

Access+ HMO® 15-20%/Zero Facility Deductible

Benefit Summary (For groups of 51 and above)

(Uniform Health Plan Benefits and Coverage Matrix)

Blue Shield of California

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

Effective July 1, 2010

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.

DEDUCTIBLES	
Calendar year facility deductible	None
Calendar year copayment maximum ¹ (For many covered services)	\$1,500 per member
LIFETIME MAXIMUM	
	None
Covered Services	Member Copayment
PROFESSIONAL SERVICES	
Professional (physician) benefits	
<ul style="list-style-type: none"> 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. 	\$15 per visit
<ul style="list-style-type: none"> Outpatient X-ray, pathology and laboratory 	No charge
Allergy testing and treatment benefits	
<ul style="list-style-type: none"> Office visits (includes visits for allergy serum injections) 	\$15 per visit
Access+ SpecialistSM benefits (Self-referred office visits and consultations only) ^{1,2}	
<ul style="list-style-type: none"> Office visit, examination or other consultation 	\$30 per visit
Preventive care benefits	
<ul style="list-style-type: none"> Routine physical exams 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. 	\$15 per visit
<ul style="list-style-type: none"> Vision and hearing screening (through the age of 18) 	No charge
<ul style="list-style-type: none"> Medically necessary immunizations (according to age schedule) 	No charge
OUTPATIENT SERVICES	
Hospital benefits (facility services)	
<ul style="list-style-type: none"> Outpatient surgery performed in a Participating Ambulatory Surgery Center (ASC)³ 	No charge
<ul style="list-style-type: none"> Outpatient surgery in a hospital 	No charge
<ul style="list-style-type: none"> Outpatient services for treatment of illness or injury and necessary supplies (Except as described under "Rehabilitation services") 	No charge
HOSPITALIZATION SERVICES	
Hospital benefits (facility services)	
<ul style="list-style-type: none"> Inpatient physician benefits 	No charge
<ul style="list-style-type: none"> Semi-private room and board, medically necessary services and supplies 	20%
<ul style="list-style-type: none"> Inpatient medically necessary skilled nursing services including subacute care⁴ 	20%
EMERGENCY HEALTH COVERAGE	
<ul style="list-style-type: none"> Emergency room facility services (Copayment does not apply if the member is directly admitted to the hospital for inpatient services) 	\$100 per visit
<ul style="list-style-type: none"> Emergency room physician services 	No charge
AMBULANCE SERVICES	
<ul style="list-style-type: none"> Emergency or authorized transport 	\$100
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	
<ul style="list-style-type: none"> Prosthetic equipment and devices (Separate office visit copay may apply) 	No charge
<ul style="list-style-type: none"> Orthotic equipment and devices (Separate office visit copay may apply) 	No charge
DURABLE MEDICAL EQUIPMENT	
<ul style="list-style-type: none"> Durable medical equipment services¹ (Plan payment up to \$2000 maximum per calendar year) 	50% of allowed charges

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MENTAL HEALTH SERVICES (PSYCHIATRIC)⁵

- Inpatient hospital facility services 20%
 - Outpatient mental health services \$15 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 calendar year) \$15per visit
 - Medical supplies No charge
- (For home self-administered injectable medications, see "Prescription Drug Coverage.")
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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 \$15 per visit
- (For inpatient hospital services, see "Hospitalization Services.")
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Family planning and infertility benefits

- Counseling and consulting \$15 per 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^{8,9} \$100 per surgery
 - Elective abortion⁹ \$100 per surgery
 - Vasectomy⁹ \$75 per surgery
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Rehabilitation services (physical, occupational and respiratory therapy)

- In an office location \$15 per visit
- (Copayment applies to all place of services, including professional and facility settings)
-

Speech therapy benefits

- In an office location \$15per visit
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Diabetes care benefits

- Devices, equipment and non-testing supplies 50% of allowed charges
- (For testing supplies, see "Outpatient Prescription Drug Coverage Summary.")
- Diabetes self-management training \$15 per isit
-

Urgent services benefits (BlueCard[®] 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 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 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 calendar-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.

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

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