

City and County of San Francisco
 Custom HMO® 20-150 Inpatient
 Group H11054, H12054
 Benefit Summary (For groups of 300 and above)
 (Uniform Health Plan Benefits and Coverage Matrix)

THIS MATRIX IS INTENDED TO BE USED TO HELP YOU COMPARE COVERAGE BENEFITS AND IS A SUMMARY ONLY. THE EVIDENCE OF COVERAGE AND PLAN CONTRACT SHOULD BE CONSULTED FOR A DETAILED DESCRIPTION OF COVERAGE BENEFITS AND LIMITATIONS.

Blue Shield of California

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

Effective July 1, 2011

Plan year medical deductible	None
Plan year copayment maximum ¹ (For many covered services)	\$1,000 per individual/\$2,000 per family

LIFETIME BENEFIT MAXIMUM	None
Covered Services	Member Copayment

PROFESSIONAL SERVICES

Professional (physician) benefits

- Physician and specialist office visits \$20 per visit
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.
- Outpatient X-ray, pathology and laboratory No charge
- Injectable medications (other than injectables for allergy)¹⁰ No charge

Allergy testing and treatment benefits

- Office visits (includes visits for allergy serum injections) \$20 per visit

Access+ SpecialistSM benefits (Self-referred office visits and consultations only)^{1, 2}

- Office visit, examination or other consultation \$30 per visit

Preventive health benefits

- Routine physical examination office visit** (according to age schedule) Including the physical examination office visit, gynecological office visit, routine eye/ear screening for members through age 18 and pediatric and adult immunizations and the immunization agent. 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
- Immunizations (according to age schedule) No charge

OUTPATIENT SERVICES

Hospital benefits (facility services)

- Outpatient surgery performed in an ambulatory surgery center³ \$50 per surgery
- Outpatient surgery in a hospital \$50 per surgery
- Outpatient services for treatment of illness or injury and necessary supplies (Except as described under "Rehabilitation benefits") No charge

HOSPITALIZATION SERVICES

Hospital benefits (facility services)

- Inpatient physician services No charge
- Inpatient non-emergency facility services (semi-private room and board, medically necessary services and supplies) \$150 per admission
- Inpatient medically necessary skilled nursing services including subacute care⁴ No charge

EMERGENCY HEALTH COVERAGE

- Emergency room services not resulting in admission (Copayment does not apply if the member is directly admitted to the hospital for inpatient services) \$100 per visit
- Emergency room physician services No charge

AMBULANCE SERVICES

- Emergency or authorized transport \$50

PRESCRIPTION DRUG COVERAGE

Outpatient prescription drug benefits¹ A description of your outpatient prescription drug coverage is provided separately. If you do not have the separate drug summary that goes with this benefit summary, please contact your benefits administrator or call Member Services at **(800) 424-6521**.

PROSTHETICS/ORTHOTICS

- Prosthetic equipment and devices (Separate office visit copay may apply) No charge
- Orthotic equipment and devices (Separate office visit copay may apply) No charge

DURABLE MEDICAL EQUIPMENT

- Durable medical equipment (of allowed charges)¹ No charge

MENTAL HEALTH SERVICES (PSYCHIATRIC)⁵

- Inpatient hospital services \$150 per admission
 - Outpatient mental health services \$20 per visit
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CHEMICAL DEPENDENCY SERVICES (SUBSTANCE ABUSE)⁷**Please see footnote 6**

- Chemical dependency and substance abuse services Not covered
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HOME HEALTH SERVICES

- Home health care agency services (Up to 100 visits per Plan year) \$20 per visit
 - Physician's home visits \$25 per visit
 - Medical supplies and laboratory services No charge
(For home self-administered injectable medications, see "Prescription Drug Coverage.")
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Hearing Aid Services

- Audiological examination No charge
 - Hearing Aid (up to a maximum of \$2,500 per member every 36 months for the hearing aid equipment and ancillary equipment) No charge
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OTHER**Hospice program benefits**

- Routine home care No charge
 - Inpatient respite care No charge
 - 24- hour continuous home care No charge
 - General inpatient care No charge
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Pregnancy and maternity care benefits

- Prenatal and postnatal physician office visits No charge
(For inpatient hospital services, see "Hospitalization Services.")
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Family planning and infertility benefits

- Counseling and consulting \$20 per visit
 - Infertility services (of allowed charges) (Diagnosis and treatment of causes of infertility. Excludes in vitro fertilization, injectables for infertility, artificial insemination and GIFT) 50%
 - Tubal ligation^{8,9} \$100 per surgery
 - Elective abortion⁹ \$100 per surgery
 - Vasectomy⁹ \$75 per surgery
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Rehabilitation benefits (physical, occupational and respiratory therapy)

- Office location \$20 per visit
(Copayment applies to all place of services, including professional and facility settings)
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Speech therapy benefits

- Office location \$20 per visit
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Diabetes care benefits

- Devices, equipment and non-testing supplies (of allowed charges) No charge
(For testing supplies, see "Outpatient Prescription Drug Coverage Summary.")
 - Diabetes self-management training \$20 per visit
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Urgent care benefits (BlueCardSM Program)

- Urgent services outside your personal physician service area \$50 per visit
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Optional benefits¹

Optional dental, vision, infertility, substance abuse, chiropractic or chiropractic and acupuncture 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 plan-year copayment maximum. Copayments and charges for services not accruing to the member's Plan year copayment maximum continue to be the member's responsibility after the Plan year copayment maximum is reached. Please refer to the Evidence of Coverage 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 services must be provided by a MHSA network participating provider.

3 Participating ambulatory surgery centers may not be available in all areas. Regardless of their availability, you can obtain outpatient surgery services from a hospital or an ambulatory surgery center affiliated with a hospital with payment according to your health plan's hospital services benefits.

4 Skilled nursing services are limited to 100 preauthorized days during a Plan year except when received through a hospice program provided by a participating hospice agency. This 100 preauthorized day maximum on skilled nursing services is a combined maximum between SNF in a hospital unit and skilled nursing facilities.

5 Mental health services are accessed through Blue Shield's Mental Health Service Administrator (MHSA) using Blue Shield's MHSA participating 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 substance abuse treatment benefits are available. If your employer purchased these benefits, a description of the benefit is attached hereto as "Substance Abuse Treatment Benefits."**

7 Inpatient services for acute detoxification are covered under the medical benefit; see hospitalization services for benefit details. Services for medical acute detoxification are accessed through Blue Shield using Blue Shield HMO providers.

8 Copayment does not apply when procedure is performed in conjunction with delivery or abdominal surgery.

9 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.

10 Serum administered during the office visit is included. For serum purchased separately from the office, the member is responsible for 50% of the allowed charges. Plan designs may be modified to ensure compliance with state and federal requirements.