

City and County of San Francisco  
 Custom HMO 20-0 Inpatient Group #H11054  
 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, 2010 – June 30, 2011

<b>DEDUCTIBLES</b>	
<b>Plan year medical deductible</b>	None
<b>Plan year copayment maximum<sup>1</sup></b> (For many covered services)	\$1,000 per individual/\$2,000 per family
<b>LIFETIME MAXIMUM</b>	
	None
<b>Covered Services</b>	<b>Member Copayment</b>
<b>PROFESSIONAL SERVICES</b>	
<b>Professional (physician) benefits</b>	
<ul style="list-style-type: none"> <li>Physician and authorized specialist office visits  <small>Note: A woman may self-refer to an OB/GYN or family practice physician in her personal physician's medical group or IPA for OB/GYN services.</small></li> <li>Outpatient X-ray, pathology and laboratory</li> <li>Injectable medications (other than injectables for allergy)<sup>10</sup></li> </ul>	<ul style="list-style-type: none"> <li>\$20/visit</li> <li>No charge</li> <li>No charge</li> </ul>
<b>Allergy testing and treatment benefits</b>	
<ul style="list-style-type: none"> <li>Office visits (includes visits for allergy serum injections)</li> </ul>	\$20/visit
<b>Access+ Specialist<sup>SM</sup> benefits</b> (Self-referred office visits and consultations only) <sup>1, 2</sup>	
<ul style="list-style-type: none"> <li>Office visit, examination or other consultation</li> </ul>	\$30/visit
<b>Preventive care benefits</b>	
<ul style="list-style-type: none"> <li>Routine physical exams  <small>Note: A woman may self-refer to an OB/GYN or family practice physician in her personal physician's medical group or IPA for OB/GYN services.</small></li> <li>Vision and hearing screening (through the age of 18)</li> <li>Medically necessary immunizations (according to age schedule)</li> </ul>	<ul style="list-style-type: none"> <li>\$15/visit</li> <li>No charge</li> <li>No charge</li> </ul>
<b>OUTPATIENT SERVICES</b>	
<b>Hospital benefits (facility services)</b>	
<ul style="list-style-type: none"> <li>Outpatient surgery performed in a Participating Ambulatory Surgery Center (ASC)<sup>3</sup></li> <li>Outpatient surgery in a hospital</li> <li>Outpatient services for treatment of illness or injury and necessary supplies (Except as described under "Rehabilitation services")</li> </ul>	<ul style="list-style-type: none"> <li>\$50/surgery</li> <li>\$50/surgery</li> <li>No charge</li> </ul>
<b>HOSPITALIZATION SERVICES</b>	
<b>Hospital benefits (facility services)</b>	
<ul style="list-style-type: none"> <li>Inpatient physician benefits</li> <li>Semi-private room and board, medically necessary services and supplies</li> <li>Inpatient medically necessary skilled nursing services including subacute care<sup>4</sup></li> </ul>	<ul style="list-style-type: none"> <li>No charge</li> <li>\$100/admission</li> <li>No charge</li> </ul>
<b>EMERGENCY HEALTH COVERAGE</b>	
<ul style="list-style-type: none"> <li>Emergency room services not resulting in admission  <small>(Copayment does not apply if the member is directly admitted to the hospital for inpatient services)</small></li> <li>Emergency room physician services</li> </ul>	<ul style="list-style-type: none"> <li>\$100/visit</li> <li>No charge</li> </ul>
<b>AMBULANCE SERVICES</b>	
<ul style="list-style-type: none"> <li>Emergency or authorized transport</li> </ul>	\$50
<b>PRESCRIPTION DRUG COVERAGE</b>	
<b>Outpatient prescription drug benefits<sup>1</sup></b>	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 <b>(800) 424-6521</b> .
<b>PROSTHETICS/ORTHOTICS</b>	
<ul style="list-style-type: none"> <li>Prosthetic equipment and devices (Separate office visit copay may apply)</li> <li>Orthotic equipment and devices (Separate office visit copay may apply)</li> </ul>	<ul style="list-style-type: none"> <li>No charge</li> <li>No charge</li> </ul>
<b>DURABLE MEDICAL EQUIPMENT</b>	
<ul style="list-style-type: none"> <li>Durable medical equipment services<sup>1</sup></li> </ul>	No charge

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<b>MENTAL HEALTH SERVICES (PSYCHIATRIC)<sup>5</sup></b>	
• Inpatient hospital facility services	\$100/admission
• Outpatient mental health services	\$20/visit
<b>CHEMICAL DEPENDENCY SERVICES (SUBSTANCE ABUSE)<sup>7</sup></b> Please see footnote 6	
• Chemical dependency and substance abuse services	Not covered
<b>HOME HEALTH SERVICES</b>	
• Home health care agency services (Up to 100 visits per plan year)	\$20/visit
• Physicians home visits	\$25/visit
• Medical supplies (For home self-administered injectable medications, see "Prescription Drug Coverage.")	No charge
<b>HEARING AID SERVICES</b>	
• Audiological Evaluation	No charge
• Hearing Aid (up to a maximum of \$2,500 per member every 36 months for the hearing aid instrument and ancillary equipment)	No charge
<b>OTHER</b>	
<b>Hospice program benefits</b>	
• Routine home care	No charge
• Inpatient respite care	No charge
• 24-hour continuous home care	No charge
• General inpatient care	No charge
<b>Pregnancy and maternity care benefits</b>	
• Prenatal and postnatal physician office visits (For inpatient hospital services, see "Hospitalization Services.")	\$15/visit
<b>Family planning and infertility benefits</b>	
• Counseling and consulting	\$20/visit
• Infertility services (Diagnosis and treatment of causes of infertility. Excludes in vitro fertilization, injectables for infertility, artificial insemination and GIFT)	50% of allowed charges
• Tubal ligation <sup>8,9</sup>	\$100
• Elective abortion <sup>9</sup>	\$100
• Vasectomy <sup>9</sup>	\$75
<b>Rehabilitation services</b> (physical, occupational and respiratory therapy)	
• In an office location (Copayment applies to all place of services, including professional and facility settings)	\$20/visit
<b>Speech therapy benefits</b>	
• In an office location (Speech therapy services by a licensed speech pathologist or certified speech therapist)	\$20/visit
<b>Diabetes care benefits</b>	
• Devices, equipment and non-testing supplies (For testing supplies, see "Outpatient Prescription Drug Coverage Summary.")	No charge
• Diabetes self-management training	\$20/visit
<b>Urgent services benefits (BlueCard<sup>®</sup> Program)</b>	
• Urgent services outside your personal physician service area	\$50/visit
<b>Optional benefits<sup>1</sup></b> Optional dental, vision, chiropractic, chiropractic and acupuncture or infertility benefits are available. If your employer purchased any of these benefits, a description of the benefit is provided separately.	

1 Copayments marked with a (1) do not accrue to 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