

# Local Access+ HMO® Enhanced 45†

Benefit Summary (For groups 2 to 50)

(Uniform Health Plan Benefits and Coverage Matrix)

## Blue Shield of California

Effective January 1, 2012

This plan is available only in certain California counties and cities ("Service Area") as described in the Benefit Summary Guide and the *Evidence of Coverage*. You must live and/or work in this select Service Area in order to enroll in this Plan. You must choose your doctor from this exclusive Local Access+ HMO provider network.

**THIS MATRIX IS INTENDED TO BE USED TO HELP YOU COMPARE COVERAGE BENEFITS AND IS A SUMMARY ONLY. THE *EVIDENCE OF COVERAGE* AND THE PLAN CONTRACT SHOULD BE CONSULTED FOR A DETAILED DESCRIPTION OF COVERAGE BENEFITS AND LIMITATIONS.**

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### DEDUCTIBLE

<b>Calendar Year Medical Deductible</b>	None
<b>Calendar Year Brand Name Drug Deductible</b>	\$300 per member
<b>Calendar Year Copayment Maximum<sup>1</sup></b> (For many covered services)	\$5,000 per individual/\$10,000 per family

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**LIFETIME BENEFIT MAXIMUM** None

**Covered Services** Member Copayment

### PROFESSIONAL SERVICES

#### Professional (Physician) Benefits

- |  |                |
|--|----------------|
| • Physician and specialist office visits (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) | \$45 per visit |
| • Outpatient X-ray, pathology and laboratory   | No charge      |

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#### Allergy Testing and Treatment Benefits

- |  |                |
|--|----------------|
| • Office visits (includes visits for allergy serum injections) | \$45 per visit |
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#### Access+ *Specialist*<sup>SM</sup> Benefits

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|--|----------------|
| • Office visit, Examination or Other Consultation (Self-referred office visits and consultations only) | \$50 per visit |
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#### Preventive Health Benefits

- |   |           |
|---|-----------|
| • Preventive Health Services (see the description of Preventive Health Services in the definitions section of <i>Evidence of Coverage</i> for more information) | No charge |
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### OUTPATIENT SERVICES

#### Hospital Benefits (Facility Services)

- |   |           |
|---|-----------|
| • Outpatient surgery performed at an Ambulatory Surgery Center <sup>3</sup>   | 35%       |
| • Outpatient surgery in a hospital  | 45%       |
| • Outpatient Services for treatment of illness or injury and necessary supplies (except as described under "Rehabilitation benefits") | No charge |

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### HOSPITALIZATION SERVICES

#### Hospital Benefits (Facility Services)

- |   |           |
|---|-----------|
| • Inpatient Physician Services  | No charge |
| • Inpatient Non-emergency Facility Services (Semi-private room and board, and medically necessary Services and supplies, including Subacute Care) | 45%       |
| • Inpatient Medically Necessary skilled nursing Services including Subacute Care <sup>4</sup>   | 45%       |

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## Covered Services

## Member Copayment

**EMERGENCY HEALTH COVERAGE**

- Emergency room Services not resulting in admission (Copayment does not apply if the member is directly admitted to the hospital for inpatient services) \$150 per visit
- Emergency room Physician Services No charge

**AMBULANCE SERVICES**

- Emergency or authorized transport (surface or air) \$100

**PRESCRIPTION DRUG COVERAGE<sup>5, 6, 11</sup>**

	Participating Pharmacy <sup>1</sup>	Non-Participating Pharmacy <sup>1</sup>
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**Retail Prescriptions** (up to a 30-day supply)

- |                                  |                       |             |
|----------------------------------|-----------------------|-------------|
| • Formulary Generic Drugs        | \$10 per prescription | Not covered |
| • Formulary Brand Name Drugs     | \$30 per prescription | Not covered |
| • Non-Formulary Brand Name Drugs | \$50 per prescription | Not covered |

**Mail Service Prescriptions** (up to a 90-day supply)

- |                                  |                        |             |
|----------------------------------|------------------------|-------------|
| • Formulary Generic Drugs        | \$20 per prescription  | Not covered |
| • Formulary Brand Name Drugs     | \$60 per prescription  | Not covered |
| • Non-Formulary Brand Name Drugs | \$100 per prescription | Not covered |

**Specialty Pharmacies** (up to a 30-day supply)

- |   |   |             |
|---|---|-------------|
| • Specialty Drugs (May require prior authorization from Blue Shield Pharmacy Services. Specialty drugs are covered only when dispensed by select participating pharmacies in the Specialty Pharmacy Network. Drugs from non-participating pharmacies are not covered except in emergency and urgent situations. Mail service prescriptions are not covered. Member pays up to \$100 copayment maximum per prescription) | 20% up to a maximum of \$100 per prescription | Not covered |
|---|---|-------------|

**PROSTHETICS/ORTHOTICS**

- |  |           |
|--|-----------|
| • Prosthetic equipment and devices (Separate office visit copay may apply) | No charge |
| • Orthotic equipment and devices (Separate office visit copay may apply)   | No charge |

**DURABLE MEDICAL EQUIPMENT**

- |  |     |
|--|-----|
| • Durable Medical Equipment (member share is based upon allowed charges) | 50% |
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**MENTAL HEALTH SERVICES (PSYCHIATRIC)<sup>7</sup>**

