blue of california

Summary of Benefits

Group Plan

Access+ HMO® Per Admit 20-250

HMO Benefit Plan

This Summary of Benefits shows the amount you will pay for covered services under this Blue Shield of California benefit plan. It is only a summary and it is part of the contract for health care coverage, called the Evidence of Coverage (EOC).[1] Please read both documents carefully for details.

Provider Network:

Access+ HMO Network

This benefit plan uses a specific network of health care providers, called the Access+ HMO provider network. Medical groups, independent practice associations (IPAs), and physicians in this network are called participating providers. You must select a primary care physician from this network to provide your primary care and help you access services, but there are some exceptions. Please review your Evidence of Coverage for details about how to access care under this plan. You can find participating providers in this network at blueshieldca.com.

Calendar Year Deductibles (CYD)[2]

A calendar year deductible (CYD) is the amount a member pays each calendar year before Blue Shield pays for covered services under the benefit plan.

		When using a participating provider[3]
Calendar year medical deductible	*Individual coverage*	$0
	Family coverage	$0: individual $0: family

Calendar Year Out-of-Pocket Maximum[4]

An out-of-pocket maximum is the most a member will pay for covered services each calendar year. Any exceptions are listed in the EOC.

	When using a participating provider[3]
Individual coverage	$1,500
Family coverage	$1,500: individual $3,000: family

No Lifetime Benefit Maximum

Under this benefit plan there is no dollar limit on the total amount Blue Shield will pay for covered services in a member's lifetime.

Benefits[5]	Your payment	
	When using a participating provider[3]	CYD[2] applies
Preventive Health Services[6]	$0	
Physician services		
Primary care office visit	$20/visit	
Access+ specialist care office visit	$30/visit	
Other specialist care office visit	$20/visit	
Physician home visit	$50/visit	
Physician inpatient, outpatient, and surgery services	$0	
Other professional services		
Other practitioner office visit	$20/visit	
Includes nurses, nurse practitioners, and therapists.		
Teladoc consultation	$5/consult	
Family planning		
• Counseling, consulting, and education	$0	
• Injectable contraceptive; diaphragm fitting, intrauterine device (IUD), implantable contraceptive, and related procedure.	$0	
• Tubal ligation	$0	
• Vasectomy	$0	
• Infertility services	50%	
Podiatric services	$20/visit	
Pregnancy and maternity care[6]		
Physician office visits: prenatal and postnatal	$0	
Physician services for pregnancy termination	$0	
Emergency services and urgent care		
Emergency room services	$100/visit	
If admitted to the hospital, this payment for emergency room services does not apply. Instead, you pay the participating provider payment under Inpatient facility services/ Hospital services and stay.		
Emergency room physician services	$0	
Urgent care physician services	$20/visit	
Inside your primary care physician's service area, services must be provided or referred by your primary care physician or medical group/IPA. Services outside your primary care physician's service area are also covered. Services inside your primary care physician's service area not provided or referred by your primary care physician or medical group/IPA are not covered.		
Ambulance services	$100/transport	

Benefits[5]	Your payment	
	When using a participating provider[3]	CYD[2] applies
Outpatient facility services		
Ambulatory surgery center	$100/surgery	
Outpatient department of a hospital: surgery	$150/surgery	
Outpatient department of a hospital: treatment of illness or injury, radiation therapy, chemotherapy, and necessary supplies	$0	
Inpatient facility services		
Hospital services and stay	$250/admission	
Transplant services		
This payment is for all covered transplants except tissue and kidney. For tissue and kidney transplant services, the payment for Inpatient facility services/ Hospital services and stay applies.		
• Special transplant facility inpatient services	$250/admission	
• Physician inpatient services	$0	
Diagnostic x-ray, imaging, pathology, and laboratory services		
This payment is for covered services that are diagnostic, non-preventive health services, and diagnostic radiological procedures, such as CT scans, MRIs, MRAs, and PET scans. For the payments for covered services that are considered Preventive Health Services, see Preventive Health Services.		
Laboratory services		
Includes diagnostic Papanicolau (Pap) test.		
• Laboratory center	$0	
• Outpatient department of a hospital	$0	
• California Prenatal Screening Program	$0	
X-ray and imaging services		
Includes diagnostic mammography.		
• Outpatient radiology center	$0	
• Outpatient department of a hospital	$0	
Other outpatient diagnostic testing		
Testing to diagnose illness or injury such as vestibular function tests, EKG, ECG, cardiac monitoring, non-invasive vascular studies, sleep medicine testing, muscle and range of motion tests, EEG, and EMG.		
• Office location	$0	
• Outpatient department of a hospital	$0	
Radiological and nuclear imaging services		
• Outpatient radiology center	$0	
• Outpatient department of a hospital	$0	

