Gold Local Access+ HMO® 500/35 OffEx

Benefit Summary (For groups 1 to 100)
(Uniform Health Plan Benefits and Coverage Matrix)

Blue Shield of California

Effective January 1, 2017

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.

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.
With the exception of Emergency Services, you must use providers from the provider network for this health plan, which is the Local Access+ HMO® Provider Network.

This health plan uses the Local Access+ HMO® Provider Network

Calendar Year Medical Deductible[1]	$500 per Individual / $1,000 per family
Calendar Year Out-of-Pocket Maximum[1] (Any calendar year medical deductible accrues to the calendar year out-of-pocket maximum.)	$5,600 per individual / $11,200 per family
Lifetime Benefit Maximum	None
Covered Services	**Member Copayment**
PROFESSIONAL SERVICES	
Professional Benefits	
Primary care physician 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)	$35 per visit
Other practitioner office visit	$35 per visit
Specialist physician office visit (also see the **Access+ *Specialist*SM Benefit** below)	$55 per visit
Teladoc consultation	$5 per consultation
Allergy Testing and Treatment Benefits	
Primary care physician office visits (includes visits for allergy serum injections)	$35 per visit
Specialist physician office visits (includes visits for allergy serum injections)	$55 per visit
Allergy serum purchased separately for treatment	50%
Access+ *Specialist*SM Benefits[2]	
Office visit, examination or other consultation (self-referred office visits and consultations only)	$55 per visit
Preventive Health Benefits	
Preventive health services (as required by applicable Federal and California law)	No Charge
OUTPATIENT SERVICES	
Hospital Benefits (Facility Services)	
Outpatient surgery performed at a free-standing ambulatory surgery center[3]	20%
Outpatient surgery performed in a hospital or a hospital affiliated ambulatory surgery center[3]	$300 per surgery (subject to the calendar year medical deductible)
Outpatient visit	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

blue of california

An Independent Member of the Blue Shield Association

OUTPATIENT X-RAY, IMAGING, PATHOLOGY AND LABORATORY BENEFITS	
CT scans, MRIs, MRAs, PET scans, and cardiac diagnostic procedures utilizing nuclear medicine	
Performed in a hospital (prior authorization is required)	$250 per visit (subject to the calendar year medical deductible)
Performed in a free-standing radiological center (prior authorization is required)	$50 per visit
Outpatient diagnostic x-ray and imaging	
Performed in a hospital	$50 per visit
Performed in a free-standing or affiliated facility	$50 per visit
Outpatient diagnostic pathology and laboratory	
Performed in a hospital	$35 per visit
Performed in a free-standing or affiliated facility	$35 per visit
HOSPITALIZATION SERVICES	
Hospital Benefits (Facility Services)	
Inpatient professional (physician) services	No Charge
Inpatient non-emergency facility services (semi-private room and board, and medically-necessary services and supplies, including subacute care)	20% (subject to the calendar year medical deductible)
INPATIENT SKILLED NURSING BENEFITS[5] (combined maximum of up to 100 days per benefit period; prior authorization is required; semi-private accommodations)	
Services by a free-standing skilled nursing facility	$300 per day (subject to the calendar year medical deductible)
Skilled nursing unit of a hospital	$300 per day (subject to the calendar year medical deductible)
EMERGENCY HEALTH COVERAGE	
Emergency room services not resulting in admission – facility fee (copayment does not apply if the Member is directly admitted to the hospital for inpatient services)	$250 per visit (subject to the calendar year medical deductible)
Emergency room services resulting in admission – facility fee (copayment does not apply if the Member is directly admitted to the hospital for inpatient services)	20% (subject to the calendar year medical deductible)
Emergency room services not resulting in admission – physician fee (copayment does not apply if the Member is directly admitted to the hospital for inpatient services)	No Charge
Emergency room services resulting in admission – physician fee	No Charge
AMBULANCE SERVICES	
Emergency or authorized transport (ground or air)	$100
PRESCRIPTION DRUG (PHARMACY) COVERAGE[4, 6, 7, 9, 10, 11, 12]	
Retail Pharmacies (up to a 30-day supply)	
Contraceptive drugs and devices[7]	No Charge
Tier 1 Drugs	$15 per prescription
Tier 2 Drugs	$30 per prescription
Tier 3 Drugs	$50 per prescription
Tier 4 Drugs (excluding Specialty Drugs)	20% up to $250 maximum per prescription
Mail Service Pharmacies (up to a 90-day supply)	
Contraceptive drugs and devices[7]	No Charge
Tier 1 Drugs	$30 per prescription
Tier 2 Drugs	$60 per prescription
Tier 3 Drugs	$100 per prescription
Tier 4 Drugs (excluding Specialty Drugs)	20% up to $500 maximum per prescription