- |  |                |
|--|----------------|
| • Inpatient Hospital Services  | 45%            |
| • Outpatient visits for severe mental health conditions  | \$45 per visit |
| • Outpatient visits for non-severe mental health conditions <sup>1</sup> (up to 20 visits per Calendar Year combined with outpatient chemical dependency visits) | \$25 per visit |

**CHEMICAL DEPENDENCY SERVICES (SUBSTANCE ABUSE)<sup>7</sup> PLEASE SEE FOOTNOTE 9**

- |   |                |
|---|----------------|
| • Inpatient Hospital Services for medical acute detoxification  | 45%            |
| • Outpatient visits <sup>1</sup> (up to 20 visits per Calendar Year combined with outpatient non-severe mental health visits) | \$25 per visit |

**HOME HEALTH SERVICES**

- |   |                |
|---|----------------|
| • Home health care agency Services (up to 100 visits per Calendar Year)                           | \$45 per visit |
| • Medical supplies and laboratory Services (See "Prescription Drug Coverage" for specialty drugs) | No charge      |

**OTHER****Hospice Program Benefits**

- |                                |               |
|--------------------------------|---------------|
| • Routine home care            | No charge     |
| • Inpatient Respite Care       | No charge     |
| • 24-hour Continuous Home Care | \$200 per day |

Covered Services	Member Copayment
<ul style="list-style-type: none"> <li>General Inpatient care</li> </ul>	\$200 per day
<b>Pregnancy and Maternity Care Benefits</b>	
<ul style="list-style-type: none"> <li>Prenatal and postnatal Physician office visits (For inpatient hospital services, see "Hospitalization Services.")</li> </ul>	No charge
<b>Family Planning and Infertility Benefits</b>	
<ul style="list-style-type: none"> <li>Counseling and consulting</li> </ul>	\$45 per visit
<ul style="list-style-type: none"> <li>Infertility Services (Diagnosis and treatment of cause of infertility. Excludes in vitro fertilization, injectables for infertility, artificial insemination and GIFT)</li> </ul>	50%
<ul style="list-style-type: none"> <li>Tubal ligation<sup>8, 10</sup></li> </ul>	\$100 per surgery
<ul style="list-style-type: none"> <li>Elective abortion<sup>10</sup></li> </ul>	\$100 per surgery
<ul style="list-style-type: none"> <li>Vasectomy<sup>10</sup></li> </ul>	\$75 per surgery
<b>Rehabilitation Benefits</b>	
<ul style="list-style-type: none"> <li>Office location</li> </ul>	\$45 per visit
<b>Diabetes Care Benefits</b>	
<ul style="list-style-type: none"> <li>Devices, equipment, and non-testing supplies (member share is based upon allowed charges; for testing supplies see Prescription Drug Coverage.)</li> </ul>	50%
<ul style="list-style-type: none"> <li>Diabetes self-management training</li> </ul>	\$45 per visit
<b>Urgent Care Benefits</b> (BlueCard® Program)	
<ul style="list-style-type: none"> <li>Urgent Services outside your Personal Physician Service Area</li> </ul>	\$50 per visit

**Optional benefits<sup>1</sup>** Optional dental, vision, infertility, substance abuse, chiropractic or chiropractic and acupuncture benefits are available. If your employer purchased any of these benefits, a description of the benefit is provided separately.

1 Copayments marked with a (1) do not accrue to the 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* 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 days during a 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 SNF in a hospital unit and skilled nursing facilities.

5 This plan's prescription drug coverage is on average equivalent to or better than the standard benefit set by the federal government for Medicare Part D (also called "creditable" coverage). Since this plan's prescription drug coverage is creditable, you do not have to enroll in Medicare Part D while you maintain this coverage; however, you should be aware that if you have a subsequent break in this coverage of 63 days or more before enrolling in Medicare Part D you could be subject to payment of higher Medicare Part D premiums.

6 If the member requests a brand-name drug and a generic drug equivalent is available, the member is responsible for paying the difference between the cost to Blue Shield of California of the brand-name drug and its generic drug equivalent, as well as the applicable generic drug copayment. Specialty drugs are covered only when dispensed by select participating pharmacies in the Specialty Pharmacy Network. Drugs from non-participating pharmacies are not covered except in emergency and urgent situations. Please note that if you switch from another plan, your prescription drug deductible credit from the previous plan during the calendar year, if applicable, will not carry forward to your new plan.

7 Mental health and chemical dependency services, other than medical acute detoxification, are accessed through Blue Shield's Mental Health Service Administrator (MHSA) – using Blue Shield's 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.

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

**9 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".**

10 Copayment shown is for physician's services. If the procedure is performed in a facility setting (hospital or outpatient surgery center), an additional facility copayment may apply.

11 Specialty Drugs are specific Drugs used to treat complex or chronic conditions which usually require close monitoring such as multiple sclerosis, hepatitis, rheumatoid arthritis, cancers, and other conditions that are difficult to treat with traditional therapies. Specialty Drugs are listed in the Blue Shield Outpatient Drug Formulary. Specialty Drugs may be self-administered in the home by injection by the patient or family member (subcutaneously or intramuscularly), by inhalation, orally or topically. Infused or Intravenous (IV) medications are not included as Specialty Drugs. These Drugs may also require special handling, special manufacturing processes, and may have limited prescribing or limited pharmacy availability. Specialty Drugs must be considered safe for self-administration by Blue Shield's Pharmacy & Therapeutics Committee, be obtained from a Blue Shield Specialty Pharmacy and may require prior authorization for Medical Necessity by Blue Shield.

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

<sup>†</sup>Pending regulatory approval