

CSAC/EIA Health: City of Huntington Beach  
 Custom PPO Plan – Retirees  
 Benefit Summary  
 (Uniform Health Plan Benefits and Coverage Matrix)

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

**Blue Shield of California**

Effective January 1, 2012

	Preferred Providers <sup>1</sup>	Non-Preferred Providers <sup>1</sup>
<b>Calendar year Medical Deductible<sup>2</sup></b> (All providers combined)	\$0 per individual \$0 per family	\$500 per individual \$1,000 per family
<b>Calendar year Copayment Maximum<sup>2</sup></b> (Copayments for Preferred Providers accrue to both Preferred and Non-Preferred Provider Calendar-year Copayment Maximum amounts.)	\$2,000 per individual \$4,000 per family	\$10,000 per individual \$20,000 per family
<b>LIFETIME BENEFIT MAXIMUM</b>	None	
Covered Services	Member Copayment	
	Preferred Providers <sup>1</sup>	Non-Preferred Providers <sup>1</sup>
<b>PROFESSIONAL SERVICES</b>		
<b>Professional (Physician) Benefits</b>		
• Physician and specialist office visits	No charge	40%
• CT scans, MRIs, MRAs, PET scans, and cardiac diagnostic procedures utilizing nuclear medicine <sup>3</sup> (prior authorization is required)	No charge	40%
• Other outpatient X-ray, pathology and laboratory (Diagnostic testing by providers other than outpatient laboratory, pathology, and imaging departments of hospitals/facilities) <sup>3</sup>	No charge	40%
<b>Allergy Testing and Treatment Benefits</b>		
• Office visits (includes visits for allergy serum injections)	No charge	40%
<b>Preventive Health Benefits</b>		
• Annual routine physical examination office visit: including the physical examination office visit, routine eye/ear screening for members through age 18 and pediatric and adult immunizations and the immunization agent.	No charge	40%
• Annual routine gynecological office visit: including the gynecological examination office visit, routine mammography, routine Papanicolaou (Pap) test or other FDA approved cervical cancer screening test, human papillomavirus (HPV) screening tests (One per calendar year)	No charge	40%
• Routine laboratory services	No charge	40%
• Well baby office visit: including well baby examination office visit, pediatric immunizations and the immunization agent, well baby vision and hearing screening including well baby laboratory services	No charge	Not covered
<b>OUTPATIENT SERVICES</b>		
<b>Hospital Benefits (Facility Services)</b>		
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 \$350 per day. Members are responsible for 40% of this \$350 per day, plus all charges in excess of \$350.		
• Outpatient surgery performed at an Ambulatory Surgery Center <sup>4</sup>	No charge	40%
• Outpatient surgery in a hospital	No charge	40%
• Outpatient Services for treatment of illness or injury and necessary supplies (Except as described under "Rehabilitation benefits")	No charge	40%
• CT scans, MRIs, MRAs, PET scans, and cardiac diagnostic procedures utilizing nuclear medicine performed in a hospital (prior authorization is required) <sup>3</sup>	No charge	40%
• Other outpatient X-ray, pathology and laboratory performed in a hospital <sup>3</sup>	No charge	40%
• Bariatric Surgery (pre-authorization required; medically necessary surgery for weight loss, only for morbid obesity) <sup>5</sup>	No charge	40%
<b>HOSPITALIZATION SERVICES</b>		
<b>Hospital Benefits (Facility Services)</b>		
• Inpatient Physician Services	No charge	40%
• Inpatient Non-emergency Facility Services (Semi-private room and board, medically necessary services and supplies)	No charge	40% <sup>6</sup>
• Bariatric Surgery (pre-authorization required; medically necessary surgery for weight loss, only for morbid obesity) <sup>5</sup>	No charge	40% <sup>6</sup>

