ElAHealth/County of Santa Barbara
ASO High Deductible Health 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 PLAN CONTRACT SHOULD BE CONSULTED FOR A DETAILED DESCRIPTION OF COVERAGE BENEFITS AND LIMITATIONS.

Blue Shield of California

Highlights: $1,500 individual coverage deductible
or $3,000 family coverage deductible

Effective: January 1, 2016

	Preferred Providers	Non-Preferred Providers
Calendar Year Medical Deductible (All providers combined) (Note: For family coverage, the full family deductible must be met before the enrollee or covered dependents can receive benefits for covered services)	$1,500 per Individual / $3,000 per Family	
Calendar Year Out-of-Pocket Maximum (Includes the plan medical deductible) (For family coverage, the full family out-of-pocket maximum must be met before the enrollee or covered dependents can receive 100% benefits for covered services.)	$4,500 per individual / $9,000 per Family	
LIFETIME BENEFIT MAXIMUM	None	
Covered Services	**Member Copayment**	
PROFESSIONAL SERVICES	**Preferred Providers[1]**	**Non-Preferred Providers[1]**
Professional (Physician) Benefits		
• Physician and specialist office visits	20%	40%
• CT scans, MRIs, MRAs, PET scans, and cardiac diagnostic procedures utilizing nuclear medicine[2] (prior authorization is required)	No Charge	40%
• Other outpatient X-ray, pathology and laboratory (Diagnostic testing by providers other than outpatient laboratory, pathology, and imaging departments of hospitals/facilities)[2]	No Charge	40%
Allergy Testing and Treatment Benefits		
• Office visits (includes visits for allergy serum injections)	20%	40%
Preventive Health Benefits		
• Preventive Health Services (As required by applicable federal law.)	No Charge (Not subject to the Calendar-Year Deductible)	40%
OUTPATIENT SERVICES		
Hospital Benefits (Facility Services)		
• Outpatient surgery performed at an Ambulatory Surgery Center[3]	20%	40%[4]
• Outpatient surgery in a hospital	20%	40%[4]
• Outpatient Services for treatment of illness or injury and necessary supplies (Except as described under "Rehabilitation Benefits")	20%	40%[4]
• CT scans, MRIs, MRAs, PET scans, and cardiac diagnostic procedures utilizing nuclear medicine performed in a hospital (prior authorization is required)[2]	No Charge	40%[4]
• Other outpatient X-ray, pathology and laboratory performed in a hospital[2]	No Charge	40%[4]
• Bariatric Surgery[5] (prior authorization required by the Plan; medically necessary surgery for weight loss, for morbid obesity only)	20%	40%[4]
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)	20%	40%[6]
• Bariatric Surgery[5] (prior authorization required by the Plan; medically necessary surgery for weight loss, for morbid obesity only)	20%	40%[6]
Skilled Nursing Facility Benefits[7, 8] (Combined maximum of up to 100 prior authorized days per Calendar Year; semi-private accommodations)		
• Services by a free-standing Skilled Nursing Facility	20%	20%[6,8]
• Skilled Nursing Unit of a Hospital	20%	40%[6]

