

# Access+ HMO® 20-250/Admit Inpatient Benefit Summary (For groups of 51 and above)

(Uniform Health Plan Benefits and Coverage Matrix)

## Blue Shield of California

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.**

Effective January 1, 2008

DEDUCTIBLES	
Calendar-year medical deductible	None
Calendar-year copayment maximum <sup>1</sup> (For many covered services)	\$1,500 per individual/ \$3,000 per family
LIFETIME MAXIMUMS	
	None
Covered Services	Member Copayment
PROFESSIONAL SERVICES	
<b>Physician services – outpatient</b>	
<ul style="list-style-type: none"> <li>Physician and authorized specialist office visits <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></li> </ul>	\$20/visit
<ul style="list-style-type: none"> <li>Allergy testing or treatment</li> </ul>	\$20/visit
<ul style="list-style-type: none"> <li><b>Access+ Specialist<sup>SM</sup></b> (Self-referred office visits and consultations only)<sup>1, 2</sup></li> </ul>	\$30/visit
<b>Laboratory, X-ray and diagnostic tests</b>	No charge
<b>Preventive care</b>	
<ul style="list-style-type: none"> <li>Routine physical exam <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></li> <li>Eye/ear screenings and immunizations according to age schedule</li> </ul>	No charge
OUTPATIENT SERVICES	
<b>Non-emergency</b>	
<ul style="list-style-type: none"> <li>Outpatient surgery performed in a Participating Ambulatory Surgery Center<sup>3</sup> (ASC)</li> <li>Outpatient surgery in hospital/facility</li> <li>Outpatient treatment (Except as described under "Rehabilitative therapy services"), and necessary supplies</li> </ul>	\$100/surgery \$150/surgery No charge
HOSPITALIZATION SERVICES	
<ul style="list-style-type: none"> <li>Inpatient physician services, including pregnancy and maternity care</li> <li>Semi-private room and board, medically necessary services and supplies</li> <li>Skilled nursing facility (SNF) services<sup>4</sup></li> </ul>	No charge \$250/admission \$100/day
EMERGENCY HEALTH COVERAGE	
<ul style="list-style-type: none"> <li>Emergency room facility services (Waived if the member is directly admitted to the hospital for inpatient services)</li> <li>Emergency room physician visits</li> </ul>	\$100/visit No charge
AMBULANCE SERVICES	
	\$50
<b>PRESCRIPTION DRUG COVERAGE<sup>1</sup></b>	A description of your outpatient prescription drug coverage is provided separately. If you do not have the separate drug sheet that goes with this benefit summary, please contact your benefits administrator or call Member Services at <b>(800) 424-6521</b> .
PROSTHETICS/ORTHOTICS (Equipment and devices only)	
	No charge
DURABLE MEDICAL EQUIPMENT <sup>1</sup>	
	20% of allowed charges (Plan payment up to \$2000 maximum per calendar year)
MENTAL HEALTH SERVICES (PSYCHIATRIC) <sup>5</sup>	
<ul style="list-style-type: none"> <li>Inpatient hospital facility services</li> <li>Outpatient visits for severe mental health conditions</li> <li>Outpatient visits for non-severe mental health conditions<sup>1</sup> <small>(Up to 20 visits per calendar year combined with outpatient chemical dependency visits)</small></li> </ul>	\$250/admission \$20/visit \$25/visit
CHEMICAL DEPENDENCY SERVICES (SUBSTANCE ABUSE) <sup>5</sup>	
<b>Please see footnote 6</b>	
<ul style="list-style-type: none"> <li>Inpatient services for medical acute detoxification</li> <li>Outpatient visits<sup>1</sup> <small>(Up to 20 visits per calendar year combined with outpatient non-severe mental health visits)</small></li> </ul>	See "Hospitalization Services" \$25/visit

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**HOME HEALTH SERVICES**

- Agency visits (Up to 100 visits per calendar year) \$20/visit
  - Medical supplies/IV solutions No charge  
(For home self-administered injectable medications, see "Prescription Drug Coverage.")
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**OTHER****Hospice**

- Routine home care and inpatient respite care No charge
  - 24 hour continuous home care and general inpatient care \$150/day
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**Pregnancy and maternity care**

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

- Family planning counseling \$20/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>7, 8</sup> and elective abortion<sup>7, 8</sup> \$100
  - Vasectomy<sup>8</sup> \$75
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**Rehabilitative therapy services**

- Outpatient visits \$20/visit  
(Copayment applies to all place of services, including professional and facility settings)
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**Urgent care outside service area (BlueCard<sup>®</sup> Program)**

\$50/visit

**Diabetes care**

- Equipment, devices and non-testing supplies 20% of allowed charges  
(For testing supplies, see "Prescription Drug Coverage.")
  - Self-management training and education \$20/visit
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**Optional benefits**<sup>1</sup> 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.

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1 Copayments marked with a (1) do not accrue to 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, the Disclosure Form and the Plan Contract for exact terms and conditions of coverage.

2 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.

3 Participating ambulatory surgery centers may not be available in all areas. Regardless of their availability, you can obtain outpatient surgery services from a hospital or an ambulatory surgery center affiliated with a hospital; with payment according to your health plan's hospital services benefits.

4 Skilled nursing services are limited to 100 preauthorized days during a calendar-year except when received through a hospice program provided by a participating hospice agency. This preauthorized 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) - 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 **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."**

7 Copayment waived when procedure is performed in conjunction with delivery or abdominal surgery.

8 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.

Plan designs may be modified to ensure compliance with state and federal requirements