An Independent member of the Blue Shield Association

<b>Skilled Nursing Facility Benefits</b>		
(Combined maximum of up to 365 preauthorized days per calendar year; semi-private accommodations)		
• Services by a free-standing Skilled Nursing Facility	No charge (First 100 days, 20% thereafter)	No charge <sup>7</sup> (First 100 days, 20% thereafter)
• Skilled Nursing Unit of a Hospital	No charge (First 100 days, 20% thereafter)	40% <sup>6</sup>
<b>EMERGENCY HEALTH COVERAGE</b>		
• Emergency room Services not resulting in admission (If ER services do not result in a direct admission the Calendar-Year Deductible does not apply)	No charge	No charge
• Emergency room Services resulting in admission (When the member is admitted directly from the ER)	No charge	No charge
• Emergency room Physician Services	No charge	No charge
<b>AMBULANCE SERVICES</b>		
• Emergency or authorized transport	No charge	No charge
<b>PROSTHETICS/ORTHOTICS</b>		
• Prosthetic equipment and devices (Separate office visit copay may apply)	No charge	40%
• Orthotic equipment and devices (Separate office visit copay may apply)	No charge	40%
<b>DURABLE MEDICAL EQUIPMENT</b>		
• Durable Medical Equipment	No charge	40%
<b>MENTAL HEALTH SERVICES (PSYCHIATRIC)<sup>8</sup></b>		
• Inpatient Hospital Services	No charge	40% <sup>6</sup>
• Outpatient Mental Health Services	No charge	40%
<b>CHEMICAL DEPENDENCY SERVICES (SUBSTANCE ABUSE)<sup>8, 9</sup></b>		
• Inpatient Hospital Services	No charge	40% <sup>6</sup>
• Outpatient Chemical Dependency (Substance Abuse) Services	No charge	40%
<b>HOME HEALTH SERVICES<sup>10</sup></b>		
• Home health care agency Services	No charge	Not Covered <sup>10</sup>
• Home infusion/home intravenous injectable therapy and infusion nursing visits provided by a Home Infusion Agency	No charge	Not Covered <sup>10</sup>
<b>OTHER</b>		
<b>Hospice Program Benefits<sup>10</sup></b>		
• Routine home care	No charge	Not Covered <sup>10</sup>
• Inpatient Respite Care	No charge	Not Covered <sup>10</sup>
• 24-hour Continuous Home Care	No charge	Not Covered <sup>10</sup>
• General Inpatient care	No charge	Not Covered <sup>10</sup>
-----		
<b>Chiropractic Benefits<sup>11</sup></b>		
• Chiropractic Services - provided by a chiropractor (Up to 12 visits per calendar year)	No charge	40%
-----		
<b>Acupuncture Benefits<sup>11</sup></b>		
• Acupuncture (Up to 20 visits per calendar year)	No charge	No charge
<b>Rehabilitation Benefits (Physical, Occupational and Respiratory Therapy)</b>		
• Office location	No charge	40%
-----		
<b>Speech Therapy Benefits</b>		
• Office location	No charge	40%
-----		
<b>Pregnancy and Maternity Care Benefits</b>		
• Prenatal and Postnatal Physician Office Visits (For inpatient hospital services, see "Hospitalization Services.")	10%	40%
-----		
<b>Family Planning Benefits</b>		
• Counseling and consulting	\$20 per visit	Not Covered
• Elective abortion <sup>12</sup>	10%	Not Covered
• Tubal ligation <sup>12</sup>	10%	Not Covered
• Vasectomy <sup>12</sup>	10%	Not Covered
• Intrauterine device (IUD)	No charge	40%
• Insertion/removal of intrauterine device	\$20 per visit	40%
-----		
<b>Diabetes Care Benefits</b>		
• Devices, equipment, and non-testing supplies	No charge	40%
• Diabetes self-management training (If billed by your provider, you will also be responsible for the office visit copayment)	No charge	40%
-----		

---

### Hearing Aid

- Hearing Aid Instrument and ancillary equipment (Plan payment maximum of \$1,000 per member every 24 months) No charge No charge
- Audiological exams No charge 40%

---

**Care Outside of Plan Service Area** 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/BlueShield provider.

- Within US: BlueCard Program See Applicable Benefit See Applicable Benefit
- Outside of US: BlueCard Worldwide See Applicable Benefit See Applicable Benefit

- 1 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.
- 2 Deductible and copayments marked with a (2) 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 Plan Contract for exact terms and conditions of coverage.
- 3 Participating non-Hospital based ("freestanding") outpatient X-ray, pathology and laboratory facilities centers may not be available in all areas. Regardless of their availability, you can obtain outpatient X-ray, pathology and laboratory 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 Participating ambulatory surgery facilities 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.
- 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 Plan Contract for further benefit details.
- 6 The maximum allowed charges for non-emergency hospital services received from a non-preferred hospital is \$600 per day. Members are responsible for 40 percent of this \$600 per day, plus all charges in excess of \$600.
- 7 Services may require prior authorization by Blue Shield. When these services are prior authorized, members pay the preferred or participating provider amount.
- 8 Mental health and chemical dependency (substance abuse) services are accessed through Blue Shield - using Blue Shield's participating and non-participating providers.
- 9 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's preferred providers or non-preferred providers.
- 10 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.
- 11 All outpatient chiropractic and acupuncture visits accrue to the calendar-year visit maximum regardless of whether the plan deductible has been met.
- 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.

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

A17268 (1/12)ME\_082511\_ASO