Benefit	Member Copayment
Network Specialty Pharmacies[6] (up to a 30-day supply)	
Tier 4 Drugs	20% up to $250 maximum per prescription
Oral anticancer medications	20% up to $200 maximum per prescription
PROSTHETICS/ORTHOTICS	
Prosthetic equipment and devices (separate office visit copayment may apply)	No Charge
Orthotic equipment and devices (separate office visit copayment may apply)	No Charge
DURABLE MEDICAL EQUIPMENT	
Breast pump	No Charge
Other durable medical equipment (Member share is based upon allowed charges)	50%
MENTAL HEALTH AND BEHAVIORAL HEALTH SERVICES[8]	
Inpatient Hospital Services (prior authorization is required)	20% (subject to the calendar year medical deductible)
Residential Care (prior authorization is required)	20% (subject to the calendar year medical deductible)
Inpatient Professional (Physician Services)	No Charge
Routine Outpatient Mental Health and Behavioral Health Services (includes professional/physician visits)	$35 per visit
Non-routine outpatient mental health and behavioral health services (includes behavioral health treatment, electroconvulsive therapy, intensive outpatient programs, psychological testing, partial hospitalization programs, and transcranial magnetic stimulation. Some services may require prior authorization and facility charges.)	No Charge
SUBSTANCE USE DISORDER SERVICES[8]	
Inpatient Hospital Services (prior authorization is required)	20% (subject to the calendar year medical deductible)
Residential Care (prior authorization is required)	20% (subject to the calendar year medical deductible)
Inpatient Professional (Physician) Services	No Charge
Routine Outpatient Substance Use Disorder Services (includes professional/physician visits)	$35 per visit
Non-routine outpatient substance use disorder services (includes intensive outpatient programs, partial hospitalization programs, and office-based opioid detoxification and/or maintenance therapy. Some services may require prior authorization and facility charges.)	No Charge
HOME HEALTH SERVICES	
Home health care agency services (up to 100 visits per calendar year)	$35 per visit
Medical supplies (see "prescription drug coverage" for specialty drugs)	No Charge
HOSPICE PROGRAM BENEFITS	
Routine home care	No Charge
Inpatient respite care	No Charge (subject to the calendar year medical deductible)
24-hour continuous home care	No Charge
Short-term inpatient care for pain and symptom management	No Charge (subject to the calendar year medical deductible)
CHIROPRACTIC BENEFITS	
Chiropractic services[1] (up to 15 visits per calendar year)	$15 per visit
ACUPUNCTURE BENEFITS	
Acupuncture services	$15 per visit
PREGNANCY AND MATERNITY CARE BENEFITS	
Prenatal and preconception physician office visits (for inpatient hospital services, see "Hospitalization Services")	No Charge
Postnatal physician office visit: initial visit (for inpatient hospital services, see "Hospitalization Services")	No Charge
Delivery and all inpatient physician 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

Benefit	Member Share
FAMILY PLANNING AND INFERTILITY BENEFITS	
Counseling, consulting, and education (includes insertion of IUD, as well as injectable and implantable contraceptives for women)	No Charge
Infertility services[1] (Diagnosis and treatment of cause of infertility. Excludes services such as in vitro fertilization. Member share of cost for self-administered drugs for infertility is described under "Prescription Drug Coverage")	50%
Tubal ligation	No Charge
Vasectomy (an additional facility copayment may apply when services are rendered in a hospital or outpatient surgery center)	$75 per surgery
REHABILITATION/HABILITATIVE BENEFITS (Physical, Occupational, and Respiratory Therapy)	
Office location	$35 per visit
SPEECH THERAPY BENEFITS	
Office location	$35 per visit
DIABETES CARE BENEFITS	
Devices, equipment, and non-testing supplies (Member share is based upon allowed charges; for testing supplies see "Prescription Drug Coverage")	50%
Diabetes self-management training in an office setting	No charge
URGENT CARE BENEFITS (BlueCard® Program)	
Urgent services outside your personal physician service area	$35 per visit

PEDIATRIC VISION BENEFITS[17] – Pediatric vision benefits are available for Members through the end of the month in which the Member turns 19. All pediatric vision benefits are provided through MESVision, Blue Shield's Vision Plan Administrator.