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)	20%	20%
• Emergency room Services resulting in admission (when the member is admitted directly from the ER)	20%	20%
• Emergency room Physician Services	20%	20%
AMBULANCE SERVICES		
• Emergency or authorized transport	20%	20%
PRESCRIPTION DRUG COVERAGE[9, 10, 11, 12, 13, 14, 15] (Subject to deductible)	**Participating Pharmacy**	**Non-Participating Pharmacy**
Outpatient Prescription Drug Benefits		
Retail Prescriptions (For up to a 30-day supply)		
• Contraceptive Drugs and Devices[16]	No Charge	Not Covered
• Formulary Generic Drugs	20%	20%
• Formulary Brand Name Drugs	20%	20%
• Non-Formulary Brand Name Drugs	20%	20%
Mail Service Prescriptions (For up to a 90-day supply)		
• Contraceptive Drugs and Devices[16]	No Charge	Not Covered
• Formulary Generic Drugs	20%	Not Covered
• Formulary Brand Name Drugs	20%	Not Covered
• Non-Formulary Brand Name Drugs	20%	Not Covered
Specialty Pharmacies (up to a 30-day supply)		
• Specialty Drugs	20% up to $100 out-of-pocket copayment maximum per prescription	Not Covered
PROSTHETICS/ORTHOTICS		
• Prosthetic equipment and devices (Separate office visit copay may apply)	20%	40%
• Orthotic equipment and devices (Separate office visit copay may apply)	20%	40%
DURABLE MEDICAL EQUIPMENT		
• Breast pump	No Charge (Not subject to the Calendar-Year Deductible)	Not Covered
• Other Durable Medical Equipment	20%	40%
MENTAL HEALTH AND SUBSTANCE ABUSE SERVICES)[17, 18]		
• Inpatient Hospital Services	20%	40%[6]
• Residential Care	20%	40%[6]
• Outpatient Mental Health Services	20%	40%
HOME HEALTH SERVICES[19]		
• Home health care agency Services[7] (up to 100 prior authorized visits per Calendar Year)	20%	Not Covered[19]
• Home infusion/home intravenous injectable therapy and infusion nursing visits provided by a Home Infusion Agency	20%	Not Covered[19]
OTHER		
Hospice Program Benefits[19]		
• Routine home care	No Charge	Not Covered[19]
• Inpatient Respite Care	No Charge	Not Covered[19]
• 24-hour Continuous Home Care	20%	Not Covered[19]
• General Inpatient care	20%	Not Covered[19]
Chiropractic Benefits[7]		
• Chiropractic Services (Up to 26 visits per Calendar Year combined with rehabilitation services)	20%	Not Covered
Acupuncture Benefits[7]		
• Acupuncture (Up to 12 visits per Calendar Year, up to $50 per visit)	20%	20%
Rehabilitation Benefits (Physical, Occupational and Respiratory Therapy)[7]		
• Office location (Up to 26 visits per calendar year combined with chiropractic services)	20%	Not Covered
Speech Therapy Benefits		
• Office Visit	20%	40%

Pregnancy and Maternity Care Benefits		
• Prenatal and postnatal Physician office visits (For inpatient hospital services, see "Hospitalization Services.")	20%	40%
• Abortion Services[20]	20%	40%
Family Planning Benefits		
• Counseling and consulting	No Charge (Not subject to the Calendar-Year Deductible)	40%
• Intrauterine device (IUD)	No Charge (Not subject to the Calendar-Year Deductible)	Not Covered
• Insertion/removal of intrauterine device	No Charge (Not subject to the Calendar-Year Deductible)	Not Covered
• Tubal ligation	No Charge (Not subject to the Calendar-Year Deductible)	40%
• Vasectomy[20]	20%	40%
• Infertility Services (Diagnosis and treatment of causes of infertility. Excludes in vitro fertilization, injectables for infertility, artificial insemination and GIFT)	50% of allowed charges	Not Covered
Diabetes Care Benefits		
• Devices, equipment, and non-testing supplies (for testing supplies see Outpatient Prescription Drug Benefits.)	20%	40%
• Diabetes self-management training (If billed by your provider, you will also be responsible for the office visit copayment)	20%	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 for out-of-state emergency and non-emergency care are provided at the preferred level of the local Blue Plan allowable amount when you use a Blue Cross/Blue Shield provider)		
• Within US: BlueCard Program	See Applicable Benefit	See Applicable Benefit
• Outside of US: BlueCard Worldwide	See Applicable Benefit	See Applicable Benefit

1 Member is responsible for copayment in addition to any charges above allowable amounts. The copayment percentage indicated is a percentage of allowed amounts. Preferred providers accept Blue Shield's allowable amount as full payment for covered services. Non-preferred providers can charge more than these amounts. When members use non-preferred providers, they must pay the applicable copayment plus any amount that exceeds Blue Shield's allowable amount. Charges in excess of the allowable amount do not count toward the calendar-year deductible or out-of-pocket maximum. Payments applied to your calendar-year deductible accrue towards the out-of-pocket maximum.

2 Participating non Hospital based ("freestanding") outpatient X-ray, pathology and laboratory facilities centers may not be available in all areas. Regardless of their availability, you can obtain outpatient X-ray, pathology and laboratory services from a hospital or an ambulatory surgery center affiliated with a hospital, with payment according to your health plan's hospital services benefits.

