

Access+ HMO SaveNet® 15-500/  
 Admit Inpatient  
 Benefit Summary (For groups of 51 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.

This plan has a special network including a limited number of Physicians, Independent Practice Associations (IPAs) and Medical Groups and a limited Service Area which includes only certain counties and cities as described in the Evidence of Coverage and Access+ HMO Comparison. You must live and/or work in this limited Service Area in order to enroll in this Plan.

Effective July 1, 2010

<b>DEDUCTIBLES</b>	
<b>Calendar year medical deductible</b>	None
<b>Calendar year copayment maximum</b> <sup>1</sup> (For many covered services)	\$2,000 per individual/\$4,000 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> </ul>	\$15 per visit  No charge
<b>Allergy testing and treatment benefits</b>	
<ul style="list-style-type: none"> <li>Office visits (includes visits for allergy serum injections)</li> </ul>	\$15 per 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 per 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>	No charge  No charge No charge
<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>	\$100 per surgery \$200 per surgery No charge
<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>	No charge \$500 per admission \$100 per day
<b>EMERGENCY HEALTH COVERAGE</b>	
<ul style="list-style-type: none"> <li>Emergency room services not resulting in admission (Copayment does not apply if the member is directly admitted to the hospital for inpatient services)</li> <li>Emergency room physician services</li> </ul>	\$100 per visit  No charge
<b>AMBULANCE SERVICES</b>	
<ul style="list-style-type: none"> <li>Emergency or authorized transport</li> </ul>	\$100
<b>PRESCRIPTION DRUG COVERAGE</b>	
<b>Outpatient prescription drug benefits</b> <sup>1</sup>	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>	No charge No charge
<b>DURABLE MEDICAL EQUIPMENT</b>	

An Independent Member of the Blue Shield Association

<ul style="list-style-type: none"> <li>Durable medical equipment services<sup>1</sup> (Plan payment up to \$2000 maximum per calendar year)</li> </ul>	20% of allowed charges
<b>MENTAL HEALTH SERVICES (PSYCHIATRIC)<sup>5</sup></b>	
<ul style="list-style-type: none"> <li>Inpatient hospital facility services</li> <li>Outpatient mental health services</li> </ul>	\$500 per admission \$15 per visit
<b>CHEMICAL DEPENDENCY SERVICES (SUBSTANCE ABUSE)<sup>7</sup></b>	
<b>Please see footnote 6</b>	
<ul style="list-style-type: none"> <li>Chemical dependency and substance abuse services</li> </ul>	Not covered
<b>HOME HEALTH SERVICES</b>	
<ul style="list-style-type: none"> <li>Home health care agency services (Up to 100 visits per calendar year)</li> <li>Medical supplies (For home self-administered injectable medications, see "Prescription Drug Coverage.")</li> </ul>	\$15 per visit No charge
<b>OTHER</b>	
<b>Hospice program benefits</b>	
<ul style="list-style-type: none"> <li>Routine home care</li> <li>Inpatient respite care</li> <li>24- hour continuous home care</li> <li>General inpatient care</li> </ul>	No charge No charge \$150 per day \$150 per day
<b>Pregnancy and maternity care benefits</b>	
<ul style="list-style-type: none"> <li>Prenatal and postnatal physician office visits (For inpatient hospital services, see "Hospitalization Services.")</li> </ul>	No charge
<b>Family planning and infertility benefits</b>	
<ul style="list-style-type: none"> <li>Counseling and consulting</li> <li>Infertility services (Diagnosis and treatment of causes of infertility. Excludes in vitro fertilization, injectables for infertility, artificial insemination and GIFT)</li> <li>Tubal ligation<sup>8,9</sup></li> <li>Elective abortion<sup>9</sup></li> <li>Vasectomy<sup>9</sup></li> </ul>	\$15 per visit 50% of allowed charges \$100 per surgery \$100 per surgery \$75 per surgery
<b>Rehabilitation services (physical, occupational and respiratory therapy)</b>	
<ul style="list-style-type: none"> <li>In an office location (Copayment applies to all place of services, including professional and facility settings)</li> </ul>	\$15 per visit
<b>Speech therapy benefits</b>	
<ul style="list-style-type: none"> <li>In an office location</li> </ul>	\$15 per visit
<b>Diabetes care benefits</b>	
<ul style="list-style-type: none"> <li>Devices, equipment and non-testing supplies (For testing supplies, see "Outpatient Prescription Drug Coverage Summary.")</li> <li>Diabetes self-management training</li> </ul>	20% of allowed charges \$15 per visit
<b>Urgent services benefits (BlueCard<sup>®</sup> Program)</b>	
<ul style="list-style-type: none"> <li>Urgent services outside your personal physician service area</li> </ul>	\$50 per visit
<b>Optional benefits<sup>1</sup></b>	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 MHS 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 (MHS) using Blue Shield's MHS 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