

Plan Modifications

Access+HMO® Plan 5

Effective January 1, 2007 and thereafter

Please review this document for important modifications to your health plan benefits. If you have any questions about the programs and services, or questions about the changes listed in this document, please contact your benefits administrator or call Customer Service at (800) 200-3242.

	Plan Modification	Current
	Access+HMO Plan 5 (effective 1/1/2007 and thereafter)	Access+HMO Plan 5
Calendar year copayment maximum# (individual/family)	\$1,500/\$3,000 Calendar-year copayment maximum changes	\$1,000/\$2,000
EMERGENCY HEALTH COVERAGE (not resulting in direct admission to the Hospital as an Inpatient from the ER)	\$100/visit Copayment change	\$50/visit

Copayments marked with a (#) do not accrue to the 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* and the *Group Health Service Agreement* for exact terms and conditions of coverage.

Language and legislative changes affecting this plan

Information regarding creditable coverage

To comply with Centers for Medicare & Medicaid Services (CMS) requirements, the language describing creditable coverage is as follows:

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 Medicare Part D premiums.

Clarification to Durable/Home Medical Equipment language

To clarify the scope of the Activities of Daily Living (ADL) benefit limit, we have revised the ADL definition to include more specific wording and to apply ADL to prosthetics and Home Medical Equipment. We have changed the name of the Home Medical Equipment to Durable Medical Equipment.

Autologous Chondrocytes Transplantation (ACT) benefit reclassified as covered surgical procedure

Members are no longer required to have an Autologous Chondrocyte Implantation/Transplantation performed at a special transplant center.

Preventive eye and ear screening language clarification

We have changed the preventive eye and ear screening benefit language. New language indicates coverage "through age 18" which clarifies the previous "covered under age 18" description.

Clarification of HMO Urgent Services changes

HMO and POS members who need urgent care within California, but outside the service area of their Personal Physician's IPA or medical group, should phone Member Services or check "Find a Provider" at blueshieldca.com for the nearest network urgent care provider.

COBRA continuation of coverage after COBRA and/or CalCOBRA

Certain aspects of the COBRA Continuation of Coverage were repealed in 2005 and therefore are no longer valid and have been deleted. The deletions refer to an extension of coverage after COBRA and CalCOBRA and the notification requirements of this extension. The coverage, called Senior COBRA, was repealed in January 2005 and so the notice requirements are being deleted since no current or new members will qualify.

Clarification of third party liability

We have clarified a member's liability when a Preferred Hospital has provided third party injury services.

Independent Practice Association (IPA)/Medical Group (MG) changes while pregnant

HMO and POS members are not permitted to change their medical group/IPA during the third trimester of pregnancy or while hospitalized. If a member requests such a change, the effective date will be the first day of the month following discharge from the hospital, or when pregnant, following the completion of post-partum care. Exceptions must be approved by a Blue Shield Medical Director.

Revision to exclusion for travel immunizations

The coverage description for immunizations under Preventive Care Benefits is revised to:

Pediatric and adult immunizations and the immunizing agent, as recommended by the American Academy of Pediatrics and the United States Public Health Service through its U. S. Preventive Services Task Force and/or the Advisory Committee on Immunization Practices (ACIP) of the Centers for Disease Control (CDC), except for immunizations and vaccinations by any mode of administration (oral, injection or otherwise) solely for the purpose of travel.

The exclusion for travel immunizations in the General Exclusion section is also revised with the same wording.

The following new exclusion is added to the Outpatient Prescription Drug inserts:

Immunizations and vaccinations by any mode of administration (oral, injection or otherwise) solely for the purpose of travel.

Clarification to Inpatient Substance Abuse optional benefit

The Inpatient Substance Abuse optional benefit has been clarified to note that all services must be medically necessary and that residential care is not covered.

New requirement for receiving dialysis services

Members are now required to obtain pre-service review prior to receiving dialysis services. Members or their providers can obtain this review by calling **(800) 343-1691**. Services included in this requirement are dialysis related laboratory tests, equipment, medications, supplies and dialysis self-management training for home dialysis. Services provided by dialysis centers in the preferred network are paid at the plan's percentage of the allowable amount, while services provided by non-preferred dialysis centers or non-preferred hospitals are paid at the plan's coinsurance amount of the allowable amount, up to \$300 per day

Clarification of role of the medical group or IPA

We are clarifying your benefits to note that your Personal Physician coordinates with your designated medical group or IPA to direct all your medical care needs and refer you to specialists or hospitals within your medical group/IPA, unless because of your health condition care is unavailable from your medical group/IPA.

Clarification to benefit following changing medical group or IPA

Any time you change to a new medical group/IPA, all previous authorizations for specialty care or procedures must be transitioned to specialists affiliated with your new medical group/IPA. All authorizations made by your previous medical group/IPA are no longer valid, even if you remain with the same Personal Physician.

Clarification to preventive care benefits

While your preventive care benefits are not changing, your plan's *Evidence of Coverage* has been revised to clarify that immunizations for the purpose of travel are not included in your benefits.

Continuation coverage advisory

To comply with new legislation, the following paragraph is being added to the beginning of the "Continuation of Group Coverage" section of the *Evidence of Coverage*:

"Please examine your options carefully before declining this coverage. You should be aware that companies selling individual health insurance typically require a review of your medical history that could result in a higher premium or you could be denied coverage entirely."

Domestic partner eligibility requirement clarification

We are clarifying domestic partner requirements. The current requirements specify domestic partners in California must register with the Secretary of State. The new requirements clarify domestic partners living outside of California don't have to register

If your coverage includes any of these Optional Benefits please note the following changes:

Dental Plan changes:

Enhanced dental PPO benefits for pregnant women

The following additional or enhanced periodontal benefits are available for women during the term of a pregnancy: One additional routine adult prophylaxis (including one additional periodontal prophylaxis for pregnancy gingivitis) and one

periodontal maintenance visit if warranted by a history of periodontal treatment, and one course (up to four quadrants) of periodontal scaling and root planing for women with a documented existing periodontal condition.

Vision Plan changes:

Vision providers using wholesale pricing

If your coverage includes vision benefits, your vision coverage has a maximum allowable frame allowance of \$75.00 or \$100.00 at participating providers, depending on your plan. When a participating provider uses wholesale pricing, the maximum allowable frame allowance will be \$47.00 to \$65.80 respectively.

Polycarbonate lens benefit for dependent children

All new and renewing vision plans effective January 2007 will include a polycarbonate lens benefit for covered dependent children (with no additional cost). These lenses are virtually unbreakable and provide protection for children and reassurance for their parents.

Some dental and vision plans are underwritten by Blue Shield of California Life & Health Insurance Company.

All Blue Shield of California plans are subject to limitations and exclusions. This document is only a summary for informational purposes. It is not a contract. Please refer to the *Evidence of Coverage* and the *Group Health Service Agreement* for the exact terms and conditions of coverage. Benefits are subject to modification by Blue Shield for subsequently enacted state or federal legislation.