

# Core Flex HMO® 20

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.

**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.**

This plan is part of a package of 4 plans that must be offered together: Core Flex Basic HMO® 45, Core Flex HMO® 40, Core Flex HMO® 30, and Core Flex HMO® 20. You should receive a benefit summary to review for each plan. Please note that the rates you pay for yourself and your dependents vary between the plans. Your employer may have purchased a PPO plan in addition to this package. Please check with your employer for details.

Effective July 1, 2010

<b>DEDUCTIBLES</b>	
<b>Calendar year medical deductible</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
<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> </ul>	\$20 per visit
<ul style="list-style-type: none"> <li>Outpatient X-ray, pathology and laboratory</li> </ul>	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>	\$20 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>	\$20 per visit 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>	20% 20% 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 20% 20%
<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>	\$200 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<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>	No charge No charge

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<b>DURABLE MEDICAL EQUIPMENT</b>	
<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>	50% 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>	20% \$20 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>	\$20 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 \$200 per day \$200 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>	\$20 per visit
<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>	\$20 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>	\$20 per visit
<b>Speech therapy benefits</b>	
<ul style="list-style-type: none"> <li>In an office location</li> </ul>	\$20 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>	50% of allowed charges \$20 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.

<sup>1</sup> 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.

<sup>2</sup> 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.

<sup>3</sup> 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.

<sup>4</sup> 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.

<sup>5</sup> 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.

<sup>6</sup> **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."**

<sup>7</sup> 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.

<sup>8</sup> Copayment does not apply when procedure is performed in conjunction with delivery or abdominal surgery.

<sup>9</sup> 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