

City of Modesto
 Custom Access+ HMO® Plan
 Benefit Summary (For groups of 300 and above)
 (Uniform Health Plan Benefits and Coverage Matrix)

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.

Blue Shield of California

Highlights: A description of the prescription drug coverage is provided separately.

Effective August 1, 2009

DEDUCTIBLES	
Calendar-year facility deductible	None
Calendar-year copayment maximum¹ (For many covered services)	\$1,500 per member
LIFETIME MAXIMUM	
	None
Covered Services	Member Copayment
PROFESSIONAL SERVICES	
Physician services – outpatient	
<ul style="list-style-type: none"> Physician and authorized specialist office visits <small>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.</small> 	\$30/visit
<ul style="list-style-type: none"> Allergy testing or treatment 	\$30/visit
Access+ SpecialistSM (Self-referred office visits and consultations only) ^{1, 2}	\$45/visit
Laboratory, X-ray and diagnostic tests	No charge
Preventive care	
<ul style="list-style-type: none"> Routine physical exam <small>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.</small> 	\$30/visit
<ul style="list-style-type: none"> Eye/ear screenings and immunizations according to age schedule 	No charge
OUTPATIENT SERVICES	
Non-emergency	
<ul style="list-style-type: none"> Outpatient surgery performed in a Participating Ambulatory Surgery Center³(ASC) 	No charge
<ul style="list-style-type: none"> Outpatient surgery in hospital/facility 	No charge
<ul style="list-style-type: none"> Outpatient treatment (Except as described under "Rehabilitative therapy services"), and necessary supplies 	No charge
HOSPITALIZATION SERVICES	
<ul style="list-style-type: none"> Inpatient physician services, including pregnancy and maternity care 	No charge
<ul style="list-style-type: none"> Semi-private room and board, medically necessary services and supplies 	20%
<ul style="list-style-type: none"> Skilled nursing facility (SNF) services⁴ 	20%
EMERGENCY HEALTH COVERAGE	
<ul style="list-style-type: none"> Emergency room facility services (Copayment does not apply if the member is directly admitted to the hospital for inpatient services) 	\$150/visit
<ul style="list-style-type: none"> Emergency room physician visits 	No charge
AMBULANCE SERVICES	
	\$100
PRESCRIPTION DRUG COVERAGE¹	A description of your outpatient prescription drug coverage is provided separately. If you do not have the separate drug sheet that goes with this benefit summary, please contact your benefits administrator or call Member Services at (800) 424-6521 .
PROSTHETICS/ORTHOTICS (Equipment and devices only. Separate office visit copay may apply)	No charge
DURABLE MEDICAL EQUIPMENT¹	20% of allowed charges (Plan payment up to \$2000 maximum per calendar year)
MENTAL HEALTH SERVICES (PSYCHIATRIC)	Coverage is provided separately from your Blue Shield plan. For more information, please contact your benefits administrator or call Member Services at (800) 424-6521 .
CHEMICAL DEPENDENCY SERVICES (SUBSTANCE ABUSE)⁵	
<ul style="list-style-type: none"> Inpatient services for medical acute detoxification 	See "Hospitalization Services"
<ul style="list-style-type: none"> Outpatient visits 	Coverage is provided separately from your Blue Shield plan. For more information, please contact your benefits administrator or call Member Services at (800) 424-6521 .

An Independent Member of the Blue Shield Association

HOME HEALTH SERVICES

- Agency visits (Up to 100 visits per calendar year) \$30/visit
 - Medical supplies/IV solutions No charge
(For home self-administered injectable medications, see "Prescription Drug Coverage.")
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OTHER**Hospice**

- Routine home care No charge
 - Inpatient respite care No charge
 - 24 hour continuous home care \$200/day
 - General inpatient care \$200/day
-

Pregnancy and maternity care

- Prenatal and postnatal professional (physician) services \$30/visit
(For all necessary inpatient hospital services, see "Hospitalization Services.")
-

Family planning and infertility services

- Family planning counseling \$30/visit
 - Diagnosis and treatment of causes of infertility 50% of allowed charges
(Excludes in vitro fertilization, injectables for infertility, artificial insemination and GIFT)
 - Tubal ligation and elective abortion^{6,7} \$100
 - Vasectomy⁷ \$75
-

Rehabilitative therapy services

- Outpatient visits \$30/visit
(Copayment applies to all place of services, including professional and facility settings)
-

Diabetes care

- Equipment, devices and non-testing supplies 20% of allowed charges
(For testing supplies, see "Prescription Drug Coverage.")
 - Self-management training and education \$30/visit
-

Urgent care outside service area (BlueCard[®] Program)

\$50/visit

Optional benefits¹ Optional dental, vision, chiropractic, chiropractic and acupuncture or infertility 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 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, the Disclosure Form 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.

