EIA Health/City of Huntington Beach
ASO HDHP 2000/4000

Benefit Summary
(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) For individual on family coverage plan, one or more in the family can satisfy the family deductible.	$2,000 per individual contract / $6,000 per family	$4,000 per individual contract / $12,000 per family
Calendar Year Out-of-Pocket Maximum (Includes the Calendar Year medical deductible) For individual on family coverage plan, the individual can receive 100% benefits for covered services once individual out-of-pocket maximum is met. Out-of-pocket maximum accumulates separately for Participating and Non Participating providers.)	$6,350 per individual and an individual in a family / $12,700 per family	$12,700 per individual contract / $38,100 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%	50%
Outpatient diagnostic x-ray, imaging, pathology, laboratory and other testing services (Diagnostic testing by providers by providers other than outpatient laboratory, pathology, and imaging department of hospitals/facilities)	30%	50%
Radiological and nuclear imaging (CT scans, MRIs, MRAs, PET scans and cardiac diagnostic procedures utilizing nuclear medicine; prior authorization is required)	30%	50%
Allergy Testing and Treatment Benefits		
Allergy testing, treatment and serum injections (separate office visit copayment may apply)	30%	50%
Preventive Health Benefits[11]		
Preventive health services (as required by applicable Federal law)	No Charge (not subject to the calendar year medical deductible)	Not Covered
OUTPATIENT FACILITY SERVICES		
Outpatient surgery performed at a free-standing ambulatory surgery center	30%	50%[3]
Outpatient surgery performed in a hospital or a hospital affiliated ambulatory surgery center	30%	50%[3]
Outpatient services for treatment of illness or injury and necessary supplies (except as described under "Rehabilitation Benefits" and "Speech Therapy Benefits")	30%	50%[3]
Outpatient diagnostic x-ray, imaging, pathology, laboratory and other testing services	30%	50%[3]
Radiological and nuclear imaging (CT scans, MRIs, MRAs, PET scans and cardiac diagnostic procedures utilizing nuclear medicine; prior authorization is required)	30%	50%[3]
Bariatric surgery[4] (prior authorization is required; medically necessary surgery for weight loss, for morbid obesity only)	30%	50%[3]

HOSPITALIZATION SERVICES		
Hospital Benefits (Facility Services)		
Inpatient physician services	30%	50%
Inpatient non-emergency facility services (semi-private room and board, and medically necessary services and supplies, including subacute care)	30%	50%[5]
Bariatric surgery[4] (prior authorization is required; medically necessary surgery for weight loss, for morbid obesity only)	30%	50%[5]
Inpatient Skilled Nursing Benefits[6] (combined maximum of up to 100 days per calendar year; prior authorization is required; semi-private accommodations)		
Free-standing skilled nursing facility	30%	30%[7]
Skilled nursing unit of a hospital	30%	50%[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)	30%	30%
Emergency room services resulting in admission (when the member is admitted directly from the ER)	30%	30%
Emergency room physician services	30%	30%
AMBULANCE SERVICES		
Emergency or authorized transport (ground or air)	30%	30%
PRESCRIPTION DRUG COVERAGE[10, 11, 12, 13, 14, 15] (Subject to deductible; includes covered diabetic drugs and testing supplies)	**Participating Pharmacy**	**Non-Participating Pharmacy**
Outpatient Prescription Drug Benefits		
Retail Prescriptions Drug Benefits (For up to a 30-day supply)		
Contraceptive Drugs and Devices[16]	No Charge	Not Covered
Formulary Generic Drugs	30% per prescription	30% per prescription
Forumary Brand Name Drugs	30% per prescription	30% per prescription
Non-Formulary Brand Name Drugs	30% per prescription	30% per prescription
Mail Service Prescriptions (For up to a 90-day supply)		
Contraceptive Drugs and Devices[16]	No Charge	Not Covered
Formulary Generic Drugs	30% per prescription	Not Covered
Forumary Brand Name Drugs	30% per prescription	Not Covered
Non-Formulary Brand Name Drugs	30% per prescription	Not Covered
Specalty Pharmacies (up to a 30-day supply)[12, 13]		
Specialty Drugs	30% per prescription	Not Covered
PROSTHETICS/ORTHOTICS	**Participating Providers[1]**	**Non-Participating Providers[2]**
Prosthetic equipment and devices (separate office visit copayment may apply)	30%	50%
Orthotic equipment and devices (separate office visit copayment may apply)	30%	50%
DURABLE MEDICAL EQUIPMENT		
Breast pump	No Charge (not subject to the calendar year medical deductible)	Not Covered
Other durable medical equipment	30%	50%
MENTAL HEALTH AND SUBSTANCE ABUSE SERVICES[8,9]		
Inpatient hospital services	30%	50%[5]
Residential care	30%	50%[5]
Inpatient physician services	30%	50%
Routine outpatient mental health and substance abuse services (includes professional/physician visits)	30%	50%
Non-routine outpatient mental health and substance abuse services (includes behavioral health treatment, electroconvulsive therapy, intensive outpatient programs, office-based opioid treatment, partial hospitalization program, psychological testing and transcranial magnetic stimulation)	30%	50%

