendar-year deductible	None
Copayment per visit	\$10
Calendar-year chiropractic appliance benefit ^{11, 12}	\$50
Out-of-network coverage	None

- 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 and 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 pre-authorized days during a calendar-year except when received through a hospice program provided by a participating hospice agency. This 100-pre-authorized-day maximum on skilled nursing services is a combined maximum between skilled nursing facilities 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.
- 9 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.
- 10 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 from a non-specialty pharmacy network are not covered, unless medically necessary for a covered emergency.
- 11 Chiropractic appliances are covered up to a maximum of \$50 in a calendar-year as authorized by ASH Plans.
- 12 As authorized by ASH Plans, this allowance is applied toward the purchase of items determined necessary, such as supports, collars, pillows, heel lifts, ice packs, cushions, orthotics, rib belts, and home traction units.
- 13 Home self-administered injectable drugs are covered only when dispensed by select participating pharmacies in the Specialty Pharmacy Network unless Medically Necessary for a covered emergency.
- 14 Certain formulary and non-formulary drugs and most home self-administered injectables require prior authorization by Blue Shield for Medical Necessity, and when effective, lower cost alternatives are available.
- 15 Select drugs for the treatment of asthma and diabetes. For additional details, please refer to the printed formulary under (Respiratory: asthma inhalants, Respiratory: asthma orals, Endocrine: diabetes) and the EOC booklet. This benefit does not apply to those Medicare members enrolled in the Part D drug plan.

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.

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

City of San Jose Custom Access+ HMO® Plan 10 Group H11756 – Active employees and early retirees

For groups of 300 or more.

Blue Shield of California

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Effective January 1, 2009

Deductibles

Calendar-year medical deductible	None
Calendar-year copayment maximum¹ (for many covered services)	\$1,000 per individual/\$2,000 per family
Calendar-year brand-name drug deductible (prescription drug coverage benefits are not subject to the medical plan deductible.)	None
Lifetime maximum	None

Covered services

Member copayment

Professional services		
Physician services – outpatient		
Physician and authorized specialist office visits 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.	\$10/visit	
Allergy testing or treatment	\$10/visit	
Access+ SpecialistSM (self-referred office visits and consultations only) ¹⁻²	\$30/visit	
Laboratory, X-ray, and diagnostic tests	No charge	
Preventive care		
Routine physical exam 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.	No charge	
Eye/ear screenings and immunizations according to age schedule	No charge	
Outpatient services		
Non-emergency		
Outpatient surgery performed in a participating ambulatory surgery center ³ (ASC)	No charge	
Outpatient surgery in hospital/facility	No charge	
Outpatient treatment (except as described under "Rehabilitative Therapy Services") and necessary supplies	No charge	
Hospitalization services		
Inpatient physician services (including pregnancy and maternity care)	No charge	
Semi-private room and board, medically necessary services, and supplies	No charge	
Skilled nursing facility (SNF) services ⁴	No charge	
Emergency health coverage		
Emergency room facility services (waived if the member is directly admitted to the hospital for inpatient services)	\$50/visit	
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.)	Participating pharmacy (for up to a 30-day supply)	Mail-service prescriptions (for up to a 90-day supply)
Select generics ¹⁵	\$0/prescription	\$0/prescription
Select brand-names ¹⁵	\$5/prescription	\$10/prescription
Generic drugs	\$5/prescription	\$10/prescription
Formulary brand-name drugs	\$10/prescription	\$20/prescription
Non-formulary brand-name drugs	\$15/prescription	\$30/prescription
Home self-administered injectable medications ¹³	\$30/prescription	Not covered

Covered services

Member copayment

Prosthetics and orthotics (equipment and devices only)	No charge
Durable medical equipment¹	No charge
Mental health services (psychiatric)⁵	
Inpatient hospital facility services	No charge
Outpatient visits for severe mental health conditions	\$10/visit
Outpatient visits for non-severe mental health conditions ¹ (up to 20 visits per calendar year combined with outpatient chemical dependency visits)	\$25/visit
Chemical dependency services (substance abuse)⁵	
Inpatient services for medical acute detoxification	See "Hospitalization Services"
Outpatient visits ¹ (up to 20 visits per calendar year combined with outpatient non-severe mental health visits)	\$25/visit
Health services	
Agency visits (up to 100 visits per calendar year)	\$10/visit
Medical supplies/IV solutions (for home self-administered injectable medications, see "Prescription Drug Coverage")	No charge
Other	
Hospice	
Routine home care and inpatient respite care	No charge
Inpatient respite care	No charge
24-hour continuous home care and general inpatient care	No charge
General inpatient care	No charge
Pregnancy and maternity care	
Prenatal and postnatal professional (physician) services (for all necessary inpatient hospital services, see "Hospitalization Services")	No charge
Family planning and infertility services	
Family planning counseling	No charge
Diagnosis and treatment of causes of infertility (excludes in vitro fertilization, injectables for infertility, artificial insemination, and GIFT)	50% of allowed charges
Tubal ligation ^{7, 8} and elective abortion ⁸	\$100
Vasectomy ⁸	\$75
Rehabilitative therapy services	
Outpatient visits (copayment applies to all places of services, including professional and facility settings)	\$10/visit
Diabetes care	
Equipment, devices, and non-testing supplies (for testing supplies, see "Prescription Drug Coverage")	No charge
Self-management training and education	\$10/visit
Urgent care outside service area (BlueCard [®] Program)	\$50/visit
Hearing aids	
Audiological evaluations	No charge
Hearing-aid instrument and ancillary equipment (up to a maximum of \$1,000 per member every 36 months for the hearing-aid and ancillary equipment)	No charge