Benefit	Member Share
Comprehensive Eye Exam[13]: one per calendar year (includes dilation, if professionally indicated)	
Ophthalmologic - Routine ophthalmologic exam with refraction – new patient (S0620) - Routine ophthalmologic exam with refraction – established patient (S0621)	No Charge
Optometric - New patient exams (92002/92004) - Established patient exams (92012/92014)	No Charge
Eyeglasses	
Lenses: one pair per calendar year - Single vision (V2100-2199) - Conventional (Lined) bifocal (V2200-2299) - Conventional (Lined) trifocal (V2300-2399) - Lenticular (V2121, V2221, V2321) Lenses include choice of glass, plastic, or polycarbonate lenses, all lens powers (single vision, bifocal, trifocal, lenticular), fashion and gradient tinting, scratch coating, oversized and glass-grey #3 prescription sunglass lenses.	No Charge
Optional Lenses and Treatments	
UV coating	No Charge
Polycarbonate lenses	No Charge
Anti-reflective coating	$35
High-index lenses	$30
Photochromic lenses – plastic	$25
Photochromic lenses – glass	$25
Polarized lenses	$45
Standard progressives	$55
Premium progressives	$95
Frame[14] (one frame per calendar year)	
Collection frames Note: "Collection" frames are available at no cost at participating independent providers. Retail chain providers typically do not display the "Collection," but are required to maintain a comparable selection of frames that are covered in full.	No Charge
Non-Collection frames (V2020)	Covered Up to $150 maximum Allowance
Contact Lenses[15]	
Non-Elective (Medically Necessary) – hard or soft[22]	No Charge
Elective (Cosmetic/Convenience) – standard hard (V2500,V2510)	No Charge

Elective (Cosmetic/Convenience) – standard soft (V2520) (One pair per month, up to 6 months, per Calendar Year)	No Charge
Elective (Cosmetic/Convenience) – non-standard hard (V2501-V2503, V2511-V2513, V2530-V2531)	No Charge
Elective (Cosmetic/Convenience) – non-standard soft (V2521-V2523) (One pair per month, up to 3 months, per Calendar Year)	No Charge
Other Pediatric Vision Benefits	
Comprehensive low vision exam[22] (Once every 5 Calendar Years)	35%
Low vision devices[22] (One aid per Calendar Year)	35%
Diabetes management referral	No Charge

PEDIATRIC DENTAL BENEFITS[18] – Pediatric dental benefits are available for Members through the end of the month in which the Member turns 19. All pediatric dental benefits are provided by Blue Shield's Dental Plan Administrator.

Diagnostic and Preventive	
Oral exam	No Charge
Preventive – cleaning	No Charge
Preventive – x-ray	No Charge
Sealants per tooth	No Charge
Topical fluoride application	No Charge
Space maintainers – fixed	No Charge
Basic Services[19]	
Restorative procedures	20%
Periodontal maintenance services	20%
Major Services[19]	
Crowns and casts	50%
Endodontics	50%
Periodontics (other than maintenance)	50%
Prosthodontics	50%
Oral surgery	50%
Orthodontics[19,20]	
Medically necessary orthodontics	50%

1. For family coverage, there is an individual medical deductible within the family medical deductible. This means that the medical deductible will be met for an individual who meets the individual medical deductible prior to meeting the family medical deductible. There is also an individual out-of-pocket maximum within the family out-of-pocket maximum. This means that the out-of-pocket maximum will be met for an individual who meets the individual out-of-pocket maximum prior to the family meeting the family out-of-pocket maximum.

   Copayments or coinsurance for covered services accrue to the calendar year out-of-pocket maximum, except copayments or coinsurance for:
   - Charges in excess of specified benefit maximums
   - Family planning benefits: infertility services
   - Chiropractic benefits

   Copayments and charges for services not accruing to the Member's calendar year out-of-pocket maximum continue to be the Member's responsibility after the calendar year out-of-pocket maximum is reached. Please refer to the Summary of Benefits and *Evidence of Coverage* 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 use disorder services must be provided by a MHSA network participating provider.

3. Participating ambulatory surgery centers may not be available in all areas. Outpatient surgery services may also be obtained from a hospital or an ambulatory surgery center that is affiliated with a hospital, and paid according to the hospital services benefits.

4. Specialty drugs are available from a Network Specialty Pharmacy. A Network Specialty Pharmacy provides specialty drugs by mail or upon Member request, at an associated retail store for pickup.

5. 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 skilled nursing services is a combined maximum between SNF in a hospital unit and skilled nursing facilities.

6. Network Specialty Pharmacies dispense Specialty Drugs which require coordination of care, close monitoring, or extensive patient training that generally cannot be met by a retail pharmacy. Network Specialty Pharmacies also dispense Specialty Drugs requiring special handling or manufacturing processes, restriction to certain physicians or pharmacies, or reporting of certain clinical events to the FDA. Specialty Drugs are generally high cost.

