

**CSAC/EIA Health Small Group**  
**Custom Access+ HMO 15-0 Inpatient**  
 Benefit Summary  
 (Uniform Health Plan Benefits and Coverage Matrix)

**Blue Shield of California**

Effective: January 1, 2016

**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.**

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|---|---|
| <b>Calendar Year Medical Deductible</b>   | None  |
| <b>Calendar Year Out-of-Pocket Maximum</b>  | \$1,500 per individual / \$3,000 per family |
| <b>Lifetime Benefit Maximum</b>   | None  |
| <b>Covered Services</b>   | <b>Member Copayment</b>                     |
| <b>OUTPATIENT PROFESSIONAL SERVICES</b>   |   |
| <b>Professional (Physician) Benefits</b>  |   |
| Physician and specialist office visits<br>(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) | \$15 per visit                              |
| Outpatient diagnostic x-ray, imaging, pathology, laboratory and other testing services  | No Charge                                   |
| Radiological and nuclear imaging (CT scans, MRIs, MRAs, PET scans and cardiac diagnostic procedures utilizing nuclear medicine)   | No Charge                                   |
| <b>Allergy Testing and Treatment Benefits</b>   |   |
| Allergy testing, treatment and serum injections (separate office visit copayment may apply)   | \$15 per visit                              |
| <b>Access+ Specialist<sup>SM</sup> Benefits<sup>1</sup></b>   |   |
| Office visit, examination or other consultation (self-referred office visits and consultations only)  | \$30 per visit                              |
| <b>Preventive Health Benefits</b>   |   |
| Preventive health services (as required by applicable Federal and California law)   | No Charge                                   |
| <b>OUTPATIENT FACILITY SERVICES</b>   |   |
| Outpatient surgery performed at a free-standing ambulatory surgery center   | No Charge                                   |
| Outpatient surgery performed in a hospital or a hospital affiliated ambulatory surgery center   | No Charge                                   |
| Outpatient services for treatment of illness or injury and necessary supplies (except as described under "Rehabilitation Benefits" and "Speech Therapy Benefits")                       | No Charge                                   |
| Outpatient diagnostic x-ray, imaging, pathology, laboratory and other testing services  | No Charge                                   |
| Radiological and nuclear imaging (CT scans, MRIs, MRAs, PET scans and cardiac diagnostic procedures utilizing nuclear medicine)   | No Charge                                   |
| <b>HOSPITALIZATION SERVICES</b>   |   |
| <b>Hospital Benefits (Facility Services)</b>  |   |
| Inpatient physician services  | No Charge                                   |
| Inpatient non-emergency facility services (semi-private room and board, and medically necessary services and supplies, including subacute care)   | No Charge                                   |
| <b>INPATIENT SKILLED NURSING BENEFITS<sup>2,3</sup></b><br>(combined maximum of up to 100 days per benefit period; prior authorization is required; semi-private accommodations)        |   |
| Free-standing skilled nursing facility  | No Charge                                   |
| Skilled nursing unit of a hospital  | No Charge                                   |
| <b>EMERGENCY HEALTH COVERAGE</b>  |   |
| Emergency room services not resulting in admission (copayment does not apply if the member is directly admitted to the hospital for inpatient services)                                 | \$50 per visit                              |
| Emergency room physician services   | No Charge                                   |
| <b>AMBULANCE SERVICES</b>   |   |
| Emergency or authorized transport (ground or air)   | \$50  |