Optional benefits¹

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

Chiropractic services

The plan covers medically necessary chiropractic and acupuncture services including:

- Initial and subsequent examinations
- Office visits and adjustments (subject to annual limits)
- Adjunctive therapies
- X-rays and laboratory tests (chiropractic only)

Calendar-year maximum

30 combined Visits

Calendar-year deductible

None

Copayment per visit

\$10

Calendar-year chiropractic appliance benefit^{11, 12}

\$50

Out-of-network coverage

None

- 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 and 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 pre-authorized days during a calendar-year except when received through a hospice program provided by a participating hospice agency. This 100-pre-authorized-day maximum on skilled nursing services is a combined maximum between skilled nursing facilities 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.
- 9 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.
- 10 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 from a Non-Specialty Pharmacy Network are not covered, unless medically necessary for a covered emergency.
- 11 Chiropractic appliances are covered up to a maximum of \$50 in a calendar year as authorized by ASH Plans.
- 12 As authorized by ASH Plans, this allowance is applied toward the purchase of items determined necessary, such as supports, collars, pillows, heel lifts, ice packs, cushions, orthotics, rib belts, and home traction units.
- 13 Home self-administered injectable drugs are covered only when dispensed by select participating pharmacies in the Specialty Pharmacy Network unless Medically Necessary for a covered emergency.
- 14 Certain formulary and non-formulary drugs and most home self-administered injectables require prior authorization by Blue Shield for Medical Necessity, and when effective, lower cost alternatives are available.
- 15 Select drugs for the treatment of asthma and diabetes. For additional details, please refer to the printed formulary under (Respiratory: asthma inhalants, Respiratory: asthma orals, Endocrine: diabetes) and the EOC booklet. This benefit does not apply to those Medicare members enrolled in the Part D drug plan.

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.

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

City of San Jose Custom Access+ HMO® Plan 5 Group H11336 – Retirees

For groups of 300 or more.

Blue Shield of California

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.

Effective January 1, 2009

Deductibles

Calendar-year medical deductible	None
Calendar-year copayment maximum¹ (for many covered services)	\$1,000 per individual/\$2,000 per family
Calendar-year brand-name drug deductible (Prescription drug coverage benefits are not subject to the medical plan deductible.)	None
Lifetime maximum	None

Covered services

Member copayment

Covered services	Member copayment	
Professional services		
Physician services – outpatient		
Physician and authorized specialist office visits 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.	\$5/visit	
Allergy testing or treatment	\$5/visit	
Access+ SpecialistSM (self-referred office visits and consultations only) ^{1, 2}	\$30/visit	
Laboratory, X-ray, and diagnostic tests	No charge	
Preventive care		
Routine physical exam 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.	No charge	
Eye/ear screenings and immunizations according to age schedule	No charge	
Outpatient services		
Non-emergency		
Outpatient surgery performed in a participating ambulatory surgery center ³ (ASC)	No charge	
Outpatient surgery in hospital/facility	No charge	
Outpatient treatment (except as described under "Rehabilitative Therapy Services") and necessary supplies	No charge	
Hospitalization services		
Inpatient physician services (including pregnancy and maternity care)	No charge	
Semi-private room and board, medically necessary services, and supplies	No charge	
Skilled nursing facility (SNF) services ⁴	No charge	
Emergency health coverage		
Emergency room facility services (waived if the member is directly admitted to the hospital for inpatient services)	\$50/visit	
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.)	Participating pharmacy (for up to a 30-day supply)	Mail-service prescriptions (for up to a 90-day supply)
Select generics ¹³	\$0/prescription	\$0/prescription
Select brand-names ¹³	\$5/prescription	\$10/prescription
Generic drugs	\$5/prescription	\$10/prescription
Formulary brand-name drugs	\$10/prescription	\$20/prescription
Non-formulary brand-name drugs	\$15/prescription	\$30/prescription
Home self-administered injectable medications ¹¹	\$30/prescription (up to 30 days supply) ⁹	Not covered

