

Access+ HMO Plan



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

Uniform Health Plan Benefits & Coverage Matrix

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.

All the benefits listed below are covered by the Access+ HMO plan. Plan services and supplies are covered when performed, prescribed or authorized by your Personal Physician. Other than the exceptions listed in the EOC, services that are not obtained from or approved by your Personal Physician will not be covered.

Benefits that are available before you meet any deductible are shown in a shaded box. **Please note:** Network hospitals are designated as either **Choice** or **Affiliate**, and different copayments may apply. Please see the Glossary for descriptions of **Choice** and **Affiliate** Hospitals.

DEDUCTIBLE*	\$1,500 (\$3,000 Family)
CALENDAR-YEAR OUT-OF-POCKET MAXIMUM The calendar year out-of-pocket maximum includes the plan deductible. (The copayments indicated with ∞ do not apply towards the out-of-pocket maximum amount.)	\$3,000 (\$6,000 Family)
LIFETIME MAXIMUM	No Limit
* Benefits for covered brand-name drugs are subject to a separate \$150 brand-name drug deductible per person for formulary and non-formulary.	

COVERED SERVICES ¹		MEMBER COPAYMENTS	
PROFESSIONAL SERVICES			
– Personal Physician office visits, specialists, OB/GYN services, urgent care, allergy testing and treatment, asthma self-management training		\$10/visit	
– Allergy serum purchased separately for treatment		50%	
– Injectable medications, lab and X-ray (infertility injectables are not covered; insulin is covered under the outpatient prescription drug benefit)		No Charge	
– Access+ <i>Specialist</i> (Self-referred physician office visits and other consultations only) ²		\$30/visit [∞]	
– Physician home visits		\$25/visit	
PREVENTIVE CARE			
– Scheduled Routine Physical Exams, annual Gynecological Exam, immunizations, vision, hearing and routine lab screenings		No Charge	
OUTPATIENT SERVICES			
Non-Emergency			
– Outpatient Surgery (in a hospital)		\$150/visit with Choice Hospitals \$250/visit with Affiliate Hospitals	
– Outpatient Surgery (in an Ambulatory Surgery Center)		\$150/visit	
– Outpatient Services and Supplies (in a hospital; includes radiation and intravenous chemotherapy)		\$25/visit with Choice Hospitals \$35/visit with Affiliate Hospitals	
– Outpatient Services and Supplies (in an Ambulatory Surgery Center)		\$25/visit	
HOSPITALIZATION SERVICES			
– Inpatient physician visits and consultations, surgeons and assistants, anesthesiologists, pathologists, radiologists (covered inpatient hospital, skilled nursing facility and subacute care physician services)		No Charge	
– Inpatient semiprivate room and board, intensive care units, subacute care, special treatment rooms, services and supplies		No Charge w/ Choice Hospitals \$150/admit w/ Affiliate Hospitals	
EMERGENCY HEALTH COVERAGE			
– Emergency room services (\$50 copayment waived if the member is admitted directly to the hospital as an inpatient)		\$50/visit	
– Inpatient hospital services and supplies		No Charge w/Choice Hospitals \$150/admit w/Affiliate Hospitals	
AMBULANCE SERVICES (Surface or Air) ³			
		\$50/trip	
PRESCRIPTION DRUG COVERAGE ⁴ (brand-name drugs subject to a \$150 brand-name drug deductible; includes coverage for formulary drugs, formulary oral contraceptives, diaphragms, diabetic testing supplies, asthma inhalers and inhaler spacers)		At Participating Pharmacies (up to a 30-day supply)	Mail Service Prescriptions (up to a 60-day supply)
– Generic drugs		\$10/prescription [∞]	\$20/prescription [∞]
– Formulary brand-name drugs ⁵		\$30/prescription [∞]	\$60/prescription [∞]
– Home self-administered injectables ⁶		20% (up to \$100/prescription) [∞]	Not Covered
DURABLE MEDICAL EQUIPMENT			
– Prosthetics, Orthotics ⁷ , Home Medical Equipment, Asthma Nebulizers (including face masks and tubing) and Peak Flow Monitors		50% [∞]	

COVERED SERVICES¹**MEMBER COPAYMENTS****MENTAL HEALTH SERVICES^{8,11}**

- Inpatient Hospital Facility Services
- Inpatient Physician Services
- Outpatient visits for severe mental health conditions²
- Outpatient visits for non-severe mental health conditions (up to 20 visits per calendar year combined with chemical dependency visits)²

No Charge
No Charge
\$10/visit (\$30/visit if provider is
MHSA Access+ *Specialist* provider)
\$25/visit³ (\$30/visit if provider is
MHSA Access+ *Specialist* provider)

CHEMICAL DEPENDENCY SERVICES (Substance Abuse)¹¹

- Inpatient hospital facility services for medical acute detoxification
- Outpatient visits (up to 20 visits per calendar year combined with non-severe mental health visits)²

No Charge w/Choice Hospitals
\$150/admit w/Affiliate Hospitals
\$25/visit³ (\$30/visit if provider is
MHSA Access+ *Specialist* provider)

HOME HEALTH SERVICES (up to 100 visits per calendar year)

