EIAHealth/County of Santa Barbara
ASO PPO 750-80/60 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]	Non Participating Providers[2]
Calendar Year Medical Deductible (All providers combined)	$750 per individual / $2,250 per family	
Calendar Year Out-of-Pocket Maximum (Copayments or coinsurance for covered services from Participating providers accrue to both the Participating and Non Participating provider Calendar Year out-of-pocket maximum amount.)	$4,750 per individual / $10,250 per family	$6,750 per individual / $14,250 per family
Lifetime Benefit Maximum	None	
Covered Services	**Member Copayment**	
OUTPATIENT PROFESSIONAL SERVICES	**Participating Providers[1]**	**Non Participating Providers[2]**
Professional (Physician) Benefits		
Physician and specialist office visits	$30 per visit (not subject to the Calendar Year medical deductible)	40%
Outpatient diagnostic x-ray, imaging, pathology, laboratory and other testing services	20%	40%
Radiological and nuclear imaging (CT scans, MRIs, MRAs, PET scans and cardiac diagnostic procedures utilizing nuclear medicine)	20%	40%
Allergy Testing and Treatment Benefits		
Allergy testing, treatment and serum injections (separate office visit copayment may apply)	20%	40%
Preventive Health Benefits[11]		
Preventive health services (as required by applicable Federal law)	No Charge (not subject to the Calendar Year medical deductible)	40%
OUTPATIENT FACILITY SERVICES		
Outpatient surgery performed at a free-standing ambulatory surgery center	20%	40% up to $350 per day[3]
Outpatient surgery performed in a hospital or a hospital affiliated ambulatory surgery center	20%	40% up to $350 per day[3]
Outpatient services for treatment of illness or injury and necessary supplies (except as described under "Rehabilitation Benefits" and "Speech Therapy Benefits")	20%	40% up to $350 per day[3]
Outpatient diagnostic x-ray, imaging, pathology, laboratory and other testing services	20%	40% up to $350 per day[3]
Radiological and nuclear imaging (CT scans, MRIs, MRAs, PET scans and cardiac diagnostic procedures utilizing nuclear medicine)	20%	40% up to $350 per day[3]
Bariatric surgery (prior authorization is required; medically necessary surgery for weight loss, for morbid obesity only)[4]	20%	40% up to $350 per day[3]
HOSPITALIZATION SERVICES		
Hospital Benefits (Facility Services)		
Inpatient physician services	20%	40%
Inpatient non-emergency facility services (semi-private room and board, and medically necessary services and supplies, including subacute care)	$250 per admission + 20%	40% up to $600 per day[5]
Bariatric surgery (prior authorization is required; medically necessary surgery for weight loss, for morbid obesity only)[4]	$250 per admission + 20%	40% up to $600 per day[5]

Inpatient Skilled Nursing Benefits[6] (combined maximum of up to 100 days per benefit period; prior authorization is required; semi-private accommodations)		
Free-standing skilled nursing facility	20%	20%[7]
Skilled nursing unit of a hospital	20%	40% up to $600 per day[5]
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)	$75 per visit + 20% (not subject to the Calendar Year medical deductible)	$75 per visit + 20% (not subject to the Calendar Year medical deductible)
Emergency room services resulting in admission (when the member is admitted directly from the ER)	$250 per admission + 20%	$250 per admission + 20%
Emergency room physician services	20%	20%
AMBULANCE SERVICES		
Emergency or authorized transport (ground or air)	20%	20%
PROSTHETICS/ORTHOTICS		
Prosthetic equipment and devices (separate office visit copayment may apply)	20%	40%
Orthotic equipment and devices (separate office visit copayment may apply)	20%	40%
DURABLE MEDICAL EQUIPMENT		
Breast pump	No Charge (not subject to the Calendar Year medical deductible)	Not Covered
Other durable medical equipment	20%	40%
MENTAL HEALTH AND SUBSTANCE ABUSE SERVICES[8, 9]		
Inpatient hospital services	$250 per admission + 20%	40% up to $600 per day[5]
Residential care	$250 per admission + 20%	40% up to $600 per day[5]
Inpatient physician services	No Charge	40%
Routine outpatient mental health and substance abuse services (includes professional/physician visits)	$30 per visit (not subject to the Calendar Year medical deductible)	40%
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	40%
HOME HEALTH SERVICES		
Home health care agency services (up to 100 visits per Calendar Year)[6]	20%	Not Covered[10]
Home infusion/home injectable therapy and infusion nursing visits provided by a home infusion agency	20%	Not Covered[10]
HOSPICE PROGRAM BENEFITS		
Routine home care	No Charge (not subject to the Calendar Year medical deductible)	Not Covered[10]
Inpatient respite care	No Charge (not subject to the Calendar Year medical deductible)	Not Covered[10]
24-hour continuous home care	20%	Not Covered[10]
Short-term inpatient care for pain and symptom management	20%	Not Covered[10]
CHIROPRACTIC BENEFITS[6]		
Chiropractic spinal manipulation (up to 26 visits per Calendar Year combined with rehabilitation benefits)	20%	Not Covered
ACUPUNCTURE BENEFITS[6]		
Acupuncture services (up to 12 visits per Calendar Year; up to $50 per visit)	20%	20%
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 benefits.)	20%	40%
SPEECH THERAPY BENEFITS		
Office location (an additional facility copayment may apply when services are rendered in a hospital or skilled nursing facility)	20%	40%
PREGNANCY AND MATERNITY CARE BENEFITS		
Prenatal and postnatal physician office visits (when billed as part of global maternity fee including hospital inpatient delivery services)	20%	40%
Abortion services (an additional facility copayment may apply when services are rendered in a hospital or outpatient surgery center)	20%	40%