3 Participating ambulatory surgery facilities 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 The maximum allowed charges for non-emergency surgery and services performed in a non-participating Ambulatory Surgery Center or outpatient unit of a non-preferred hospital is $350 per day. Members are responsible for 40% of this $350 per day, plus all charges in excess of $350.

5 Bariatric surgery is covered when pre-authorized by the Plan.

6 The maximum allowed charge for non-emergency hospital services received from a non-preferred hospital is $600 per day. Members are responsible for 40% of this $600 per day, plus all charges in excess of $600. Payments that exceed the allowed charge do not count toward the calendar-year out-of-pocket maximum, and continue to be owed after the maximum is reached.

7 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 plan medical deductible has been met.

8 Services may require prior authorization by the Plan. When services are prior authorized, members pay the preferred or participating provider amount.

9 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). Because this plan's prescription drug coverage is creditable, you do not have to enroll in a Medicare prescription drug plan 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 anytime after you were first eligible to enroll in a Medicare prescription drug plan, you could be subject to a late enrollment penalty in addition to your Part D premium.

10 If the member requests a brand-name drug when a generic drug equivalent is available, the member is responsible for paying the difference between the cost to Blue Shield for the brand-name Drug and its generic drug equivalent, as well as the applicable generic drug Copayment. This difference in cost that the member must pay is not applied to their calendar-year medical deductible and is not included in the calendar-year out-of-pocket maximum responsibility calculations.

11 Please note that if you switch from another plan, your prescription drug deductible credit from the previous plan during the calendar year, if applicable, will not carry forward to your new plan.

12 For the Outpatient Prescription Drugs Benefit, covered Drugs obtained from Non-Participating Pharmacies will be subject to and accrue to the Calendar Year Deductible and the Calendar Year Out-of-Pocket Maximum for Preferred Providers.

13 Specialty drugs are covered only when dispensed by select pharmacies in the Specialty Pharmacy Network unless Medically Necessary for a covered emergency.

14 Selected formulary and non-formulary drugs require prior authorization by Blue Shield for Medical Necessity, and when effective, lower cost alternatives are available.

15 Specialty Drugs are specific Drugs used to treat complex or chronic conditions which usually require close monitoring such as multiple sclerosis, hepatitis, rheumatoid arthritis, cancers, and other conditions that are difficult to treat with traditional therapies. Specialty Drugs are listed in the Blue Shield Outpatient Drug Formulary. Specialty Drugs may be self-administered in the home by injection by the patient or family member (subcutaneously or intramuscularly), by inhalation, orally or topically. Infused or Intravenous (IV) medications are not included as Specialty Drugs. These Drugs may also require special handling, special manufacturing processes, and may have limited prescribing or limited pharmacy availability. Specialty Drugs must be considered safe for self-administration by Blue Shield's Pharmacy & Therapeutics Committee, be obtained from a Blue Shield Specialty Pharmacy and may require prior authorization for Medical Necessity by

Blue Shield.

16 Contraceptive Drugs and Devices covered under the outpatient prescription drug benefits will no longer require a copayment and will not be subject to the calendar-year deductible. However, if a brand-name contraceptive is requested when a generic equivalent is available, the member will still be responsible for paying the difference between the cost to the Plan for the brand-name contraceptive and its generic drug equivalent. In addition, select contraceptives may need prior authorization to be covered without a copayment.

17 Mental health and substance abuse services are accessed through Blue Shield using Blue Shield's participating and non-participating providers.

18 Inpatient services for acute detoxification are covered under the medical benefit; see hospitalization services for benefit details. Services for medical acute detoxification are accessed through Blue Shield using Blue Shield's preferred providers or non-preferred providers.

19 Out of network home health care, home infusion and hospice services are not covered unless pre-authorized. When these services are pre-authorized, the member pays the Preferred Provider Copayment.

20 Copayment shown is for physician's services. If the procedure is performed in a facility setting (hospital or outpatient surgery center), an additional facility copayment may apply. Services from non-participating providers and non-preferred facilities are not covered under this benefit.

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