- Home Health Agency visits (up to 4 visits per day, 2 hours per visit)
- Consultations and evaluations by a licensed medical social worker, and medically necessary services or supplies which would be covered in the hospital

\$10/visit
No Charge

OTHER**Pregnancy and Maternity Care^{9,10}**

- Outpatient prenatal and postnatal physician office visits
- Delivery and all necessary inpatient hospital services

No Charge
No Charge w/ Choice Hospitals
\$150/admit w/ Affiliate Hospitals

Family Planning

- Counseling
- Tubal ligation,¹⁰ elective abortion
- Vasectomy
- Injectable Contraceptives¹²

\$10/visit
\$100/occurrence
\$75/occurrence
\$25 per injection

Rehabilitation Services - physical, occupational and respiratory therapy

- Received in a physician's office visit or in a hospital outpatient department
- In Inpatient rehabilitation unit of hospital

\$10/visit
No Charge with Choice Hospitals
\$150/admit with Affiliate Hospitals

Skilled Nursing Facility (SNF) and Subacute Care (subject to all of the inpatient hospital services provisions and limited to a benefit maximum of 100 days per calendar year; custodial care is not covered)

\$50/day

Urgent Care (outside your Plan Service Area)¹³

\$50/visit

Diabetes Care

- Diabetic Equipment (diabetic testing supplies are covered under the Outpatient Prescription Drug benefit.)
- Diabetes Self-Management Training

50%
\$10/day

Dental Services (for details please see the Dental Highlights Matrix, page 43)

- Access+ *Dentist*

Embedded within this Plan

Other optional dental benefits are available for an additional cost through the Blue Shield Dental PPO or Dental HMO plans.

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

- Access+ HMO benefits are provided only for services that are medically necessary, as determined by the Personal Physician or Access+ HMO except in an emergency or as otherwise specified, and must be received while the patient is a current member. Mental health and substance abuse services are accessed through the mental health services administrator (MHSA) utilizing MHSA participating providers.
- To use the Access+ *Specialist* option, for other than mental health or substance abuse services, your Personal Physician must belong to a medical group or IPA that has decided to become an Access+ Provider Group. Access+ *Specialist* visits for mental health services for other than Severe Mental Illnesses or Serious Emotional Disturbances of a Child, and for Substance Abuse Care will accrue towards the 20-visit-per-calendar-year maximum. In addition, all Access+ *Specialist* visits require a \$30 copayment per visit. Mental health and substance abuse Access+ *Specialist* visits are accessed through the MHSA utilizing MHSA participating providers.
- Members who reasonably believe that they have an emergency medical condition which requires an emergency response are encouraged to appropriately use the 911 emergency response system where available.
- Only medically necessary outpatient formulary drugs are covered. The drug formulary is a comprehensive list of recommended drugs based on safety, efficacy, FDA bioequivalency and cost-effectiveness, and is reviewed and updated four times per year. Always present your Blue Shield ID card to obtain benefits for prescription drugs at a participating pharmacy. Call Member Services to find out if a particular drug is on the formulary, or to request a copy of the formulary. The most current version of the formulary may be accessed on the Blue Shield of California Web site at mylifepath.com. Non-formulary drugs may be covered only if prior authorization is obtained from Blue Shield Pharmacy Services. After all necessary documentation is available from your Physician, prior authorization approval or denial will be provided to your Physician within two working days of the request.
- Only drugs in the Blue Shield Drug Formulary are covered. If a member or the physician requests a brand-name drug when an equivalent generic drug is available, the member pays the generic copayment plus the cost difference between the brand and generic drug at retail or mail order pharmacies.
- Home self-administered injectables are available through pharmacies designated in a specialty network. They are only covered when obtained from a pharmacy designated in a specialty network, and they require prior authorization from Blue Shield Pharmacy Services.
- All covered orthotic equipment and services have a benefit maximum of \$2,000 per member per calendar year, except those services covered under the Diabetes Care benefit.
- 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 (EOC)*.
- Except for the treatment of involuntary complications of pregnancy, pregnancy/maternity benefits for a pregnancy that qualifies as a Waivered Condition are not available during the six-month period beginning as of the effective date of coverage. Coverage is applied for inpatient benefits of no less than 48 hours following a normal delivery and no less than 96 hours following a delivery by cesarean section, unless the treating physician, in consultation with the mother, decides on an early discharge.
- The tubal ligation copayment does not apply when the procedure is performed in conjunction with delivery or abdominal surgery.
- Blue Shield of California has contracted with a specialized health care service plan to act as the plan's mental health services administrator (MHSA) and to provide mental health and substance abuse services, other than inpatient services for medical acute detoxification, through a separate network of MHSA participating providers. Inpatient services for medical acute detoxification are accessed through Blue Shield utilizing HMO network providers. For all other mental health and substance abuse services, members should access MHSA participating providers.
- Member is responsible for the office visit copayment in addition to the \$25 copayment for the injectable contraceptives.
- Authorization by Blue Shield is required for more than two out-of-area follow-up outpatient visits or for out-of-area follow-up care that involves a surgical or other procedure or inpatient stay. After all necessary documentation is available from your Physician, prior authorization approval or denial will be provided to your Physician within two working days of the request.