FAMILY PLANNING BENEFITS		
Counseling and consulting	No Charge (not subject to the Calendar Year medical deductible)	40%
Intrauterine device (IUD)	No Charge (not subject to the Calendar Year medical deductible)	Not Covered
Insertion/removal of intrauterine device	No Charge (not subject to the Calendar Year medical deductible)	Not Covered
Infertility (diagnosis and treatment of causes of infertility. Excludes in vitro fertilization, injectables for infertility, artificial insemination and GIFT)	50% of allowed charges	Not Covered
Tubal ligation (an additional facility copayment may apply when services are rendered in a hospital or skilled nursing facility)	No Charge (not subject to the Calendar Year medical deductible)	40%
Vasectomy (an additional facility copayment may apply when services are rendered in a hospital or outpatient surgery center)	20%	40%
DIABETES CARE BENEFITS		
Devices, equipment, and non-testing supplies (for testing supplies see Outpatient Prescription Drug Benefits)	20%	40%
Diabetes self-management training	$30 per visit (not subject to the Calendar Year medical deductible)	40%
HEARING AID		
Hearing Aid instrument and ancillary equipment (plan payment maximum of $700 per member every 24 months)	20%	20%
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	See Applicable Benefit
Outside of US: BlueCard Worldwide	See Applicable Benefit	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 Non Participating providers can charge more than Blue Shield's allowable amounts. When members use Non Participating providers, they must pay the applicable deductibles, copayments or coinsurance plus any amount that exceeds Blue Shield's allowable amount. Charges above the allowable amount do not count toward the Calendar Year deductible or out-of-pocket maximum.

3 The maximum allowed charges for non-emergency surgery and services performed in a Non Participating ambulatory surgery center or outpatient unit of a Non Participating hospital is $350 per day. Members are responsible for 40% of this $350 per day, and all charges in excess of $350 per day. Amounts that exceed the benefit maximums do not count toward the Calendar Year out-of-pocket maximum and continue to be the member's financial responsibility after the Calendar Year maximums are reached.

4 Bariatric surgery is covered when pre-authorized by the plan.

5 The maximum allowed charges for non-emergency hospital services received from a Non Participating hospital is $600 per day. Members are responsible for 40% of this $600 per day, and all charges in excess of $600 per day. Amounts that exceed the benefit maximum do not count toward the Calendar Year out-of-pocket maximum and continue to be the member's responsibility after the Calendar Year maximums are reached.

6 For plans with a Calendar Year medical deductible amount, services with a day or visit limit accrue to the Calendar Year day or visit limit maximum regardless of whether the Calendar Year medical deductible has been met.

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

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

9 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 or with Non Participating providers.

10 Services from Non Participating providers for home health care and hospice services are not covered unless prior authorized. When these services are prior authorized, the member's copayment or coinsurance will be calculated at the Participating provider level, based upon the agreed upon rate between Blue Shield and the agency.

11 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.

12 Deductibles and copayments marked with this footnote do not accrue to the Calendar Year Out-of-pocket maximum. 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. Dedcutible does not apply towards the Calendar Year Out-of-pocket maximum. Please refer to the Plan Contract for exact terms and conditions of coverage.

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