Covered services

Member copayment

Prosthetics and orthotics (equipment and devices only)	No charge
Durable medical equipment ¹	No charge
Mental health services (psychiatric) ⁵	
Inpatient hospital facility services	No charge
Outpatient visits for severe mental health conditions	\$5/visit
Outpatient visits for non-severe mental health conditions ¹ (up to 20 visits per calendar year combined with outpatient chemical dependency visits)	\$25/visit
Chemical dependency services (substance abuse) ⁵	
Inpatient services for medical acute detoxification	See "Hospitalization Services"
Outpatient visits ¹ (up to 20 visits per calendar year combined with outpatient non-severe mental health visits)	\$25/visit
Health services	
Agency visits (up to 100 visits per calendar year)	\$5/visit
Medical supplies/IV solutions (for home self-administered injectable medications, see "Prescription Drug Coverage")	No charge
Other	
Hospice	
Routine home care and inpatient respite care	No charge
Inpatient respite care	No charge
24-hour continuous home care and general inpatient care	No charge
General inpatient care	No charge
Pregnancy and maternity care	
Prenatal and postnatal professional (physician) services (for all necessary inpatient hospital services, see "Hospitalization Services")	No charge
Family planning and infertility services	
Family planning counseling	No charge
Diagnosis and treatment of causes of infertility (excludes in vitro fertilization, injectables for infertility, artificial insemination, and GIFT)	50% of allowed charges
Tubal ligation ^{7, 8} and elective abortion ⁸	\$100
Vasectomy ⁸	\$75
Rehabilitative therapy services	
Outpatient visits (copayment applies to all places of services, including professional and facility settings)	\$5/visit
Diabetes care	
Equipment, devices, and non-testing supplies (for testing supplies, see "Prescription Drug Coverage")	No charge
Self-management training and education	\$5/visit
Urgent care outside service area (BlueCard® Program)	\$50/visit
Hearing aids	
Audiological evaluations	No charge
Hearing-aid instrument and ancillary equipment (up to a maximum of \$1,000 per member every 36 months for the hearing aid and ancillary equipment)	No charge

Optional benefits¹

Optional dental, vision, 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 and 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 pre-authorized days during a calendar-year except when received through a hospice program provided by a participating hospice agency. This 100-pre-authorized-day maximum on skilled nursing services is a combined maximum between skilled nursing facilities 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.
- 9 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.
- 10 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 from a Non-Specialty Pharmacy Network are not covered, unless medically necessary for a covered emergency.
- 11 Home self-administered injectable drugs are covered only when dispensed by select participating pharmacies in the Specialty Pharmacy Network unless Medically Necessary for a covered emergency.
- 12 Certain formulary and non-formulary drugs and most home self-administered injectables require prior authorization by Blue Shield for Medical Necessity, and when effective, lower cost alternatives are available.
- 13 Select drugs for the treatment of asthma and diabetes. For additional details, please refer to the printed formulary under (Respiratory: asthma inhalants, Respiratory: asthma orals, Endocrine: diabetes) and the EOC booklet. This benefit does not apply to those Medicare members enrolled in the Part D drug plan.

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.

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

City of San Jose Custom PPO 90/70 Plan Groups 975567 and 975571 – Active employees and early retirees

For groups of 300 or more.

Blue Shield of California

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.

Effective January 1, 2009

Deductibles ¹ (all providers combined)	Preferred providers ²	Non-preferred providers ²
Calendar-year medical deductible	\$100 per individual/\$200 per family	
Calendar-year copayment maximum¹	\$2,000 per individual/\$4,000 per family	
Calendar-year brand-name drug deductible (prescription drug coverage benefits are not subject to the medical plan deductible.)	None	
Lifetime maximum	\$6,000,000	