7. Contraceptive drugs and devices covered under the outpatient prescription drug benefits do not require a copayment. However, if a brand contraceptive is selected when a Tier 1 drug equivalent is available, the Member is responsible for paying the difference between the cost to Blue Shield for the brand contraceptive and its Tier 1 drug equivalent. The difference in cost that the Member must pay does not accrue to any calendar year medical or pharmacy deductible and is not included in the calendar year out-of-pocket maximum responsibility calculation. The Member or physician may request a medical necessity exception to the difference in cost as further described in the *Evidence of Coverage*. In addition, select contraceptives may need prior authorization to be covered without a copayment.

8. Mental Health and Substance Use Disorder Services are accessed through Blue Shield's Mental Health Service Administrator (MHSA) using Blue Shield's MHSA participating providers. For a listing of severe mental illnesses, including serious emotional disturbances of a child, and other benefit details, please refer to the Summary of Benefits and *Evidence of Coverage*. Inpatient services for acute medical 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.

9. Blue Shield's Short-Cycle Specialty Drug Program allows initial prescriptions for select Specialty Drugs to be dispensed for a 15-day trial supply, as further described in the *Evidence of Coverage*. In such circumstances, the applicable Specialty Drug copayment or coinsurance will be pro-rated.

10. If the Member or physician selects a brand drug when a generic drug equivalent is available, the Member is responsible for paying the difference in cost between the brand drug and its generic drug equivalent, in addition to the generic drug copayment. The difference in cost that the Member must pay does not accrue to the calendar year out-of-pocket maximum responsibility calculation. Refer to the *Evidence of Coverage* and Summary of Benefits for details.

11. This benefit 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). Because this benefit plan's prescription drug coverage is creditable, you do not have to enroll in Medicare prescription drug plan 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 any time after you were first eligible to enroll in a Medicare prescription drug plan, you could be subject to a late enrollment penalty in addition to your Part D premium.

12. Drugs obtained at a non-participating pharmacy are not covered, unless medically necessary for a covered emergency, including drugs for emergency contraception.

13. The comprehensive examination benefit allowance does not include fitting and evaluation fees for contact lenses.

14. This benefit covers collection frames at no cost at participating independent and retail chain providers. Participating retail chain providers typically do not display the frames as "collection" but are required to maintain a comparable selection of frames that are covered in full. For non-collection frames, the allowable amount is up to $150; however, if (a) the participating provider uses wholesale pricing, then the wholesale allowable amount will be up to $99.06, or if (b) the participating provider uses warehouse pricing, then the warehouse allowable amount will be up to $103.64. Participating providers using wholesale pricing are identified in the provider directory. If frames are selected that are more expensive than the allowable amount established for this benefit, the Member is responsible for the difference between the allowable amount and the provider's charge.

15. Contact lenses are covered in lieu of eyeglasses. See the "Definitions" section in the *Evidence of Coverage* for the definitions of Elective Contact Lenses and Non-Elective (Medically Necessary) Contact Lenses. A report from the provider and prior authorization from the Vision Plan Administrator (VPA) is required.

16. A report from the provider and prior authorization from the contracted Vision Plan Administrator is required.

17. All vision services must be provided through a participating vision care provider. For a list of participating vision providers, Members can search in the "Find a Provider" section of blueshieldca.com. All pediatric vision benefits are provided through MESVision, Blue Shield's Vision Plan Administrator. Any vision services deductibles, copayments and coinsurance for covered vision services from participating vision providers accrue to the calendar year out-of-pocket maximum. Costs for non-covered services, services from non-participating vision providers, charges in excess of benefit maximums, and premiums, do not accrue to the calendar year out-of-pocket maximum.

18. Pediatric dental benefits are available through a network of participating dentists. With the exception of emergency dental services, all dental services must be provided through a participating dentist in this network. For a list of participating dentists, Members can search in the "Find a Provider" section of blueshieldca.com. All pediatric dental benefits are provided by Blue Shield's Dental Plan Administrator.

    Copayments and coinsurance for covered dental services accrue to the calendar year out-of-pocket maximum, including any copayments for covered orthodontia services. Costs for non-covered services, charges in excess of benefit maximums, and premiums, do not accrue to the calendar year out-of-pocket maximum.

19. There are no waiting periods for pediatric dental services.

20. The Member's Copayment or Coinsurance for covered Medically Necessary Orthodontia services applies to a course of treatment even if it extends beyond a Calendar Year. This applies as long as the Member remains enrolled in the Plan.

Benefit Plans may be modified to ensure compliance with state and federal requirements.

This plan is pending regulatory approval.