EIA Health/Small Group Program
ASO HDHP 3000/6000

Benefit Summary
(Uniform Health Plan Benefits and Coverage Matrix)

Blue Shield of California

Effective: January 1, 2018

THIS MATRIX IS INTENDED TO BE USED TO HELP YOU COMPARE COVERAGE BENEFITS AND IS A SUMMARY ONLY. *PLAN CONTRACT* SHOULD BE CONSULTED FOR A DETAILED DESCRIPTION OF COVERAGE BENEFITS AND LIMITATIONS.

	Participating Providers[1]	Non Participating Providers[2]
Individual Coverage		
Individual Calendar Year Medical Deductible Applies to both medical and pharmacy services. An individual can receive benefits for covered services once individual deductible is met.	$3,000 per individual member (All providers combined)	
Individual Calendar Year Out-of-Pocket Maximum (Includes the calendar year medical deductible; all providers combined) Member will receive 100% benefits for covered services once the respective individual out-of-pocket maximum is met.	$5,950 per individual member	
Family Coverage		
Family Calendar Year Medical Deductible Applies to both medical and pharmacy services. There is an individual medical deductible within the family deductible. This means Blue Shield will pay Benefits for any family member who meets the individual medical deductible before the family medical deductible is met.	$3,000: family member / $6,000 per family (All providers combined)	
Family Calendar Year Out-of-Pocket Maximum (Includes the calendar year medical deductible; all providers combined) There is an individual out-of-pocket maximum within the family out-of-pocket maximum. This means any family member who meets the individual out-of-pocket maximum will receive 100% benefits for covered services once the respective out-of-pocket maximum is met.	$5,950: family member / $11,900 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	20%	50%
Teladoc consultation	$40 per consultation	Not Covered
Outpatient diagnostic x-ray, imaging, pathology, laboratory and other testing services	No charge	50%
Radiological and nuclear imaging (CT scans, MRIs, MRAs, PET scans and cardiac diagnostic procedures utilizing nuclear medicine)	20%	50%
Allergy Testing and Treatment Benefits		
Allergy testing, treatment and serum injections (separate office visit copayment may apply)	20%	50%
Preventive Health Benefits[21]		
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	20%	50% up to $350 per day[3]
Outpatient surgery performed in a hospital or hospital affiliated ambulatory surgery center	20%	50% 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%	50% up to $350 per day[3]
Outpatient diagnostic x-ray, imaging, pathology, laboratory and other testing services	$25 per visit + 20%	50% up to $350 per day[3]

Radiological and nuclear imaging (CT scans, MRIs, MRAs, PET scans and cardiac diagnostic procedures utilizing nuclear medicine)	$100 per visit + 20%	50% up to $350 per day[3]
Bariatric surgery (prior authorization is required; medically necessary surgery for weight loss, for morbid obesity only)[4]	20%	50% up to $350 per day[3]
HOSPITALIZATION SERVICES		
Hospital Benefits (Facility Services)		
Inpatient physician services	20%	50%
Inpatient non-emergency facility services (semi-private room and board, and medically necessary services and supplies, including subacute care)	20%	50% up to $600 per day[5]
Bariatric surgery (prior authorization is required; medically necessary surgery for weight loss, for morbid obesity only)[4]	20%	50% up to $600 per day[5]
Inpatient Skilled Nursing Benefits[6] (Coverage limited to 100 days per member per benefit period combined with hospital/free-standing skilled nursing facility.)		
Free-standing skilled nursing facility	20%	20%[7]
Skilled nursing unit of a hospital	20%	50% 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)	$100 per visit + 20%	$100 per visit + 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 (ground or air)	20%	20%
PRESCRIPTION DRUG COVERAGE[8,9,10,11,12,13,14,15,16,17] (subject to deductible)	**Participating Pharmacy**	**Non Participating Pharmacy**
Outpatient Prescription Drug Benefits		
Retail Prescriptions (up to a 30-day supply)		
Contraceptive drugs and devices[15]	No Charge	See Applicable Drug Tier Co-Pay
Tier 1 drugs	$7 per prescription	$7 per prescription
Tier 2 drugs	$25 per prescription	$25 per prescription
Tier 3 drugs	$25 per prescription	$25 per prescription
Tier 4 drugs (excluding Specialty drugs)	30% (up to $150 copayment maximum per prescription)	30% (up to $150 copayment maximum per prescription)
Mail Service Prescriptions (up to a 90-day supply)		
Contraceptive drugs and devices[15]	No Charge	Not Covered
Tier 1 drugs	$14 per prescription	Not Covered
Tier 2 drugs	$60 per prescription	Not Covered
Tier 3 drugs	$60 per prescription	Not Covered
Tier 4 drugs (excluding Specialty drugs)	30% (up to $300 copayment maximum per prescription)	Not Covered
Specialty Pharmacies[12,14] (up to a 30-day supply)		
Specialty drugs (includes orally administered anti-cancer medications)	30% (up to $150 copayment maximum per prescription)	Not Covered
PROSTHETICS/ORTHOTICS		
Prosthetic equipment and devices (separate office visit copayment may apply)	20%	50%
Orthotic equipment and devices (separate office visit copayment may apply)	20%	50%
DURABLE MEDICAL EQUIPMENT		
Breast pump	No Charge (not subject to the Calendar Year medical deductible)	Not Covered
Other durable medical equipment	20%	50%
MENTAL HEALTH AND SUBSTANCE USE DISORDER SERVICES[18,19]		
Inpatient hospital services	20%	50% up to $600 per day[5]
Residential care	20%	50% up to $600 per day[5]
Inpatient physician services	20%	50%
Routine outpatient mental health and substance use disorder services (includes professional/physician visits)	20%	50%
Non-routine outpatient mental health and substance use disorder services (includes electroconvulsive therapy, intensive outpatient programs, office-	No Charge	50%