Covered services	Member copayment	
	Preferred providers ²	Non-preferred providers ²
Professional services		
Physician services		
Physician and specialist office visits	\$10/visit (deductible waived)	30%
Laboratory and X-rays	10%	30%
Allergy testing or treatment	\$10/visit	30%
Diagnostic testing	10%	30%
Preventive care		
Annual routine physical exam, eye/ear screenings, and immunizations	\$10/visit (deductible waived)	Not covered
Laboratory, including mammogram and Pap test screening or other FDA-approved cervical cancer screening tests (one per calendar year)	10%	Not covered
Well-baby care		
Office visits and consultations (includes eye/ear screenings, immunizations, vaccinations)	\$10/visit (deductible waived)	Not covered
Laboratory	10%	Not covered
Outpatient services		
The maximum allowed charges for non-emergency surgery and services performed in a non-participating ambulatory surgery center or outpatient unit of a non-preferred hospital is \$600 per day. Members are responsible for 30% of this \$600 per day, plus all charges in excess of \$600.		
Outpatient surgery performed in a participating ambulatory surgery center ³ (ASC)	10%	30%
Outpatient surgery in hospital/facility	10%	30%
Outpatient treatment and necessary supplies	10%	30%
Bariatric surgery (pre-authorization required; medically necessary surgery for weight loss, only for morbid obesity) ⁵	10%	30%
Hospitalization services		
Inpatient services – non-emergency		
Inpatient physician services (including pregnancy and maternity care)	10%	30%
Semi-private room and board, medically necessary services, and supplies	10%	30% ⁴
Bariatric surgery (pre-authorization required; medically necessary surgery for weight loss, only for morbid obesity) ⁵	10%	30% ⁴
Skilled nursing facility (SNF) services⁶ (combined maximum of up to 100 pre-authorized days per calendar year; semi-private accommodations)		
Freestanding SNF	10%	10% with prior authorization ⁶
Hospital SNF unit	10%	30% ⁴

Covered services

Member copayment

Covered services	Member copayment	
Emergency health coverage		
ER facility services (deductible waived on services not resulting in a direct admission)	\$50/visit	\$50/visit
Inpatient facility services (when the member is admitted directly from the ER)	10%	10%
Emergency room physician services	10%	10%
Ambulance services	10%	10%
Prescription drug coverage (includes oral contraceptives, diaphragms, and covered diabetic drugs and testing supplies) 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.	Participating pharmacy	Non-participating pharmacy Member pays 25% of allowable amount plus a copayment of:
Retail prescriptions (for up to a 30-day supply)		
Select generics ¹⁶	\$0/prescription	\$0/prescription
Select brand-names ¹⁶	\$5/prescription	\$5/prescription
Generic drugs	\$5/prescription	\$5/prescription
Formulary brand-name drugs	\$10/prescription	\$10/prescription
Non-formulary brand-name drugs	\$25/prescription	\$25/prescription
Mail-service prescriptions (for up to a 90-day supply)		
Select generics ¹⁶	\$0/prescription	Not covered
Select brand-names ¹⁶	\$10/prescription	Not covered
Generic drugs	\$10/prescription	Not covered
Formulary brand-name drugs	\$20/prescription	Not covered
Non-formulary brand-name drugs	\$50/prescription	Not covered
Home self-administered injectable medications¹⁴ (available at specialty pharmacy networks only)	10%	Not covered
Prosthetics and orthotics (equipment and devices only)	10%	30%
Durable medical equipment	10%	30%
Mental health services (psychiatric)⁷	MHSA participating providers²	MHSA non-participating providers²
Inpatient hospital facility services	10%	30% ⁴
Outpatient visits for severe mental health conditions	\$10/visit (deductible waived)	30%
Outpatient visits for non-severe mental health conditions (up to 20 visits per calendar year combined with outpatient chemical dependency visits) ⁸	\$25/visit	Not covered
Chemical dependency services (substance abuse)^{7, 9}		
Inpatient services for medical acute detoxification	See "Hospitalization Services"	See "Hospitalization Services"
Outpatient visits (up to 20 visits per calendar year combined with outpatient non-severe mental health visits) ⁸	\$25/visit	Not covered
Home health services¹⁰ (combined maximum of 100 prior authorized visits per calendar year)	Preferred providers²	Non-preferred providers²
Home health and home infusion care (see "Prescription Drug Coverage" for home self-administered injectables)	10%	Not covered ¹⁰
Other		
Hospice¹⁰		
Routine home care and inpatient respite care	No charge	Not covered ¹⁰
Inpatient respite care	No charge	Not covered ¹⁰
24-hour continuous home care	10%	Not covered ¹⁰
General inpatient care	10%	Not covered ¹⁰
Alternative care⁸		
Chiropractic services (up to 20 visits per calendar year)	10%	30%
Acupuncture services (up to 20 visits per calendar year)	10%	10%
Rehabilitative therapy services		
Outpatient visits	10%	30%
Pregnancy and maternity care		
Prenatal and postnatal professional (physician) services (for all necessary inpatient hospital services, see "Hospitalization Services")	10%	30%

Covered services

Member copayment

Family planning and infertility services		
Family planning counseling	\$10/visit (deductible waived)	Not covered
Elective abortion, tubal ligation, vasectomy ¹¹	10%	Not covered
Diabetes care		
Equipment, devices, and non-testing supplies (for testing supplies, see "Prescription Drug Coverage")	10%	30%
Self-management training and education (if billed by your provider, you will also be responsible for the office visit copayment)	\$10/visit	30%
Covered out-of-state benefits (benefits provided through BlueCard® 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

Optional benefits

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.

