

Access+ HMO[®] Plan 10

Benefit Summary

(Uniform Health Plan Benefits and Coverage Matrix)

Highlights: \$10/\$25/\$45 prescription drug coverage

Effective July 1, 2006

THIS MATRIX IS INTENDED TO BE USED TO HELP YOU COMPARE COVERAGE BENEFITS AND IS A SUMMARY ONLY. THE EVIDENCE OF COVERAGE AND THE GROUP HEALTH SERVICE AGREEMENT SHOULD BE CONSULTED FOR A DETAILED DESCRIPTION OF COVERAGE BENEFITS AND LIMITATIONS.

DEDUCTIBLES

Calendar-year medical deductible	None
Calendar-year copayment maximum [#] (For many covered services)	\$1,500 per individual/\$3,000 per family

LIFETIME MAXIMUMS

None

Covered Services	Member Copayment
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PROFESSIONAL SERVICES

Physician services – outpatient

<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. 	\$10/visit
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<ul style="list-style-type: none"> Allergy testing 	\$10/visit
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Access+ Specialist SM (Self-referred office visits and consultations only) ^{1,#}	\$30/visit
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Laboratory, X-ray and diagnostic tests	No charge
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Preventive care

<ul style="list-style-type: none"> 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. 	No charge
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OUTPATIENT SERVICES

Non-emergency

<ul style="list-style-type: none"> Outpatient surgery in hospital/facility 	\$50/surgery
<ul style="list-style-type: none"> Outpatient treatment (except as described under "Rehabilitative therapy services"), and necessary supplies 	No charge

HOSPITALIZATION SERVICES

<ul style="list-style-type: none"> Inpatient physician services, including pregnancy and maternity care 	No charge
<ul style="list-style-type: none"> Semi-private room and board, medically necessary services and supplies 	\$100/admission
<ul style="list-style-type: none"> Skilled nursing facility (SNF) services² 	\$75/day

EMERGENCY HEALTH COVERAGE

(Waived if the member is directly admitted to the hospital for inpatient services)	\$75/visit
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AMBULANCE SERVICES

\$50

PRESCRIPTION DRUG COVERAGE^{3,4}

(Includes oral contraceptives, diaphragms, and covered diabetic drugs and testing supplies)	Participating Pharmacy (For up to a 30-day supply) [#]	Mail Service Prescriptions (For up to a 90-day supply) [#]
<ul style="list-style-type: none"> Generic drugs 	\$10/prescription	\$20/prescription
<ul style="list-style-type: none"> Formulary brand-name drugs 	\$25/prescription	\$50/prescription
<ul style="list-style-type: none"> Non-Formulary brand-name drugs 	\$45/prescription	\$90/prescription
<ul style="list-style-type: none"> Home self-administered injectable drugs (May require prior authorization from Blue Shield Pharmacy Services) 	20% of allowed charges (up to \$100 copayment maximum per prescription) ³	Not covered

DURABLE MEDICAL EQUIPMENT[#]

<ul style="list-style-type: none"> Home medical equipment, prosthetics/orthotics, oxygen, colostomy/ostomy supplies 	50% of allowed charges (Orthosis benefits, except for services covered under diabetes care, are limited to a \$2,000 max. per person per calendar-year)
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MENTAL HEALTH SERVICES (PSYCHIATRIC)⁵

<ul style="list-style-type: none"> Inpatient hospital facility services 	\$100/admission
<ul style="list-style-type: none"> Outpatient visits for severe mental health conditions 	\$10/visit
<ul style="list-style-type: none"> Outpatient visits for non-severe mental health conditions[#] (Up to 20 visits per calendar year combined with outpatient chemical dependency visits) 	\$25/visit

Covered Services

Member Copayment

CHEMICAL DEPENDENCY SERVICES (SUBSTANCE ABUSE)⁵

Please See Footnote 8

- Inpatient services for medical acute detoxification \$100/admission
- Outpatient visits[#] (Up to 20 visits per calendar year combined with outpatient non-severe mental health visits) \$25/visit

HOME HEALTH SERVICES

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

OTHER

Hospice

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

Pregnancy and maternity care

- Prenatal and postnatal professional (physician) services No charge
(For all necessary inpatient hospital services, see "Hospitalization Services.")

Family planning and infertility services

- Family planning counseling \$10/visit
- Diagnosis and treatment of causes of infertility 50% of allowed charges
(Excludes in vitro fertilization, injectables for infertility, artificial insemination and GIFT)
- Tubal ligation^{6,7} and elective abortion⁷ \$100
- Vasectomy⁷ \$75

Rehabilitative therapy services

- Outpatient visits \$10/visit
(Copayment applies to all place of services, including professional and facility settings)

Urgent care outside service area (BlueCard[®] Program)

\$50/visit

Diabetes care

- Equipment, devices and non-testing supplies[#] 50% of allowed charges
(For testing supplies, see "Prescription Drug Coverage.")
- Self-management training and education \$10/visit

Optional benefits[#] 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.

Copayments marked with a (#) 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 *Group Health Service Agreement* 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 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.

3 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 to another Blue Shield of California or Blue Shield of California Life & Health Insurance Company plan, your prescription drug deductible credit from the previous plan during the calendar year, if applicable, will not carry forward to your new plan.

4 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).

5 Mental health and chemical dependency services, other than medical acute detoxification, are accessed through the mental health services administrator (MHSA) – U.S. 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 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.

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 by Blue Shield for subsequently enacted state or federal legislation.

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