| <b>PRESCRIPTION DRUG COVERAGE</b>  |                               |
|--|-------------------------------|
| <b>Outpatient Prescription Drug Benefits</b>   | Carved out to Express Scripts |
| <b>PROSTHETICS/ORTHOTICS</b>   |                               |
| Prosthetic equipment and devices (separate office visit copayment may apply)   | No Charge                     |
| Orthotic equipment and devices (separate office visit copayment may apply)   | No Charge                     |
| <b>DURABLE MEDICAL EQUIPMENT</b>   |                               |
| Breast pump  | No Charge                     |
| Other durable medical equipment (member share is based upon allowed charges)   | 20%                           |
| <b>MENTAL HEALTH AND SUBSTANCE ABUSE SERVICES<sup>4, 5</sup></b>   |                               |
| Inpatient hospital services  | No Charge                     |
| Residential care   | No Charge                     |
| Inpatient physician services   | No Charge                     |
| Routine outpatient mental health and substance abuse services (includes professional/physician visits)   | \$15 per visit                |
| Non-routine outpatient mental health and substance abuse services (includes behavioral health treatment, electroconvulsive therapy, intensive outpatient programs, office-based opioid treatment, partial hospitalization programs, psychological testing and transcranial magnetic stimulation) | No Charge                     |
| <b>HOME HEALTH SERVICES</b>  |                               |
| Home health care agency services <sup>2</sup> (up to 100 visits per calendar year)   | \$15 per visit                |
| Home infusion/home injectable therapy and infusion nursing visits provided by a home infusion agency   | No Charge                     |
| <b>HOSPICE PROGRAM BENEFITS</b>  |                               |
| Routine home care  | No Charge                     |
| Inpatient respite care   | No Charge                     |
| 24-hour continuous home care   | No Charge                     |
| Short-term inpatient care for pain and symptom management  | No Charge                     |
| <b>PREGNANCY AND MATERNITY CARE BENEFITS</b>   |                               |
| Prenatal and postnatal physician office visits (when billed as part of global maternity fee including hospital inpatient delivery services)  | No Charge                     |
| Abortion services (an additional facility copayment may apply when services are rendered in a hospital or outpatient surgery center)   | \$100 per surgery             |
| <b>FAMILY PLANNING AND INFERTILITY BENEFITS</b>  |                               |
| Counseling and consulting (Includes insertion of IUD, as well as injectable and implantable contraceptives for women)  | No Charge                     |
| Contraceptive drugs and devices <sup>6</sup>   | No Charge                     |
| Infertility services (member cost share is based upon allowed charges) (diagnosis and treatment of cause of infertility. Excludes in vitro fertilization, injectables for infertility, artificial insemination and GIFT)   | 50%                           |
| Tubal ligation (an additional facility copayment may apply when services are rendered in a hospital or outpatient surgery center)  | No Charge                     |
| Vasectomy (an additional facility copayment may apply when services are rendered in a hospital or outpatient surgery center)   | \$75 per surgery              |
| <b>REHABILITATION AND HABILITATION BENEFITS (Physical, Occupational and Respiratory Therapy)</b>   |                               |
| Office location (an additional facility copayment may apply when services are rendered in a hospital or skilled nursing facility)  | \$15 per visit                |
| <b>SPEECH THERAPY BENEFITS</b>   |                               |
| Office location (an additional facility copayment may apply when services are rendered in a hospital or skilled nursing facility)  | \$15 per visit                |
| <b>DIABETES CARE BENEFITS</b>  |                               |
| Devices, equipment, and non-testing supplies (member share is based upon allowed charges; for testing supplies see Outpatient Prescription Drug Benefits)  | 20%                           |
| Diabetes self-management training  | \$15 per visit                |
| <b>URGENT CARE BENEFITS</b>  |                               |
| Urgent care services outside your personal physician service area within California  | \$15 per visit                |
| Urgent care services outside of California (BlueCard® Program)   | \$15 per visit                |

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## OPTIONAL BENEFITS

Optional dental, vision, hearing aid, infertility, chiropractic or acupuncture benefits are available. If your employer purchased any of these benefits, a description of the benefit is provided separately.

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- <sup>1</sup> 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.
- <sup>2</sup> For Plans with a facility deductible amount, services with a day or visit limit accrue to the calendar year day or visit limit maximum regardless of whether the plan deductible has been met.
- <sup>3</sup> Inpatient skilled nursing services are limited to 100 preauthorized days during a benefit period except when received through a hospice program provided by a participating hospice agency. This 100 preauthorized day maximum on inpatient skilled nursing services is a combined maximum between skilled nursing services provided in a hospital unit and skilled nursing services provided in a skilled nursing facility (SNF).
- <sup>4</sup> Mental Health and Substance Abuse services are accessed through Blue Shield's Mental Health Service Administrator (MHSA) using MHSA participating providers.
- <sup>5</sup> Inpatient services for acute detoxification are covered under the medical benefit; see the Hospital Benefits (Facility Services) section of the Evidence of Coverage for benefit details. Services for acute medical detoxification are accessed through Blue Shield using Blue Shield participating providers.
- <sup>6</sup> Coverage for contraceptive drugs and devices may be provided under your employer's separate prescription drug plan. To obtain contraceptive drugs and devices through the Blue Shield medical Plan, you must first pay all charges for the prescription and submit a completed Subscriber's Statement of Claim Form for reimbursement at 100%.

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

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This plan is pending regulatory approval.