EIAHealth/County of Santa Barbara
ASO EPO High Option Plan

Benefit Summary (For groups of 300 and above)
(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 *PLAN CONTRACT* SHOULD BE CONSULTED FOR A DETAILED DESCRIPTION OF COVERAGE BENEFITS AND LIMITATIONS.

	Participating Providers[1]
Calendar Year Medical Deductible	$0 per individual / $0 per family
Calendar Year Out-of-Pocket Maximum	$1,500 per individual / $3,000 per family
Lifetime Benefit Maximum	None
Covered Services	**Member Copayment**
OUTPATIENT PROFESSIONAL SERVICES	**Participating Providers[1]**
Professional (Physician) Benefits	
Physician office visits (physicians include OB/GYN, Pediatrician, Internal Medicine, Family Practice and General Practice)	$20 per visit
Specialist office visits (specialists include all other provider designations)[3]	$30 per visit
Outpatient diagnostic x-ray, imaging, pathology, laboratory and other testing services	No Charge
Radiological and nuclear imaging (CT scans, MRIs, MRAs, PET scans and cardiac diagnostic procedures utilizing nuclear medicine)	No Charge
Allergy Testing and Treatment Benefits	
Allergy testing, treatment and serum injections (separate office visit copayment may apply)[3]	$20 per visit
Preventive Health Benefits[7]	
Preventive health services (as required by applicable Federal law)	No Charge
OUTPATIENT FACILITY SERVICES	
Outpatient surgery performed at a free-standing ambulatory surgery center	No Charge
Outpatient surgery performed in a hospital or a hospital affiliated ambulatory surgery center	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
Outpatient diagnostic x-ray, imaging, pathology, laboratory and other testing services	No Charge
Radiological and nuclear imaging (CT scans, MRIs, MRAs, PET scans and cardiac diagnostic procedures utilizing nuclear medicine)	No Charge
Bariatric surgery (prior authorization is required; medically necessary surgery for weight loss, for morbid obesity only)[2]	No Charge
HOSPITALIZATION SERVICES	
Hospital Benefits (Facility Services)	
Inpatient physician services	No Charge
Inpatient non-emergency facility services (semi-private room and board, and medically necessary services and supplies, including subacute care)	$300 per admission + 20%
Bariatric surgery (prior authorization is required; medically necessary surgery for weight loss, for morbid obesity only)[2]	$300 per admission + 20%
Inpatient Skilled Nursing Benefits[4, 8] (combined maximum of up to 100 days per benefit period; prior authorization is required; semi-private accommodations)	
Free-standing skilled nursing facility	20%
Skilled nursing unit of a hospital	20%

EMERGENCY HEALTH COVERAGE	
Emergency room services not resulting in admission (copayment does not apply if the member is directly admitted to the hospital for inpatient services)	$150 per visit
Emergency room services resulting in admission (when the member is admitted directly from the ER)	$300 per admission + 20%
Emergency room physician services	No Charge
AMBULANCE SERVICES	
Emergency or authorized transport (ground or air)	$50 per transport
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	No Charge
MENTAL HEALTH AND SUBSTANCE ABUSE SERVICES[5, 6]	
Inpatient hospital services	$300 per admission + 20%
Residential care	$300 per admission + 20%
Inpatient physician services	No Charge
Routine outpatient mental health and substance abuse services (includes professional/physician visits)	$20 per visit
Non-routine outpatient mental health and substance abuse services (includes electroconvulsive therapy, intensive outpatient programs, office-based opioid treatment, partial hospitalization program, psychological testing and transcranial magnetic stimulation)	No Charge
HOME HEALTH SERVICES	
Home health care agency services (up to 100 visits per Calendar Year)[8]	20%
Home infusion/home injectable therapy and infusion nursing visits provided by a home infusion agency	20%
HOSPICE PROGRAM BENEFITS	
Routine home care	No Charge
Inpatient respite care	No Charge
24-hour continuous home care	20%
Short-term inpatient care for pain and symptom management	20%
CHIROPRACTIC BENEFITS	
Chiropractic spinal manipulation (up to 26 visits per Calendar Year combined with Rehabilitation Services)	$20 per visit
ACUPUNCTURE BENEFITS	
Acupuncture services (up to 12 visits per Calendar Year; up to $50 per visit)	$20 per visit
REHABILITATION AND HABILITATION BENEFITS (Physical, Occupational and Respiratory Therapy)	
Office location (an additional facility copayment may apply when services are rendered in a hospital or skilled nursing facility; up to 26 visits per Calendar Year combined with Chiropractic services)	$20 per visit
SPEECH THERAPY BENEFITS	
Office location (an additional facility copayment may apply when services are rendered in a hospital or skilled nursing facility)	$20 per visit
PREGNANCY AND MATERNITY CARE BENEFITS	
Prenatal and postnatal physician office visits (when billed as part of global maternity fee including hospital inpatient delivery 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
FAMILY PLANNING BENEFITS	
Counseling and consulting (includes insertion of IUD, as well as injectable and implantable contraceptives for women)	No Charge
Tubal ligation (an additional facility copayment may apply when services are rendered in a hospital or skilled nursing facility)	No Charge
Vasectomy (an additional facility copayment may apply when services are rendered in a hospital or outpatient surgery center)	$75 per surgery
Infertility services (diagnosis and treatment of causes of infertility. Excludes in vitro fertilization, injectables for infertility, artificial insemination and GIFT)	50% of allowed charges
DIABETES CARE BENEFITS	
Devices, equipment, and non-testing supplies (for testing supplies see Outpatient Prescription Drug Benefits)	No Charge
Diabetes self-management training	$20 per visit
HEARING AID	
Hearing Aid Instrument (plan payment maximum of $700 per member every 24 months)	No Charge

CARE OUTSIDE OF PLAN SERVICE AREA

Benefits provided through the BlueCard® Program are paid at the Participating level. Member's cost share will be either a copayment or coinsurance based on the lower of billed charges or the negotiated allowable amount for Participating providers as agreed upon with the local Blue's Plan.

Within US: BlueCard Program	See Applicable Benefit
Outside of US: BlueCard Worldwide	See Applicable Benefit

1 Unless otherwise specified, copayments/coinsurance are calculated based on allowable amounts. After the Calendar Year medical deductible is met, the member is responsible for copayments/coinsurance for covered services from Participating providers. Participating providers agree to accept Blue Shield's allowable amount plus any applicable member copayment or coinsurance as full payment for covered services.

2 Bariatric surgery is covered when pre-authorized by Blue Shield.

3 When services are provided by a Participating Specialist, a $30 copayment per visit applies.

4 Services may require prior authorization. When services are prior authorized, members pay the Participating provider amount.

5 Mental Health and Substance Abuse services are accessed through Blue Shield's Participating providers.

6 Inpatient services for acute detoxification are covered under the medical benefit; see the Hospital Benefits (Facility Services) section of the Plan Contract for benefit details. Services for acute medical detoxification are accessed through Blue Shield using Blue Shield's Participating providers.

7 Preventive Health Services, including an annual preventive care or well-baby care office visit, are not subject to the Calendar Year medical deductible. Other covered non-preventive services received during, or in connection with, the preventive care or well-baby care office visit are subject to the Calendar Year medical deductible and applicable member copayment/coinsurance.

8 Services with day or visit limits accrue to the Calendar Year day or visit limit maximum regardless of whether the plan deductible has been met.

Plan designs may be modified to ensure compliance with Federal requirements.