

\$5 Copay Access+ HMO Plan

Benefits and Coverage Matrix

WITH ACCESS+ HMO, MEMBERS HAVE UNLIMITED LIFETIME BENEFITS. THIS BLUE SHIELD ACCESS+ HMO PLAN IS AVAILABLE TO GROUPS WITH TWO OR MORE ELIGIBLE EMPLOYEES.

DEDUCTIBLES

Calendar Year Medical Deductible	None
Calendar Year Copayment Maximum [#]	
– Per individual	\$1,000*
– Per family	\$2,000*

LIFETIME MAXIMUMS

None

COVERED SERVICES

MEMBER COPAYMENT

PROFESSIONAL SERVICES

Physician Services – Outpatient

– Personal Physician office visits and consultations	\$5/visit
– Specialist visits and consultations (with an authorized referral)	\$5/visit
– Obstetrical/Gynecological (OB/GYN) physician services (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.)	\$5/visit
– Allergy testing or treatment ³	\$5/visit
– Injectable medications administered during office visit (other than injectables for allergy ³)	No Charge

Access+ <i>Specialist</i> (self-referred office visits or consultations only ⁴)	\$30/visit
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Laboratory, X-ray and diagnostic tests	No Charge
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Preventive Care

– Scheduled Routine Physical Exams	No Charge
– Well-baby, child and adult exams according to age schedule	No Charge
– Annual gynecological exams (A woman may self-refer to an OB/GYN or Family Practice Physician in her Personal Physician's Medical Group or IPA.)	No Charge
– Immunizations	No Charge
– Vision screenings up to age 18 ¹⁰	No Charge

OUTPATIENT SERVICES

Non-Emergency

– Outpatient surgery ¹	No Charge
– Outpatient treatment, renal dialysis and necessary supplies ²	No Charge

HOSPITALIZATION SERVICES

– Inpatient physician visits and consultations	No Charge
– Surgeons and assistants, anesthesiologists, pathologists, radiologists	No Charge
– Semi-private room and board, medically necessary services and supplies, including subacute care ¹	No Charge

EMERGENCY HEALTH COVERAGE (waived if admitted directly to the hospital as an inpatient)	\$50/visit
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AMBULANCE SERVICES	\$50
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DURABLE MEDICAL EQUIPMENT

– Home medical equipment, prosthetics/orthotics, oxygen, colostomy/ostomy supplies	20% of Allowed Charges
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MENTAL HEALTH SERVICES (PSYCHIATRIC)⁵

– Inpatient services	No Charge
– Outpatient visits for severe mental health conditions	\$5/visit
– Outpatient visits for non-severe mental health conditions (up to 20 visits per calendar year combined with outpatient chemical dependency visits)	\$25/visit

* Copayments for many covered services accrue to the calendar-year copayment maximum.

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.

COVERED SERVICES

MEMBER COPAYMENT

CHEMICAL DEPENDENCY SERVICES (SUBSTANCE ABUSE)⁵

– 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

HOME HEALTH SERVICES

– Agency visits (up to 100 visits per calendar year)	\$5/visit
– Medical supplies/IV solutions/Home self injectables from Home Infusion Agency ⁹	No Charge
– Home self-injectables obtained from Blue Shield of California Participating Pharmacy ⁹	\$30/prescription up to 30 days supply

HOSPICE¹⁰

– Routine Home Care and Inpatient Respite Care	No Charge
– 24 Hour Continuous Home Care and General Inpatient Care	No Charge

OTHER

Pregnancy and Maternity Care

– Prenatal and postnatal physician office visits	No Charge
– All necessary inpatient hospital services	See "Hospitalization Services"

Family Planning and Infertility Services

– Family planning counseling	No Charge
– Diagnosis and treatment of causes of infertility ⁶	50% of Allowed Charges
– Elective abortion ¹² and tubal ligation ^{7,12}	\$100
– Vasectomy ¹²	\$75

Rehabilitative Therapy Services – Physical, Speech, Occupational and Respiratory Therapy

– Outpatient visits	\$5/visit
– In rehab unit of hospital	See "Hospitalization Services"
– In (Skilled Nursing Facility) SNF rehab unit ¹¹	No Charge

Skilled Nursing Facility Services (up to 100 days per calendar year)¹¹

No Charge

Diabetes Care

– Equipment, devices, and non-testing supplies (for testing supplies, please see "Prescription Drug Coverage")	50% of Allowed Charges
– Self-management training and education	\$5/visit

Urgent Care Outside Service Area (BlueCard Program)

\$50/visit

PRESCRIPTION DRUG COVERAGE^{8*}

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

	Participating Pharmacy (for up to a 30-day supply per prescription)	Mail Service Prescriptions (for up to a 90-day supply per prescription)
– Generic Drugs	\$5	\$10
– Formulary Brand Drugs	\$15	\$30

¹ There are Choice and Affiliated Access+ HMO hospitals. An additional \$100 member copayment per day, visit or surgery will be charged for non-emergency hospital services obtained from an Affiliated Provider. The additional \$100 member copayment per day charge is limited to a 7 days per Calendar Year maximum. Services received from Affiliated Providers do not apply to the calendar year copayment maximum.

² There are Choice and Affiliated Access+ HMO hospitals. An additional \$10 member copayment per visit will apply for all non-emergency outpatient treatment obtained from an Affiliated Provider. Services received from an Affiliated Provider do not apply to the calendar year copayment maximum.

³ Serum administered during the office visit is included. For serum purchased separately from the office visit, the member copayment is 50% of Allowed Charges.

⁴ 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 an 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 towards the 20-visit per calendar-year maximum. In addition, all Access+ *Specialist* visits require a \$30 member copayment per visit.

⁵ 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. For mental health and chemical dependency, other than medical acute detoxification, services are administered through the Mental Health Services Administrator (MHSA) utilizing MHSA Participating Providers. Inpatient services for medical acute detoxification are accessed through Blue Shield using Blue Shield HMO Plan Providers.

⁶ *In vitro* fertilization, injectables for infertility, artificial insemination and GIFT are excluded. See page 43 for information about the optional infertility benefit.

⁷ Copayment does not apply when performed in conjunction with delivery or abdominal surgery.

⁸ Only drugs on the *Blue Shield Drug Formulary* are covered unless prior authorized by Blue Shield Pharmacy Services. If the physician or member requests a brand name drug and a generic is available, the member is responsible for the difference in cost between the brand and the generic in addition to the generic copayment. Drugs from non-participating pharmacies are not covered.

⁹ Home self injectable medications may require prior authorization by Blue Shield.

¹⁰ Covered Hospice Services received from any Hospice agency must be prior authorized by Blue Shield. If Blue Shield prior authorizes Hospice Services from a Non-Participating Hospice agency, those Hospice Services will be reimbursed at the Participating Hospice Agency level.

¹¹ Skilled Nursing services are limited to 100 days during any 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 Hospital and Skilled Nursing Facilities.

¹² Physician services copayment in the office or outpatient hospital facility only. If procedure is performed in an inpatient hospital facility setting, additional hospital services copayment will apply.

This chart is only a summary of the \$5 Copay Access+ HMO Plan. Please see the Evidence of Coverage, the Disclosure Form and the Group Health Service Contract for the exact terms and conditions of coverage.

Benefits are subject to modification for subsequently-enacted State or Federal legislation.