Benefits[5]	Your payment	
	When using a participating provider[3]	CYD[2] applies
Rehabilitation and habilitative services		
Includes physical therapy, occupational therapy, respiratory therapy, and speech therapy services.		
Office location	$20/visit	
Outpatient department of a hospital	$20/visit	
Durable medical equipment (DME)		
DME	20%	
Breast pump	$0	
Orthotic equipment and devices	$0	
Prosthetic equipment and devices	$0	
Home health services		
Up to 100 visits per member, per calendar year, by a home health care agency. All visits count towards the limit, including visits during any applicable deductible period, except hemophilia and home infusion nursing visits.		
Home health agency services	$20/visit	
Includes home visits by a nurse, home health aide, medical social worker, physical therapist, speech therapist, or occupational therapist.		
Home visits by an infusion nurse	$20/visit	
Home health medical supplies	$0	
Home infusion agency services	$0	
Hemophilia home infusion services	$0	
Includes blood factor products.		
Skilled nursing facility (SNF) services		
Up to 100 days per member, per benefit period, except when provided as part of a hospice program. All days count towards the limit, including days during any applicable deductible period and days in different SNFs during the calendar year.		
Freestanding SNF	$100/day	
Hospital-based SNF	$100/day	
Hospice program services	$0	
Includes pre-hospice consultation, routine home care, 24-hour continuous home care, short-term inpatient care for pain and symptom management, and inpatient respite care.		
Other services and supplies		
Diabetes care services		
• Devices, equipment, and supplies	20%	

Benefits[5]	Your payment	
	When using a participating provider[3]	**CYD[2] applies**
• Self-management training	$20/visit	
Dialysis services	$0	
PKU product formulas and special food products	$0	
Allergy serum	50%	

Mental Health and Substance Use Disorder Benefits	Your payment	
Mental health and substance use disorder benefits are provided through Blue Shield's mental health services administrator (MHSA).	**When using a MHSA participating provider[3]**	**CYD[2] applies**
Outpatient services		
Office visit, including physician office visit	$20/visit	
Other outpatient services, including intensive outpatient care, behavioral health treatment for pervasive developmental disorder or autism in an office setting, home, or other non-institutional facility setting, and office-based opioid treatment	$0	
Partial hospitalization program	$0	
Psychological testing	$0	
Inpatient services		
Physician inpatient services	$0	
Hospital services	$250/admission	
Residential care	$250/admission	

Notes

1 Evidence of Coverage (EOC):

The Evidence of Coverage (EOC) describes the benefits, limitations, and exclusions that apply to coverage under this benefit plan. Please review the EOC for more details of coverage outlined in this Summary of Benefits. You can request a copy of the EOC at any time.

Defined terms are in the EOC. Refer to the EOC for an explanation of the terms used in this Summary of Benefits.

2 Calendar Year Deductible (CYD):

Calendar Year Deductible explained. A deductible is the amount you pay each calendar year before Blue Shield pays for Covered Services under the benefit plan.

If this benefit plan has any Calendar Year Deductible(s), Covered Services subject to that Deductible are identified with a check mark (✔) in the Benefits chart above.

Notes

3 Using Participating Providers:

Participating Providers have a contract to provide health care services to Members. When you receive Covered Services from a Participating Provider, you are only responsible for the Copayment or Coinsurance, once any Calendar Year Deductible has been met.

Your payment for services from "Other Providers." You will pay the Copayment or Coinsurance applicable to Participating Providers for Covered Services received from Other Providers. However, Other Providers do not have a contract to provide health care services to Members and so are not Participating Providers. Therefore, you will also pay all charges above the Allowable Amount. This out-of-pocket expense can be significant.

4 Calendar Year Out-of-Pocket Maximum (OOPM):

Your payment after you reach the calendar year OOPM. You will continue to be responsible for Copayments or Coinsurance for the following Covered Services after the Calendar Year Out-of-Pocket Maximum is met:

- benefit maximum: charges for services after any benefit limit is reached

Essential health benefits count towards the OOPM.

Family coverage has an individual OOPM within the family OOPM. This means that the OOPM will be met for an individual who meets the individual OOPM prior to the family meeting the family OOPM within a Calendar Year.

5 Separate Member Payments When Multiple Covered Services are Received:

Each time you receive multiple Covered Services, you might have separate payments (Copayment or Coinsurance) for each service. When this happens, you may be responsible for multiple Copayments or Coinsurance. For example, you may owe an office visit Copayment in addition to an allergy serum Copayment when you visit the doctor for an allergy shot.

6 Preventive Health Services:

If you only receive Preventive Health Services during a physician office visit, there is no Copayment or Coinsurance for the visit. If you receive both Preventive Health Services and other Covered Services during the physician office visit, you may have a Copayment or Coinsurance for the visit.

Benefit Plans may be modified to ensure compliance with State and Federal requirements.

PENDING REGULATORY APPROVAL