

Access+ Value HMO



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.

Access+ Value HMO	
DEDUCTIBLE*	\$2,000 (\$4,000 Family)
CALENDAR-YEAR OUT-OF-POCKET MAXIMUM The calendar year copayment maximum includes the plan deductible (The copayments indicated with ∞ do not apply towards the out-of-pocket maximum amount.)	\$4,000 (\$8,000 Family)
LIFETIME BENEFIT MAXIMUM	No Limit
* Benefits for covered brand-name drugs are subject to a separate \$400 brand-name drug deductible per person for formulary and non-formulary.	

All the benefits listed below are covered by the Access+ Value 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.

COVERED SERVICES ¹	MEMBER COPAYMENTS	
PROFESSIONAL SERVICES		
– Personal Physician office visits		\$35/visit
– Injectable medications, lab and X-ray		\$35
– Access+ <i>Specialist</i> (Self-referred physician office visits or other consultations only) ²		\$50/visit [∞]
– Physician home visits		\$50/visit
PREVENTIVE CARE		
– Scheduled Routine Physical Exams, annual Gynecological Exam, immunizations, vision, hearing and routine lab screenings		\$35
OUTPATIENT SERVICES		
Non-Emergency		
– Outpatient Surgery (in a hospital)		40%/visit
– Outpatient Services and Supplies (in a hospital; includes radiation and intravenous chemotherapy)		40%/visit
HOSPITALIZATION SERVICES		
– Inpatient physician visits and consultations, surgeons and assistants, and anesthesiologists, (covered inpatient hospital, skilled nursing facility and subacute care physician services)		\$35/visit
– Inpatient semiprivate room and board, intensive care units, subacute care, special treatment rooms, services and supplies		40%/admit
EMERGENCY HEALTH COVERAGE		
– Emergency room services (\$150 copayment waived if the member is admitted directly to the hospital as an inpatient)		\$150/visit
– Inpatient hospital services and supplies		40%/admit
AMBULANCE SERVICES (Surface or Air)		
		\$50/trip
PRESCRIPTION DRUG COVERAGE³ (Brand-name drugs subject to a \$400 brand-name drug deductible. Prescription coverage differs for Home Self-Injectables. Please review the EOC before you purchase the plan.)		
	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 ⁴	\$35/prescription [∞]	\$70/prescription [∞]
DURABLE MEDICAL EQUIPMENT⁵		
		50% [∞]
MENTAL HEALTH SERVICES⁸		
– Inpatient Hospital Facility Services		40%/admit
– Inpatient Physician Services		\$35/visit
– Outpatient visits for severe mental health conditions ²		\$35/visit (\$50/visit [∞] if provider is MHSA Access+ <i>Specialist</i> provider)
– Outpatient visits for non-severe mental health conditions (up to 20 visits per calendar year combined with chemical dependency visits) ²		\$35/visit [∞] (\$50/visit [∞] if provider is MHSA Access+ <i>Specialist</i> provider)

COVERED SERVICES¹**MEMBER COPAYMENTS****CHEMICAL DEPENDENCY SERVICES** (Substance Abuse)⁸

– Inpatient hospital facility services for medical acute detoxification	40%/admit
– Outpatient visits (up to 20 visits per calendar year combined with non-severe mental health visits) ²	\$35/visit [∞] (\$50/visit [∞] if provider is MHSA Access+ <i>Specialist</i> 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)	\$35/visit
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OTHER**Pregnancy and Maternity Care⁶**

– Outpatient prenatal and postnatal physician office visits	\$35/visit
– Delivery and all necessary inpatient hospital services	40%/admit

Family Planning

– Counseling	\$35/visit
– Tubal ligation, ⁷ elective abortion	\$100/occurrence
– Vasectomy	\$75/occurrence

Rehabilitation Services – physical, occupational and respiratory therapy

– Received in a physician office visit or in hospital outpatient department	\$35/visit
– In Inpatient rehabilitation unit of hospital	40%/admit

Urgent Care (outside your Plan Service Area)⁹

	\$50/visit
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Dental Services (for details please see the Dental Highlights Matrix in the Dental, Life Insurance product sheet)

– Access+ <i>Dentist</i>	Not Covered
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Please Note: Benefits are subject to modification for subsequently enacted state or federal legislation. Access+ Value HMO is subject to regulatory approval.

- 1 Access+ Value HMO benefits are provided only for services that are medically necessary, as determined by the Personal Physician or Access+ Value HMO except in an emergency or as otherwise specified, and must be received while the patient is a current member.
- 2 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 copayment per visit. Mental health and substance abuse Access+ *Specialist* visits are accessed through the MHSA utilizing MHSA participating providers.
- 3 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.
- 4 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.
- 5 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.
- 6 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.
- 7 The tubal ligation copayment does not apply when the procedure is performed in conjunction with delivery or abdominal surgery.
- 8 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.
- 9 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.

Please Note: This document is not a contract and should only be distributed with a presale disclosure document which explains general plan exclusions and limitations. Both documents should be read together. For actual complete benefit descriptions, terms and conditions and limitations of the health plan, please read the *Evidence of Coverage and Health Service Agreement* (EOC). For a complete description of the HMO Plans, you can request a copy of the EOC by calling (800) 431-2809.