

Access+ HMOSM Plus Plan 10 Value

Benefit Summary (For groups of 51 and above)

(Uniform Health Plan Benefits and Coverage Matrix)

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, DISCLOSURE FORM AND PLAN CONTRACT SHOULD BE CONSULTED FOR A DETAILED DESCRIPTION OF COVERAGE BENEFITS AND LIMITATIONS.

There are Choice and Affiliate providers. Different copayments may apply for Choice or Affiliate providers. Refer to the footnotes for further information.

DEDUCTIBLES

Calendar-year medical deductible	None
Calendar-year copayment maximum[#]	\$2,000 per individual / \$4,000 per family
LIFETIME MAXIMUMS	None

Covered Services	Member Copayment
PROFESSIONAL SERVICES	
Physician services – outpatient	
– Physician and authorized specialist office visits	\$10/visit
<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>	
– Allergy testing or treatment	\$10/visit
Access+ SpecialistSM (Self-referred office visits and consultations only) ¹	\$30/visit
Laboratory, X-ray and diagnostic tests	No charge
Preventive care	
– Annual routine physical exam, eye/ear screenings and immunizations according to age schedule	No charge
<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>	
OUTPATIENT SERVICES	
Non-emergency	
– Outpatient surgery in hospital/facility ²	\$150/surgery
– Outpatient treatment (except as described under "Rehabilitative therapy services"), renal dialysis and necessary supplies ³	No charge
HOSPITALIZATION SERVICES	
– Inpatient physician services, including pregnancy and maternity care	No charge
– Semi-private room and board, medically necessary services and supplies ²	\$500/admission
– Skilled nursing facility (SNF) services ⁴	\$100/day
EMERGENCY HEALTH COVERAGE (Waived if the member is directly admitted to the hospital for inpatient services)	\$100/visit
AMBULANCE SERVICES	\$50
PRESCRIPTION DRUG COVERAGE	A description of your outpatient prescription drug coverage is provided separately. If you do not have the separate drug sheet that goes with this matrix, please contact your benefits administrator or call Member Services at 800-424-6521.
DURABLE MEDICAL EQUIPMENT	
– Home medical equipment, prosthetics/orthotics, oxygen, colostomy/ostomy supplies	20% of allowed charges (Plan payment up to \$2,000 maximum per calendar year)
MENTAL HEALTH SERVICES (PSYCHIATRIC)⁵	
– Inpatient hospital facility services	\$500/admission
– Outpatient visits for severe mental health conditions	\$10/visit
– Outpatient visits for non-severe mental health conditions (Up to 20 visits per calendar year combined with outpatient chemical dependency visits)	\$25/visit
CHEMICAL DEPENDENCY SERVICES (SUBSTANCE ABUSE)⁵, Please see footnote 8	
– Inpatient services for medical acute detoxification	See "Hospitalization Services"
– Outpatient visits (Up to 20 visits per calendar year combined with outpatient non-severe mental health visits)	\$25/visit

Covered Services**Member Copayment****HOME HEALTH SERVICES**

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| – Agency visits (Up to 100 visits per calendar year) | \$10/visit |
| – Medical supplies/IV solutions (For home self-administered injectable medications, see "Prescription Drug Coverage".) | No charge |

OTHER**Hospice**

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| – Routine home care and inpatient respite care | No charge |
| – 24 hour continuous home care and general inpatient care | \$75/day |

Pregnancy and maternity care

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| – Prenatal and postnatal physician office visits (For all necessary inpatient hospital services, see "Hospitalization Services".) | No charge |
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Family planning and infertility services

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| – Family planning counseling | \$10/visit |
| – Diagnosis and treatment of causes of infertility (Excludes in vitro fertilization, injectables for infertility, artificial insemination and GIFT) | 50% of allowed charges |
| – Tubal ligation ^{6, 7} and elective abortion ⁷ | \$100 |
| – Vasectomy ⁷ | \$75 |

Rehabilitative therapy services

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| – Outpatient visits (Copayment applies to all place of services, including professional and facility settings) | \$10/visit |
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Urgent care outside service area (BlueCard Program)

	\$50/visit
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Diabetes care

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| – Equipment, devices and non-testing supplies (For testing supplies, see "Prescription Drug Coverage".) | 20% of allowed charges |
| – Self-management training and education | \$10/visit |

Optional benefits 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.

Copayments and charges for services not included in the calculation of 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*, the *Disclosure Form* and the Group Health Service Contract for exact terms and conditions of coverage.

- 1 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.
- 2 There are Choice and Affiliate Access+ HMO hospitals. An additional \$100 member copayment per admission, visit or surgery will be charged for non-emergency hospital services obtained from an Affiliate provider.
- 3 There are Choice and Affiliate Access+ HMO hospitals. An additional \$10 member copayment per visit will apply for all non-emergency outpatient treatment obtained from an Affiliate provider.
- 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 Mental health and chemical dependency services, other than medical acute detoxification, are accessed through the mental health services administrator (MHSA) - US Behavioral Health Plan, California (USBHPC) - using 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.
- 6 Copayment waived when procedure is performed in conjunction with delivery or abdominal surgery.
- 7 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.
- 8 **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".**

Benefits are subject to modification for subsequently enacted state or federal legislation.