- 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 and Disclosure Form* and the Plan Contract for exact terms and conditions of coverage.
- 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.
- 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.
- The maximum allowed charge for non-emergency hospital services received from a non-preferred hospital is \$600 per day. Members are responsible for 30% of this \$600 per day, plus all charges in excess of \$600.
- 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.
- Services may require prior authorization by Blue Shield. When these services are prior authorized, members pay the preferred or participating provider amount.
- Mental health and chemical dependency services, other than medical acute detoxification, are accessed through Blue Shield's Mental Health Services Administrator (MHS) – using Blue Shield's MHS participating and non-participating providers. Only Blue Shield MHS contracted providers are administered by the Blue Shield MHS. 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.
- All outpatient non-severe mental health, outpatient substance abuse, acupuncture and chiropractic visits accrue to the calendar-year visit maximum regardless of whether the plan deductible has been met.
- 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."
- 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.
- 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.
- 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.
- 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 from a Non-Specialty Pharmacy Network are not covered, unless Medically Necessary for a covered emergency.
- Home self-administered injectable drugs are covered only when dispensed by select participating pharmacies in the Specialty Pharmacy Network unless Medically Necessary for a covered emergency.
- Certain formulary and non-formulary drugs and most home self-administered injectables require prior authorization by Blue Shield for Medical Necessity, and when effective, lower cost alternatives are available.
- Select drugs for the treatment of asthma and diabetes. For additional details, please refer to the printed formulary under (Respiratory: asthma inhalants, Respiratory: asthma orals, Endocrine: diabetes) and the EOC booklet. This benefit does not apply to those Medicare members enrolled in the Part D drug plan.

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.

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

City of San Jose Custom PPO 90/70 Plan Group 975568 – Retirees

For groups of 300 or more.

Blue Shield of California

This matrix is intended to be used to help you compare coverage benefits, and is a summary only. The *Evidence of Coverage and Disclosure Form*, and plan contract should be consulted for a detailed description of coverage benefits and limitations.

Effective January 1, 2009

Deductibles¹ (all providers combined)	Preferred providers²	Non-preferred providers²
Calendar-year medical deductible	\$0 per individual/\$0 per family	
Calendar-year copayment maximum¹	\$2,000 per individual/\$2,000 per family	
Calendar-year brand-name drug deductible (Prescription drug coverage benefits are not subject to the medical plan deductible.)	None	
Lifetime maximum	\$6,000,000	

Covered services	Member copayment	
	Preferred providers²	Non-preferred providers²
Professional services		
Physician services		
Physician and specialist office visits	\$10/visit	30%
Laboratory and X-rays	10%	30%
Allergy testing or treatment	\$10/visit	30%
Diagnostic testing	10%	30%
Preventive care		
Annual routine physical exam, eye/ear screenings, and immunizations	\$10/visit	Not covered
Laboratory	10%	Not covered
Mammogram and Pap test screening or other FDA-approved cervical cancer screening tests (one per calendar year)	\$10/visit	Not covered
Well-baby care		
Office visits and consultations (includes: eye/ear screenings, immunizations, vaccinations)	\$10/visit	Not covered
Laboratory	10%	Not covered
Outpatient services		
The maximum allowed charges for non-emergency surgery and services performed in a non-participating ambulatory surgery center or outpatient unit of a non-preferred hospital is \$600 per day. Members are responsible for 30% of this \$600 per day, plus all charges in excess of \$600.		
Outpatient surgery performed in a participating ambulatory surgery center ³ (ASC)	10%	30%
Outpatient surgery in hospital/facility	10%	30%
Outpatient treatment and necessary supplies	10%	30%
Bariatric surgery (pre-authorization required; medically necessary surgery for weight loss, only for morbid obesity) ⁵	10%	30%
Hospitalization services		
Inpatient services – non-emergency		
Inpatient physician services (including pregnancy and maternity care)	No charge	30%
Semi-private room and board, medically necessary services, and supplies	No charge	30% ⁴
Bariatric surgery (pre-authorization required; medically necessary surgery for weight loss, only for morbid obesity) ⁵	No charge	30% ⁴
Skilled nursing facility (SNF) services⁶ (combined maximum of up to 100 pre-authorized days per calendar year; semi-private accommodations)		
Freestanding SNF	10%	10% with prior authorization ⁶
Hospital SNF unit	10%	30% ⁴

