

# Silver Access+ HMO® 1700/55 OffEx

Benefit Summary (For groups 1 to 100)  
(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.**

This health plan uses the Access+ HMO® Provider Network

<b>Calendar Year Medical Deductible<sup>1</sup></b>	\$1,700 per Individual / \$3,400 per family
<b>Calendar Year Out-of-Pocket Maximum<sup>1</sup></b> (Any calendar year medical deductible and any calendar year pharmacy deductible accrue to the calendar year out-of-pocket maximum.)	\$6,500 per individual / \$13,000 per family
<b>Calendar Year Pharmacy Deductible<sup>1</sup></b> (Does not apply to contraceptive drugs and devices. Separate from the calendar year medical deductible. Otherwise applicable to covered drugs in Tiers 2, 3 and 4. Accrues to the calendar year out-of-pocket maximum.)	\$300 per individual / \$600 per family
<b>Lifetime Benefit Maximum</b>	None
<b>Covered Services</b>	<b>Member Copayment</b>
<b>PROFESSIONAL SERVICES</b>	
<b>Professional Benefits</b>	
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)	\$55 per visit
Other practitioner office visit	\$55 per visit
Specialist physician office visit (also see the <b>Access+ Specialist<sup>SM</sup> Benefit</b> below)	\$55 per visit
<b>Allergy Testing and Treatment Benefits</b>	
Primary care physician office visits (includes visits for allergy serum injections)	\$55 per visit
Specialist physician office visits (includes visits for allergy serum injections)	\$55 per visit
Allergy serum purchased separately for treatment	50%
<b>Access+ Specialist<sup>SM</sup> Benefits<sup>2</sup></b>	
Office visit, examination or other consultation (self-referred office visits and consultations only)	\$55 per visit
<b>Preventive Health Benefits</b>	
Preventive health services (as required by applicable Federal and California law)	No Charge
<b>OUTPATIENT SERVICES</b>	
<b>Hospital Benefits (Facility Services)</b>	
Outpatient surgery performed at a free-standing ambulatory surgery center <sup>3</sup>	40% (subject to the calendar year medical deductible)
Outpatient surgery performed in a hospital or a hospital affiliated ambulatory surgery center <sup>3</sup>	40% (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

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**OUTPATIENT X-RAY, IMAGING, PATHOLOGY AND LABORATORY BENEFITS**

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**CT scans, MRIs, MRAs, PET scans, and cardiac diagnostic procedures utilizing nuclear medicine**

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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) \$55 per visit

Outpatient diagnostic x-ray and imaging (non-hospital based or affiliated) \$55 per visit

Outpatient diagnostic laboratory and pathology (non-hospital based or affiliated) \$55 per visit

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**HOSPITALIZATION SERVICES**

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**Hospital Benefits (Facility Services)**

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Inpatient physician services No Charge

Inpatient non-emergency facility services (semi-private room and board, and medically-necessary services and supplies, including subacute care) 40%  
(subject to the calendar year medical deductible)

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**INPATIENT SKILLED NURSING BENEFITS<sup>5</sup>** (combined maximum of up to 100 days per benefit period; prior authorization is required; semi-private accommodations)

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Services by a free-standing skilled nursing facility 40%  
(subject to the calendar year medical deductible)

Skilled nursing unit of a hospital 40%  
(subject to the calendar year medical deductible)

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**EMERGENCY HEALTH COVERAGE**

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Emergency room services not resulting in admission – facility fee (a copayment does not apply if the member is directly admitted to the hospital for inpatient services) \$275 per visit  
(subject to the calendar year medical deductible)

Emergency room services resulting in admission – facility fee (a copayment does not apply if the member is directly admitted to the hospital for inpatient services) 40%  
(subject to the calendar year medical deductible)

Emergency room services not resulting in admission - physician fee No Charge

Emergency room services resulting in admission - physician fee No Charge

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**AMBULANCE SERVICES**

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Emergency or authorized transport (ground or air) \$100

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**PRESCRIPTION DRUG (PHARMACY) COVERAGE** <sup>4, 6, 7, 9, 10, 11, 12</sup>

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

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Contraceptive drugs and devices<sup>7</sup> No Charge

Tier 1 Drugs \$15 per prescription

Tier 2 Drugs \$55 per prescription  
(subject to the calendar year pharmacy deductible)

