

# Access+ HMO<sup>®</sup> Plan 5

## 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

<b>Calendar-year medical deductible</b>	None
<b>Calendar-year copayment maximum<sup>#</sup></b> (For many covered services)	\$1,000 per individual/\$2,000 per family

### LIFETIME MAXIMUMS

None

Covered Services	Member Copayment
------------------	------------------

### 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>	\$5/visit
--	-----------

<ul style="list-style-type: none"> <li>Allergy testing</li> </ul>	\$5/visit
---	-----------

<b>Access+ Specialist<sup>SM</sup></b> (Self-referred office visits and consultations only) <sup>1,#</sup>	\$30/visit
--	------------

<b>Laboratory, X-ray and diagnostic tests</b>	No charge
---	-----------

#### Preventive care

<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.</li> </ul>	No charge
--	-----------

### OUTPATIENT SERVICES

#### Non-emergency

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

### HOSPITALIZATION SERVICES

<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 supplies</li> </ul>	No charge
<ul style="list-style-type: none"> <li>Skilled nursing facility (SNF) services<sup>2</sup></li> </ul>	No charge

### EMERGENCY HEALTH COVERAGE

\$50/visit

(Waived if the member is directly admitted to the hospital for inpatient services)

### AMBULANCE SERVICES

\$50

### PRESCRIPTION DRUG COVERAGE<sup>3,4</sup>

(Includes oral contraceptives, diaphragms, and covered diabetic drugs and testing supplies)

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

### DURABLE MEDICAL EQUIPMENT<sup>#</sup>

<ul style="list-style-type: none"> <li>Home medical equipment, prosthetics/orthotics, oxygen, colostomy/ostomy supplies</li> </ul>	20% of allowed charges  (Orthosis benefits, except for services covered under diabetes care, are limited to a \$2,000 max. per person per calendar-year)
--	--

### MENTAL HEALTH SERVICES (PSYCHIATRIC)<sup>5</sup>

<ul style="list-style-type: none"> <li>Inpatient hospital facility services</li> </ul>	No charge
<ul style="list-style-type: none"> <li>Outpatient visits for severe mental health conditions</li> </ul>	\$5/visit
<ul style="list-style-type: none"> <li>Outpatient visits for non-severe mental health conditions<sup>#</sup> (Up to 20 visits per calendar year combined with outpatient chemical dependency visits)</li> </ul>	\$25/visit

**Covered Services**

**Member Copayment**

**CHEMICAL DEPENDENCY SERVICES (SUBSTANCE ABUSE)<sup>5</sup>**

**Please See Footnote 8**

- Inpatient services for medical acute detoxification No charge
- Outpatient visits<sup>#</sup> (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) \$5/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 No charge

**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 \$5/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<sup>6,7</sup> and elective abortion<sup>7</sup> \$100
- Vasectomy<sup>7</sup> \$75

**Rehabilitative therapy services**

- Outpatient visits \$5/visit  
(Copayment applies to all place of services, including professional and facility settings)

**Urgent care outside service area (BlueCard<sup>®</sup> Program)**

**\$50/visit**

**Diabetes care**

- Equipment, devices and non-testing supplies<sup>#</sup> 50% of allowed charges  
(For testing supplies, see "Prescription Drug Coverage.")
- Self-management training and education \$5/visit

**Optional benefits<sup>#</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.

# 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.*

®BlueCard, Blue Shield and the Shield symbols are registered marks of the BlueCross BlueShield Association, an Association of Independent Blue Cross and Blue Shield Plans. ®Access+ HMO is a registered mark and Access+ Specialist is a service mark of Blue Shield of California.



**Blue Shield of California**  
An Independent Member of the Blue Shield Association