Covered services

Member copayment

Covered services	Member copayment	
Emergency health coverage		
ER facility services (deductible waived on services not resulting in a direct admission)	\$50 + 10%	\$50 + 10%
Inpatient facility services (when the member is admitted directly from the ER)	No charge	No charge
Emergency room physician visits	10%	10%
Ambulance services	10%	10%
Prescription drug coverage (includes oral contraceptives, diaphragms, and covered diabetic drugs and testing supplies) 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.	Participating pharmacy	Non-participating pharmacy Member pays 25% of allowable amount plus a copayment of:
Retail prescriptions (for up to a 30-day supply)		
Select generics ¹⁶	\$0/prescription	\$0/prescription
Select brand-names ¹⁶	\$5/prescription	\$5/prescription
Generic drugs	\$5/prescription	\$5/prescription
Formulary brand-name drugs	\$10/prescription	\$10/prescription
Non-formulary brand-name drugs	\$25/prescription	\$25/prescription
Mail-service prescriptions (for up to a 90-day supply)		
Select generics ¹⁶	\$0/prescription	Not covered
Select brand-names ¹⁶	\$10/prescription	Not covered
Generic drugs	\$10/prescription	Not covered
Formulary brand-name drugs	\$20/prescription	Not covered
Non-formulary brand-name drugs	\$50/prescription	Not covered
Home self-administered injectable medications¹⁴ (available at specialty pharmacy networks only)	10%	Not covered
Prosthetics and orthotics (equipment and devices only)	10%	30%
Durable medical equipment	10%	30%
Mental health services (psychiatric)⁷	MHSA participating providers²	MHSA non-participating providers²
Inpatient hospital facility services	No charge	30% ⁴
Outpatient visits for severe mental health conditions	\$10/visit	30%
Outpatient visits for non-severe mental health conditions (up to 20 visits per calendar year combined with outpatient chemical dependency visits) ⁸	\$25/visit	Not covered
Chemical dependency services (substance abuse)^{7, 9}		
Inpatient services for medical acute detoxification	See "Hospitalization Services"	See "Hospitalization Services"
Outpatient visits (up to 20 visits per calendar year combined with outpatient non-severe mental health visits) ⁸	\$25/visit	Not covered
Home health services¹⁰ (combined maximum of 100 prior authorized visits per calendar year)	Preferred providers²	Non-preferred providers²
Home health and home infusion care (see "Prescription Drug Coverage" for home self-administered injectables)	10%	Not covered ¹⁰
Other		
Hospice¹⁰		
Routine home care and inpatient respite care	No charge	Not covered ¹⁰
Inpatient respite care	No charge	Not covered ¹⁰
24 hour continuous home care	10%	Not covered ¹⁰
General inpatient care	10%	Not covered ¹⁰
Alternative care⁸		
Chiropractic services (up to 20 visits per calendar year)	10%	30%
Acupuncture services (up to 20 visits per calendar year)	10%	10%
Rehabilitative therapy services		
Outpatient visits	10%	30%
Pregnancy and maternity care		

Prenatal and postnatal professional (physician) services (for all necessary inpatient hospital services, see "Hospitalization Services")	10%	30%
Family planning and infertility services		
Family planning counseling	\$10/visit (deductible waived)	Not covered
Elective abortion, tubal ligation, vasectomy ¹¹	10%	Not covered
Covered services	Member copayment	
Diabetes care		
Equipment, devices, and non-testing supplies (for testing supplies, see "Prescription Drug Coverage")	10%	30%
Self-management training and education (if billed by your provider, you will also be responsible for the office visit copayment)	\$10/visit	30%
Covered out-of-state benefits (benefits provided through BlueCard® 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

Optional benefits

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

- 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 and Disclosure Form* and the Plan Contract for exact terms and conditions of coverage.
- 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.
- 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.
- The maximum allowed charge for non-emergency hospital services received from a non-preferred hospital is \$600 per day. Members are responsible for 30% of this \$600 per day, plus all charges in excess of \$600.
- 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.
- Services may require prior authorization by Blue Shield. When services are prior authorized, members pay the preferred or participating provider amount.
- 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's 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.
- All outpatient non-severe mental health, outpatient substance abuse, acupuncture and chiropractic visits accrue to the calendar-year visit maximum regardless of whether the plan deductible has been met.
- 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."
- 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.
- 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.
- 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.
- 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 from a Non-Specialty Pharmacy Network are not covered, unless Medically Necessary for a covered emergency.
- Home self-administered injectable drugs are covered only when dispensed by select participating pharmacies in the Specialty Pharmacy Network unless Medically Necessary for a covered emergency.
- Certain formulary and non-formulary drugs and most home self-administered injectables require prior authorization by Blue Shield for Medical Necessity, and when effective, lower cost alternatives are available.
- Select drugs for the treatment of asthma and diabetes. For additional details, please refer to the printed formulary under (Respiratory: asthma inhalants, Respiratory: asthma orals, Endocrine: diabetes) and the EOC&D booklet. This benefit does not apply to those Medicare members enrolled in the Part D drug plan.

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.

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

**City of San Jose Custom POS 100/90/70
Groups MH0161 and MH0162 – Active employees and early retirees**

For groups of 300 or more.