Tier 3 Drugs \$75 per prescription  
(subject to the calendar year pharmacy deductible)

Tier 4 Drugs (excluding Specialty Drugs) 20% per prescription  
(subject to the calendar year pharmacy deductible)

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

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Contraceptive drugs and devices<sup>7</sup> No Charge

Tier 1 Drugs \$30 per prescription

Tier 2 Drugs \$110 per prescription  
(subject to the calendar year pharmacy deductible)

Tier 3 Drugs \$150 per prescription  
(subject to the calendar year pharmacy deductible)

Tier 4 Drugs (excluding Specialty Drugs) 20% per prescription  
(subject to the calendar year pharmacy deductible)

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**Network Specialty Pharmacies<sup>6</sup>** (up to a 30-day supply)

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Tier 4 Drugs 20% per prescription  
(subject to the calendar year pharmacy deductible)

Oral anticancer medications 20% up to \$200 maximum  
per prescription  
(subject to the calendar year pharmacy deductible)

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<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)	50%
<b>MENTAL HEALTH AND BEHAVIORAL HEALTH SERVICES <sup>8</sup></b>	
Inpatient hospital services (prior authorization is required)	40% (subject to the calendar year medical deductible)
Residential care (prior authorization is required)	40% (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)	\$55 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
<b>SUBSTANCE USE DISORDER SERVICES <sup>8</sup></b>	
Inpatient hospital services (prior authorization is required)	40% (subject to the calendar year medical deductible)
Residential care (prior authorization is required)	40% (subject to the calendar year medical deductible)
Inpatient professional (physician) services	No Charge
Routine outpatient substance use disorder services (includes professional/physician visits)	\$55 per visit
Non-routine outpatient substance use disorder services (includes intensive outpatient programs, partial hospitalization programs, office-based opioid treatment, and post discharge ancillary care. Some services may require prior authorization and facility charges.)	No Charge
<b>HOME HEALTH SERVICES</b>	
Home health care agency services (up to 100 visits per calendar year)	40%
Medical supplies (see "prescription drug coverage" for specialty drugs)	No Charge
<b>HOSPICE PROGRAM BENEFITS</b>	
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)
<b>CHIROPRACTIC BENEFITS</b>	
Chiropractic services <sup>1</sup> (up to 15 visits per calendar year)	\$15 per visit
<b>ACUPUNCTURE BENEFITS</b>	
Acupuncture services	\$15 per visit
<b>PREGNANCY AND MATERNITY CARE BENEFITS</b>	
Prenatal and preconception physician office visits (for inpatient hospital services, see "Hospitalization Services")	No Charge
Delivery and all inpatient physician services	No Charge
Postnatal physician office visits (for inpatient hospital services, see "Hospitalization Services")	\$55 per visit
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

Infertility services <sup>1</sup> (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
<b>REHABILITATION/HABILITATION BENEFITS</b> (Physical, Occupational, and Respiratory Therapy)	
Office location	\$55 per visit
<b>SPEECH THERAPY BENEFITS</b>	
Office location	\$55 per visit
<b>DIABETES CARE BENEFITS</b>	
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	\$55 per visit
<b>URGENT CARE BENEFITS</b> (BlueCard® Program)	
Urgent services outside your personal physician service area	\$55 per visit
<b>PEDIATRIC VISION BENEFITS<sup>17</sup></b> - 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.	
<b>Comprehensive Eye Exam<sup>13</sup>: one per calendar year</b> (includes dilation, if professionally indicated)	
<b>Ophthalmologic</b>	
- Routine ophthalmologic exam with refraction – new patient (S0620)	No Charge
- Routine ophthalmologic exam with refraction – established patient (S0621)	
<b>Optometric</b>	
- New patient exams (92002/92004)	No Charge
- Established patient exams (92012/92014)	
<b>Eyeglasses</b>	
<b>Lenses: one pair per calendar year</b>	
- Single vision (V2100-2199)	
- Conventional (Lined) bifocal (V2200-2299)	
- Conventional (Lined) trifocal (V2300-2399)	
- Lenticular (V2121, V2221, V2321)	No Charge
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.	
<b>Optional Lenses and Treatments</b>	
UV coating	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
<b>Frame<sup>14</sup></b> (one frame per calendar year)	
<b>Collection frames</b>	
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.	
Non-Collection frames (V2020)	Up to \$150 Maximum Allowance
<b>Contact Lenses<sup>15</sup></b>	
Non-Elective (Medically Necessary) hard or soft, one pair per calendar year	No Charge
Elective (Cosmetic/Convenience) standard hard (V2500, V2510), one pair per calendar year	No Charge

