

# Access+ HMO® Plan 20

Benefit Summary (For groups 2 to 50)

(Uniform Health Plan Benefits and Coverage Matrix)

## Blue Shield of California

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 THE PLAN CONTRACT SHOULD BE CONSULTED FOR A DETAILED DESCRIPTION OF COVERAGE BENEFITS AND LIMITATIONS.

### DEDUCTIBLES

<b>Calendar-Year Medical Deductibles</b>	None
<b>Calendar-Year Copayment Maximum<sup>1</sup></b> (For many covered services)	\$2,500 per individual/\$5,000 per family

<b>LIFETIME MAXIMUM</b>	None
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Covered Services	Member Copayment
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### PROFESSIONAL SERVICES

#### Physician services – outpatient

<ul style="list-style-type: none"> <li>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.)</li> </ul>	\$20/visit
<ul style="list-style-type: none"> <li>Allergy testing</li> </ul>	\$20/visit
<b>Access+ Specialist<sup>SM</sup></b> (Self-referred office visits and consultations only) <sup>1,2</sup>	\$40/visit

<b>Laboratory, X-ray and diagnostic tests</b>	No charge
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<b>Preventive care</b>	No charge
<ul style="list-style-type: none"> <li>Routine physical exam, eye/ear screenings and immunizations according to age schedule (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.)</li> </ul>	No charge

### OUTPATIENT SERVICES

<b>Non-emergency</b>	
<ul style="list-style-type: none"> <li>Outpatient surgery performed in a participating ambulatory surgery center (ASC)<sup>3</sup></li> </ul>	\$300/surgery
<ul style="list-style-type: none"> <li>Outpatient surgery in hospital/facility</li> </ul>	\$500/surgery
<ul style="list-style-type: none"> <li>Outpatient treatment (except as described under "Rehabilitative therapy services"), and necessary supplies</li> </ul>	No charge

<b>HOSPITALIZATION SERVICES</b>	
<ul style="list-style-type: none"> <li>Inpatient physician services, including pregnancy and maternity care</li> </ul>	No charge
<ul style="list-style-type: none"> <li>Semi-private room and board, medically necessary services and necessary supplies</li> </ul>	\$1,000/admission
<ul style="list-style-type: none"> <li>Skilled nursing facility (SNF) services<sup>4</sup></li> </ul>	\$150/day

<b>EMERGENCY HEALTH COVERAGE</b>	
<ul style="list-style-type: none"> <li>Emergency room facility services (Copayment waived if the member is directly admitted to the hospital as an inpatient)</li> </ul>	\$100/visit
<ul style="list-style-type: none"> <li>Emergency room physician visits</li> </ul>	No charge