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 preauthorized days during a calendar year 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.

5 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.

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

7 Physician services copayment in the office or outpatient hospital facility only. If procedure is performed in a hospital facility setting, additional hospital services copayment may apply.

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

Access+ HMO®/Added Advantage POSSM Plans
 Outpatient Prescription Drug Coverage
 (For groups of 51 and above)

Blue Shield of California

Highlight: 2-Tier/Closed Formulary
 No Calendar-Year Brand-Name Drug Deductible
 \$15 Generic/\$30 Formulary Brand-Name - Retail Pharmacy
 \$30 Generic/\$60 Formulary Brand-Name - Mail Service

THIS DRUG SUMMARY IS INTENDED TO BE USED WITH THE ACCESS+ HMO OR ADDED ADVANTAGE POS PLANS UNIFORM HEALTH PLAN BENEFITS AND COVERAGE MATRIX. THE EVIDENCE OF COVERAGE, AND PLAN CONTRACT SHOULD BE CONSULTED FOR A DETAILED DESCRIPTION OF COVERAGE BENEFITS AND LIMITATIONS.

Covered Services **Member Copayment**

DEDUCTIBLES (Prescription drug coverage benefits are not subject to the medical plan deductible.)

Calendar-year brand-name drug deductible

PRESCRIPTION DRUG COVERAGE^{1, 2, 3, 4}

(Includes oral contraceptives, diaphragms, and covered diabetic drugs and testing supplies)

- Generic drugs
- Formulary brand-name drugs
- Home self-administered injectable medications
 (Available at specialty pharmacy network only)

	Participating Pharmacy	Mail Service Prescriptions
	(For up to a 30-day supply)	(For up to a 90-day supply)
	\$15/prescription	\$30/prescription
	\$30/prescription	\$60/prescription
	20%	Not covered
	(Up to \$100 copayment maximum per prescription)	through mail service benefit

- 1 Coinsurance or Copayments and charges for these covered services are not included in the calculation of the member's medical calendar-year copayment maximum and 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 Only drugs on the Blue Shield Drug Formulary are covered unless prior authorized by Blue Shield Pharmacy Services. 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.
- 3 Home self-administered injectable drugs are covered only when dispensed by select pharmacies in the Specialty Pharmacy Network unless Medically Necessary for a covered emergency.
- 4 Selected formulary and non-formulary drugs and most home self-administered injectables require prior authorization by Blue Shield for Medical Necessity, and when effective, lower cost alternatives are available.

Note: 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 Part D premiums.

Important Prescription Drug Information

You can find details about your drug coverage three ways:

1. Check your *Evidence of Coverage*.
2. Go to **blueshieldca.com** and log onto My Health Plan from the home page.
3. Call Member Services at the number listed on your Blue Shield member ID card.

At Blue Shield of California, we're dedicated to providing you with valuable resources for managing your drug coverage. Go online to the *Pharmacy* section of **blueshieldca.com** and select the *Drug Database and Formulary* to access a variety of useful drug information that can affect your out-of-pocket expenses, such as:

- Look up drugs with generic equivalents;
- Look up drugs that require prior authorization;
- Find specifics about your prescription copayments;
- Find local network pharmacies to fill your prescriptions.

TIPS!

Using the convenient mail service pharmacy can save you time and money. If you take a consistent dose of a covered maintenance drug for a chronic condition, such as diabetes or high blood pressure, you can receive up to a 90-day supply through the mail service pharmacy with a reduced copayment. Call the mail service pharmacy at (866) 346-7200. Members using TTY equipment can call TTY/TDD 866-346-7197.

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

A16148-g (07/09)