Elective (Cosmetic/Convenience) non-standard hard (V2501-V2503, V2511-V2513, V2530-V2531), one pair per calendar year	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 soft (V2521-V2523) one pair per month, up to 3 months per calendar year	No Charge
<b>Other Pediatric Vision Benefits</b>	
Supplemental low-vision testing and equipment <sup>16</sup>	35%
Diabetes management referral	No Charge

**PEDIATRIC DENTAL BENEFITS<sup>18</sup>** - 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.

**Child Dental 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
Caries risk management	No Charge
Space maintainers – fixed	No Charge

**Child Dental Basic Services**

Amalgam fill - 1 surface <sup>20</sup>	20%
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**Child Dental Major Services<sup>19</sup>**

Root canal – molar	50%
Gingivectomy per quad	50%
Extraction - single tooth exposed root or erupted	50%
Extraction - complete bony	50%
Porcelain with metal crown	50%

**Child Orthodontics<sup>19,21</sup>**

Medically necessary orthodontics	50%
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**OPTIONAL BENEFITS**

Optional dental and vision benefits are available. If your employer purchased any of these benefits, a description of the benefit is provided separately.

- For family coverage, there is an individual medical deductible and a separate individual pharmacy deductible within the family medical and pharmacy deductibles. This means that the medical and pharmacy deductibles will be met for an individual who meets the individual medical and pharmacy deductibles prior to meeting the family medical and pharmacy deductibles. 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.

- 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.
- 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
- 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 Tier 1 drug equivalent is available, the member is responsible for paying the difference in cost between the brand drug and its Tier 1 drug equivalent, in addition to the Tier 1 drug copayment. The difference in cost that the member must pay does not accrue to 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*. Refer to the *Evidence of Coverage* and Summary of Benefits for details.
11. 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). Because this plan's prescription drug coverage is creditable, you do not have to enroll in a 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 once per calendar year. 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.

Any calendar year pediatric dental services deductible, copayments and coinsurance for covered dental services from participating dentists accrue to the calendar year out-of-pocket maximum, including any copayments for covered orthodontia services received from participating dentists. Costs for non-covered services, services from non-participating dentists, 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 major & orthodontic services.
20. Posterior composite resin, or acrylic restorations are optional services, and Blue Shield will only pay the amalgam filling rate while the member will be responsible for the difference in cost between the posterior composite resin and amalgam filling.

21. Medically necessary orthodontia services include an oral evaluation and diagnostic casts. An initial orthodontic examination (a limited oral evaluation) must be conducted which includes completion of the Handicapping Labio-Lingual Deviation (HLD) score sheet. The HLD score sheet is the preliminary measurement tool used in determining if the member qualifies for medically necessary orthodontic services (see list of qualifying conditions below). Diagnostic casts may be covered only if qualifying conditions are present. Pre-certification for all orthodontia evaluation and services is required.

Those immediate qualifying conditions are:

- Cleft lip and or palate deformities
- Craniofacial anomalies including the following: Crouzon's syndrome, Treacher-Collins syndrome, Pierre-Robin syndrome, Hemi-facial atrophy, Hemi-facial hypertrophy and other severe craniofacial deformities which result in a physically handicapping malocclusion as determined by our dental consultants.
- Deep impinging overbite, where the lower incisors are destroying the soft tissue of the palate and tissue laceration and/or clinical attachment loss are present. (Contact only does not constitute deep impinging overbite.)
- Crossbite of individual anterior teeth when clinical attachment loss and recession of the gingival margin are present (e.g., stripping of the labial gingival tissue on the lower incisors). Treatment of bi-lateral posterior crossbite is not a benefit of the program.
- Severe traumatic deviation must be justified by attaching a description of the condition.
- Overjet greater than 9mm or mandibular protrusion (reverse overjet) greater than 3.5mm.
- The remaining conditions must score 26 or more to qualify (based on the HLD Index).

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