HOME HEALTH SERVICES		
Home health care agency services[6]	30%	Not Covered[17]
Home infusion/home injectable therapy and infusion nursing visits provided by a home infusion agency	30%	Not Covered[17]
HOSPICE PROGRAM BENEFITS		
Routine home care	No Charge	Not Covered[17]
Inpatient respite care	No Charge	Not Covered[17]
24-hour continuous home care	30%	Not Covered[17]
Short-term inpatient care for pain and symptom management	30%	Not Covered[17]
CHIROPRACTIC BENEFITS[6]		
Chiropractic spinal manipulation (up to 26 visits per calendar year combined with acupuncture services)	30%	50%
ACUPUNCTURE BENEFITS[6]		
Acupuncture services (up to 26 visits per calendar year combined with chiropractic services)	30%	30%
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)	30%	50%
SPEECH THERAPY BENEFITS		
Office location (an additional facility copayment may apply when services are rendered in a hospital or skilled nursing facility)	30%	50%
PREGNANCY AND MATERNITY CARE BENEFITS		
Prenatal and postnatal physician office visits (when billed as part of global maternity fee including hospital inpatient delivery services)	30%	50%
Abortion services (an additional facility copayment may apply when services are rendered in a hospital or outpatient surgery center)	30%	Not Covered
FAMILY PLANNING BENEFITS		
Counseling and consulting (includes insertion of IUD, as well as injectable and implantable contraceptives for women)	No Charge (not subject to the calendar year medical deductible)	Not Covered
Tubal ligation	No Charge (not subject to the calendar year medical deductible)	Not Covered
Vasectomy (an additional facility copayment may apply when services are rendered in a hospital or outpatient surgery center)	30%	Not Covered
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)	30%	50%
Diabetes self-management training	30%	50%
HEARING AID		
Hearing Aid Instrument and ancillary equipment (Combined plan payment maximum of $1,000 per member every 24 months for hearing aid and ancillary equipment)	30%	30%
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 50% 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 prior authorized by Blue Shield; however, for members residing in Imperial, Kern, Los Angeles, Orange, Riverside, San Bernardino, San Diego, Santa Barbara and Ventura Counties ("Designated Counties"), bariatric surgery services are covered only when performed at designated contracting bariatric surgery facilities and by designated contracting surgeons; coverage is not available for bariatric services from any other participating provider and there is no coverage for bariatric services from non-participating providers. In addition, if prior authorized by Blue Shield, a member in a Designated County who is required to travel more than 50 miles to a designated bariatric surgery facility will be eligible for limited reimbursement for specified travel expenses for the member and one companion. Refer to the Plan Contract for further details.

5 The maximum allowed charges for non-emergency hospital services received from a non-participating hospital is $600 per day. Members are responsible for 50% 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 For the Outpatient Prescription Drug 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.

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

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

13 Specialty drugs are specific drugs used to treat complex or chonic conditions which usually require close monitoring such as multiple sclerosis, hepaitits, 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. Specialty Drugs must be considered safe for self-administration by Blue Shield's Pharmacy & Therapeutics Committee, be obtained from a Blue Shield Specialty Pharmacy. Infused or Intravenous(IV) medications are not included as Specialty Drugs.

14 Select contraceptives, including diaphragms, covered under the outpatient prescription drug benefits will no longer require a copayment and will not be subject to the caledar-year deductible. However, if a brand name select contraceptive is requested when a generic equipvalent 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, as well as the applicable generic drug copayment. In addition, select contraceptives may need prior authorization.

15 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.

16 Contraceptive Drugs and Devices covered under the outpatient prescription drug benefits will not be subject to the calendar year deductible. If a brand name contraceptive is requested when a generic equivalent is available, the member will be responsible for paying the difference between the cost to Blue Shield 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 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.

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