Blue Shield of California

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.

Effective January 1, 2009

Deductibles¹	Level I: HMO plan providers²	Level II: Preferred providers²	Level III: Non-preferred providers²
Calendar-year medical deductible	None	\$100 per individual/\$200 per family	
Calendar-year copayment maximum¹ (for many covered services)	\$1,500 per individual \$3,000 per family	\$1,500 per individual \$3,000 per family	\$4,500 per individual \$9,000 per family
Calendar-year brand-name drug deductible		None	
Lifetime maximums	None		\$2,000,000

Covered services

Member copayment

	Level I: HMO plan providers²	Level II: Preferred providers²	Level III: Non-preferred providers²
Professional services			
Physician services – outpatient			
Physician and specialist office visits <small>Note: For network benefits provider level, 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	\$10/visit	30%
Allergy testing or treatment	\$5/visit	\$10/visit	30%
Laboratory, X-rays, and diagnostics	No charge	10%	30%
Preventive care			
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 annual gynecological exams.</small>	No charge	Not covered	Not covered
Outpatient services			
Non-emergency			
Outpatient surgery performed in a participating ambulatory surgery center (ASC)	No charge	10%	30% ³
Outpatient surgery in hospital/facility	No charge	10%	30% ³
Outpatient treatment (except as described under "Rehabilitative Therapy Services") and necessary supplies	No charge	10%	30% ³
Bariatric Surgery (preauthorization required; medically necessary surgery for weight loss, only for morbid obesity)	No charge	10% ⁵	30% ^{3, 5}
Hospitalization services			
Inpatient physician services, including pregnancy and maternity care	No charge	10%	30%
Semi-private room and board, medically necessary services, and supplies	No charge	10%	30% ⁴
Bariatric surgery (pre-authorization required; medically necessary surgery for weight loss, only for morbid obesity)	No charge	10% ⁵	30% ^{4, 5}
Skilled nursing facility (SNF) services ⁶	No charge	10%	30% ⁴
Emergency health coverage			
Emergency room facility services (waived if the member is directly admitted to the hospital for inpatient services)	\$35/visit	\$35/visit	\$35/visit
Emergency room physician services	No charge	10%	10%
Ambulance services	No charge	10%	10%

Covered services

Prescription drug coverage¹ (includes oral contraceptives, diaphragms, and covered diabetic drugs and testing supplies)

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 Services.

Select generics ⁹	
Select brand-names ⁹	
Generic drugs	
Formulary brand-name drugs	
Home self-administered injectable medications (available at specialty pharmacy networks only)	

Prosthetics and orthotics (equipment and devices only)

Durable medical equipment

Mental health services (psychiatric)⁷

Inpatient hospital facility services	
Outpatient visits for severe mental health conditions	
Outpatient visits for non-severe mental health conditions (up to 20 visits per calendar year combined with outpatient chemical dependency visits)	

Chemical dependency services (substance abuse)^{7,8}

Inpatient services for medical acute detoxification	
Outpatient visits (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)	
Medical supplies/IV solutions (for home self-administered injectable medications, see "Prescription Drug Coverage")	

Other

Hospice

Routine home care and inpatient respite care	
Inpatient respite care	
24-hour continuous home care	
General inpatient care	

Pregnancy and maternity care

Prenatal and postnatal professional (physician) services (for all necessary inpatient hospital services, see "Hospitalization Services")	
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Family planning and infertility

Family planning counseling	
Diagnosis and treatment of cause of infertility (excludes in vitro fertilization, injectables for infertility, artificial insemination, and GIFT)	
Tubal ligation ^{11, 12} and elective abortion ¹²	
Vasectomy ¹²	

Rehabilitative therapy services

Outpatient visits	
Outpatient visits in a facility unit	
Inpatient skilled nursing facility (SNF) rehabilitation unit	
Inpatient rehabilitation unit of a hospital	

Member copayment

Participating pharmacy (for up to a 30-day supply) **Mail-service prescriptions** (for up to a 90-day supply)

\$0/prescription	\$0/prescription
\$5/prescription	\$10/prescription
\$5/prescription	\$10/prescription
\$10/prescription	\$20/prescription
No charge	Not covered

No charge	10%	30%
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No charge	10%	30%
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Level I: MHSA participating providers²	Level II: N/A, except for medical acute detoxification	Level III: MHSA non-participating providers
No charge	N/A	30% ⁴
\$5/visit	N/A	30%
\$35/visit ¹	N/A	30%

Level I: MHSA participating providers²	Level II: N/A, except for medical acute detoxification	Level III: MHSA non-participating providers²
See "Hospitalization Services"	See "Hospitalization Services"	See "Hospitalization Services"
\$35/visit ¹	N/A	30%

