

Access+ HMO plan

Uniform Health Plan Benefits and 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.

	Access+ HMO Plan
Deductible*	\$2,000 (\$4,000 family)
Calendar-year copayment maximum (includes the plan deductible – some services do not apply)	\$3,000 (\$6,000 family)
Lifetime maximum	No limit

* Benefits for covered brand-name drugs are subject to a separate brand-name drug deductible per person for formulary and non-formulary. The brand-name drug deductibles are as follows: Access+ HMO has a \$200 brand-name drug deductible.

● Plan benefits provided before you need to meet any medical deductible are shown below with a dot.

Plan services and supplies are covered when performed, prescribed or authorized by your Personal Physician. Limitations and exclusions apply for certain services that are not obtained from or approved by your Personal Physician. See the EOC for details.

Covered services¹

Member copayments

Covered services ¹	Member copayments
Professional services	
Personal Physician office visits	\$20/visit ●
Injectable medications, lab, and X-ray	\$20 ●
Access+ <i>Specialist</i> (self-referred physician office visits or other consultations only) ³	\$35/visit ² ●
Physician home visits	\$35 ●
Preventive care	
Scheduled routine physical exams, annual gynecological exam, immunizations, vision, hearing, and routine lab screenings	\$20 ●
Outpatient services	
Outpatient surgery (in a hospital)	\$250/visit
Outpatient surgery performed in an ambulatory surgery center (ASC) ⁴	\$150/visit
Outpatient services and supplies (in a hospital; includes radiation and intravenous chemotherapy)	\$35/visit ●
Outpatient or out-of-hospital X-ray and laboratory	\$20/visit ●
Hospitalization services	
Inpatient physician visits and consultations, surgeons and assistants, and anesthesiologists (covered inpatient hospital, skilled nursing facility, and subacute care physician services)	\$20/visit ●
Inpatient semiprivate room and board, intensive care units, subacute care, special treatment rooms, services, and supplies	\$250/admit
Emergency health coverage	
Emergency room facility services (copayment/visit waived if the member is admitted directly to the hospital as an inpatient)	\$75/visit ●
Ambulance services (surface or air)	\$50/trip ●

Prescription drug coverage ^{5,6}	At participating pharmacies	Mail service prescriptions
	(up to a 30-day supply)	(up to a 60-day supply)
Generic drugs	\$10/prescription ² ●	\$20/prescription ² ●
Formulary brand-name drugs	\$35/prescription ²	\$70/prescription ²
Brand name drug deductible (brand-name drugs subject to a brand-name drug deductible per person, per calendar year)	\$200	

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Covered services ¹	Member copayments
Durable medical equipment⁷	50% ² ●
Mental health services⁸	
Inpatient hospital facility services	\$250/admit
Inpatient physician services	\$20/visit ●
Outpatient visits for severe mental health conditions	\$20/visit (\$35/visit ² if provider is MHSA Access+ <i>Specialist</i> provider) ³ ●
Outpatient visits for non-severe mental health conditions (up to 20 visits per calendar year combined with chemical dependency visits) ⁹	\$20/visit ² (\$35/visit ² if provider is MHSA Access+ <i>Specialist</i> provider) ³ ●
Chemical dependency services⁸ (substance abuse)	
Inpatient hospital facility services for medical acute detoxification	\$250/admit
Outpatient visits (up to 20 visits per calendar year combined with non-severe mental health visits) ⁹	\$20/visit ² (\$35/visit ² if provider is MHSA Access+ <i>Specialist</i> provider) ³ ●
Home health services (up to 100 visits per calendar year)	
Home health agency visits (up to 4 visits per day, 2 hours per visit)	\$20 ●
Other	
Pregnancy and maternity care¹⁰	
Outpatient prenatal and postnatal physician office visits	\$20/visit ●
Delivery and all necessary inpatient hospital services	\$250/admit
Family planning	
Counseling	\$20/visit ●
Tubal ligation, ¹¹ elective abortion	\$100/occurrence ●
Vasectomy	\$75/occurrence ●
Rehabilitation services – physical, occupational, and respiratory therapy	
Received in a physician's office visit or in hospital outpatient department	\$20/visit ●
In an inpatient rehabilitation unit of hospital	\$250/admit
Urgent care (outside your plan service area) ¹²	\$50/visit ●
Dental services	
Access+ Dentist	Included within this plan

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

- Plan benefits provided before you need to meet the medical deductible.
- 1 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.
- 2 These copayments do not accrue to the copayment maximum.
- 3 To use the Access+ *Specialist* option, for other than mental health or chemical dependency 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 chemical dependency care, will accrue toward the 20-visit-per-calendar-year maximum. In addition, all Access+ *Specialist* visits require a copayment per visit. Mental health and chemical dependency Access+ *Specialist* visits are accessed through the MHSA utilizing MHSA participating providers.
- 4 Participating ambulatory surgery centers (ASCs) may not be available in all areas. Regardless of their availability, you can obtain outpatient surgery services from a hospital, or an ASC affiliated with a hospital with payment according to your health plan's hospital services benefits.
- 5 Only medically necessary outpatient formulary drugs are covered, unless prior authorization is obtained from Blue Shield Pharmacy Services. 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. Member is then responsible for the brand prescription copayment. Prescription coverage differs for home self-injectables. Please see the EOC for details.
- 6 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.
- 7 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.
- 8 Blue Shield of California has contracted with a specialized healthcare service plan to act as the plan's mental health services administrator (MHSA) and to provide mental health and chemical dependency 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 (not MHSA) providers. For all other mental health and chemical dependency services, members should access MHSA participating providers.
- 9 For MHSA participating providers, initial visit treated as if the condition were a severe mental illness or serious emotional disturbance of a child. For MHSA non-participating providers, initial visit treated as an MHSA participating provider.
- 10 Except for the treatment of involuntary complications of pregnancy, pregnancy/maternity benefits for a pregnancy that qualifies as a waived condition are not available during the six-month period beginning as of the effective date of coverage.
- 11 The tubal ligation copayment does not apply when the procedure is performed in conjunction with delivery or abdominal surgery.
- 12 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.