<b>AMBULANCE SERVICES</b>	\$50
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Covered Services	Member Copayment	
<p><b>PRESCRIPTION DRUG COVERAGE<sup>5, 6</sup></b> (Includes oral contraceptives, diaphragms, and covered diabetic drugs and testing supplies)</p> <ul style="list-style-type: none"> <li>Calendar-year brand-name drug deductible</li> <li>Generic drugs</li> <li>Formulary brand-name drugs</li> <li>Non-Formulary brand-name drugs</li> <li>Home self-administered injectable medications (Medications may require prior authorization from Blue Shield Pharmacy Services; member pays up to \$100 copayment maximum per prescription)</li> </ul>	<p><b>Participating Pharmacy</b> (For up to a 30-day supply)<sup>1</sup></p> <p>\$150 per member per calendar-year, applied to all covered brand-name and home self-administered injectable drugs.</p> <p>\$15/prescription</p> <p>\$30/prescription</p> <p>\$45/prescription</p> <p>20% of allowed charges</p>	<p><b>Mail Service Prescriptions</b> (For up to a 90-day supply)<sup>1</sup></p> <p>\$30/prescription</p> <p>\$60/prescription</p> <p>\$90/prescription</p> <p>Not covered charges</p>
<p><b>PROSTHETICS/ORTHOTICS</b> (Equipment and devices only. Separate office visit copay may apply)</p>	No charge	
<p><b>DURABLE MEDICAL EQUIPMENT<sup>1</sup></b> (Plan payment up to \$2,000 max per person per calendar year)</p>	50% of allowed charges	
<p><b>MENTAL HEALTH SERVICES (PSYCHIATRIC)<sup>7</sup></b></p> <ul style="list-style-type: none"> <li>Inpatient hospital facility services</li> <li>Outpatient visits for severe mental health conditions</li> <li>Outpatient visits for non-severe mental health conditions<sup>1</sup> (Up to 20 visits per calendar year combined with outpatient chemical dependency visits)</li> </ul>	<p>\$1,000/admission</p> <p>\$20/visit</p> <p>\$25/visit</p>	
<p><b>CHEMICAL DEPENDENCY SERVICES (SUBSTANCE ABUSE)<sup>7</sup> PLEASE SEE FOOTNOTE 10</b></p> <ul style="list-style-type: none"> <li>Inpatient services for medical acute detoxification</li> <li>Outpatient visits<sup>1</sup> (Up to 20 visits per calendar year combined with outpatient non-severe mental health visits)</li> </ul>	<p>\$1,000/admission</p> <p>\$25/visit</p>	
<p><b>HOME HEALTH SERVICES</b></p> <ul style="list-style-type: none"> <li>Agency visits (Up to 100 visits per calendar year)</li> <li>Medical supplies/IV (For home self-administered injectable drugs, see "Prescription Drug Coverage")</li> </ul>	<p>\$20/visit</p> <p>No charge</p>	
<p><b>OTHER</b></p> <p><b>Hospice</b></p> <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>	<p>No charge</p> <p>No charge</p> <p>\$150/day</p> <p>\$150/day</p>	
<p><b>Pregnancy and maternity care</b></p> <ul style="list-style-type: none"> <li>Prenatal and postnatal professional (physician) services (For all necessary inpatient hospital services, see "Hospitalization Services.")</li> </ul>	No charge	
<p><b>Family planning and infertility services</b></p> <ul style="list-style-type: none"> <li>Family planning counseling</li> <li>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> and elective abortion<sup>9</sup></li> <li>Vasectomy<sup>9</sup></li> </ul>	<p>\$20/visit</p> <p>50% of allowed charges</p> <p>\$100</p> <p>\$75</p>	
<p><b>Rehabilitative therapy services</b></p> <ul style="list-style-type: none"> <li>Outpatient visits (Copayment applies to all places of service, including professional and facility settings)</li> </ul>	\$20/visit	

**Covered Services**

**Member Copayment**

**Diabetes care**

- Equipment, devices and non-testing supplies (For testing supplies, see "Prescription Drug Coverage.") 50% of allowed charges
- Self-management training and education \$20/visit

**Urgent care outside service area (BlueCard® Program)**

**\$50/visit**

**Optional benefits<sup>1</sup>**

Optional dental, vision, chiropractic, chiropractic and acupuncture, or infertility benefit is 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 the 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 or substance abuse services must be provided by a MHSA network participating provider. Access+ Specialist visits for mental health services for non-severe mental illness, or non-serious emotional disturbances of a child or substance abuse will accrue toward the 20 visit per calendar year maximum.
- 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 days during a calendar year except when received through a hospice program provided by a participating hospice agency. This 100-day maximum on skilled nursing services is a combined maximum between SNF in a hospital unit and skilled nursing facilities.
- 5 If the member requests a brand-name drug and a generic drug equivalent is available, the member is responsible for paying the difference between the cost to Blue Shield of California of the brand-name drug and its generic drug equivalent, as well as the applicable generic drug copayment. Home self-administered injectable drugs are covered only when dispensed by select participating pharmacies in the Specialty Pharmacy Network. Drugs from non-participating pharmacies are not covered except in emergency and urgent situations. Please note that if you switch from another plan, your prescription drug deductible credit from the previous plan during the calendar year, if applicable, will not carry forward to your new plan.
- 6 This plan's prescription drug coverage is on average equivalent to or better than the standard benefit set by the federal government for Medicare Part D (also called "creditable" coverage). Since this plan's prescription drug coverage is creditable, you do not have to enroll in Medicare Part D while you maintain this coverage; however, you should be aware that if you have a subsequent break in this coverage of 63 days or more before enrolling in Medicare Part D you could be subject to payment of higher Medicare Part D premiums.
- 7 Mental health and chemical dependency services, other than medical acute detoxification, are accessed through Blue Shield's Mental Health Service Administrator (MHSA) — using Blue Shield's MHSA participating providers. Services for medical acute detoxification are accessed through Blue Shield using Blue Shield HMO 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.
- 8 Copayment waived when procedure is performed in conjunction with delivery or abdominal surgery.
- 9 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.
- 10 **Optional inpatient substance abuse treatment benefits are available. If your employer purchased these benefits, a description of the benefit is attached hereto as "Additional Substance Abuse Treatment Benefits".**

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