Level I: HMO plan providers²	Level II: Preferred providers²	Level III: Non-preferred providers²
\$5/visit	10%	Not covered ⁹
No charge	10%	Not covered ⁹

No charge	Not covered ¹⁰	Not covered ¹⁰
No charge	Not covered ¹⁰	Not covered ¹⁰
No charge	Not covered ¹⁰	Not covered ¹⁰
No charge	Not covered ¹⁰	Not covered ¹⁰

No charge	\$10/visit	30%
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No charge	Not covered	Not covered
50% of allowed charges	Not covered	Not covered
\$100	Not covered	Not covered
\$50	Not covered	Not covered

\$5/visit	\$10/visit	30%
\$5/visit	10%	30%
No charge	10%	30%
See "Hospitalization Services"	See "Hospitalization Services"	See "Hospitalization Services"

Covered services

Member copayment

	Level I: HMO plan providers ²	Level II: Preferred providers ²	Level III: Non-preferred providers ²
Diabetes care			
Equipment, devices, and non-testing supplies (for testing supplies, please see "Outpatient Prescription Drug Coverage")	No charge	10%	30%
Self-management training and education	\$5/visit	\$10/visit	30%
Hearing-aid services			
Audiological evaluations	No charge	\$10/visit	30%
Hearing-aid instrument and ancillary equipment (up to a maximum of \$1,000 per member every 36 months for the hearing-aid and ancillary equipment)	No charge	No charge	No charge
Urgent care outside service area (BlueCard® Program)	\$50	10%	30%

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

Chiropractic benefits

The plan covers medically necessary chiropractic services including:

- Initial and subsequent examinations
- Office visits and adjustments (subject to annual limits)
- Adjunctive therapies
- X-rays and laboratory tests (chiropractic only)

Calendar-year maximum	30 Visits
Calendar-year deductible	None
Copayment per visit	\$5
Calendar-year chiropractic appliance benefit^{15, 16}	\$50
Out-of-network coverage	None

- 1 Deductible and copayments marked with a (I) 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.
- 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. Calendar-year deductible applies to services of non-preferred providers only.
- 3 The maximum allowed charges for non-emergency surgery and services performed in a non-participating ambulatory surgery center or outpatient unit of a non-preferred hospital is \$600 per day. Members are responsible for 30% of this \$600 per day, plus all charges in excess of \$600.
- 4 The maximum allowed charge for non-emergency hospital services received from a non-preferred hospital is \$600 per day. Members are responsible for 30% of this \$600 per day, plus all charges in excess of \$600.
- 5 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.
- 6 Skilled nursing services are limited to 100 pre-authorized days during any calendar year except when received through a hospice program provided by a participating hospice agency. This 100 pre-authorized day maximum on skilled nursing services is a combined maximum between Hospital and skilled nursing facilities.
- 7 Mental health and chemical dependency services, other than services for medical acute detoxification, are accessed through Blue Shield's Mental Health Services Administrator (MHSA) – utilizing Blue Shield's MHSA Participating (Level I) and non-participating (Level III) 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. There are no Level II providers for mental health and chemical dependency services, other than for medical acute detoxification. Services for medical acute detoxification are accessed through Blue Shield using Blue Shield's HMO plan providers (Level I), preferred providers (Level II), or non-preferred providers (Level III). 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.
- 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 healthcare services are not covered unless pre-authorized. When these services are pre-authorized, the member pays the preferred provider copayment.
- 10 Out of network hospice is not covered unless pre-authorized. When these services are pre-authorized, the member pays the Level I copayment.
- 11 Copayment waived when procedure is performed in conjunction with delivery or abdominal surgery.
- 12 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.
- 13 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.
- 14 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.
- 15 Chiropractic appliances are covered up to a maximum of \$50 in a calendar-year as authorized by ASH Plans.
- 16 As authorized by ASH Plans, this allowance is applied toward the purchase of items determined necessary, such as supports, collars, pillows, heel lifts, ice packs, cushions, orthotics, rib belts, and home traction units.
- 17 Home self-administered injectable drugs are covered only when dispensed by select participating pharmacies in the Specialty Pharmacy Network unless Medically Necessary for a covered emergency.
- 18 Only drugs on the Blue Shield Drug Formulary are covered unless prior authorized by Blue Shield Pharmacy Services. Certain formulary drugs and most home self-administered injectables require prior authorization by Blue Shield for Medical Necessity, and when effective, lower cost alternatives are available.
- 19 Select drugs for the treatment of asthma and diabetes. For additional details, please refer to the printed formulary under (Respiratory: asthma inhalants, Respiratory: asthma orals, Endocrine: diabetes) and the EOC booklet. This benefit does not apply to those Medicare members enrolled in the Part D drug plan.

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.

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 works for you