based opioid treatment, partial hospitalization program, psychological testing and transcranial magnetic stimulation)		
HOME HEALTH SERVICES		
Home health care agency services[6] (Coverage limited to 100 visits per member per calendar year. Non-participating home health care and home infusion are not covered unless pre-authorized. When these services are pre-authorized, you pay the participating provider copayment.)	20%	Not Covered [20]
Home infusion/home injectable therapy and infusion nursing visits provided by a home infusion agency	20%	Not Covered [20]
HOSPICE PROGRAM BENEFITS		
Routine home care	No Charge	Not Covered [20]
Inpatient respite care	No Charge	Not Covered [20]
24-hour continuous home care	20%	Not Covered [20]
Short-term inpatient care for pain and symptom management	20%	Not Covered [20]
CHIROPRACTIC BENEFITS[6]		
Chiropractic spinal manipulation (Up to 26 visits per Calendar Year combined with Acupuncture services; plan payment maximum of up to $25 per visit)	20%	50%
ACUPUNCTURE BENEFITS[6]		
Acupuncture services (Up to 26 visits per Calendar Year combined with Chiropractic services; plan payment maximum of up to $30 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)	20%	50%
SPEECH THERAPY BENEFITS		
Office location (an additional facility copayment may apply when services are rendered in a hospital or skilled nursing facility)	20%	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)	20%	50%
Abortion services (an additional facility copayment may apply when services are rendered in a hospital or outpatient surgery center)	20%	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)	20%	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)	20%	50%
Diabetes self-management training	20%	50%
HEARING AID		
Hearing Aid Instrument and ancillary equipment (plan payment maximum of $1,000 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 a copayment/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 medical 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 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 any time 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.

9 If the member requests a brand drug when a generic drug equivalent is available, the member is responsible for paying the difference in cost between the brand drug and its generic drug equivalent, in addition to the Tier 1 drug copayment. The difference in cost that the member must pay does not accrue to any calendar year medical or pharmacy deductible and is not included in the calendar year out-of-pocket maximum responsibility calculations. Refer to the Plan Contract for details.

10 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.

11 Outpatient prescription drug copayments for covered drugs obtained from non-participating pharmacies will accrue to the calendar year medical deductible and the participating provider maximum calendar year out-of-pocket maximum.

12 Specialty drugs are available from a Network Specialty Pharmacy. A Network Specialty Pharmacy provides specialty drugs by mail or upon member request, at an associated retail store for pickup.

13 Select drugs require prior authorization by Blue Shield for medical necessity, or when effective, lower cost alternatives are available.

14 Network Specialty Pharmacies dispense Specialty drugs which require coordination of care, close monitoring, or extensive patient training that generally cannot be met by a retail pharmacy. Network Specialty Pharmacies also dispense Specialty drugs requiring special handling or manufacturing processes, restriction to certain Physicians or pharmacies, or reporting of certain clinical events to the FDA. Specialty drugs are generally high cost.

15 Contraceptive drugs and devices covered under the outpatient prescription drug benefits do not require a copayment and are not subject to the calendar year medical deductible when obtained from a participating pharmacy. However, if a brand contraceptive is requested when a generic equivalent is available, the member is responsible for paying the difference between the cost to Blue Shield for the brand contraceptive and its generic drug equivalent. The difference in cost that the member must pay does not accrue to any calendar year medical or pharmacy deductible and is not included in the calendar year out-of-pocket maximum calculation. In addition, select brand contraceptives may need prior authorization to be covered without a copayment.

16 To obtain prescription drugs, including contraceptive drugs and devices, at a non-participating pharmacy, the member must first pay all charges for the prescription and submit a completed Prescription Drug Claim Form for reimbursement. The member will be reimbursed the price paid for the drug less any applicable deductible, copayment or coinsurance and any applicable out of network charge.

17 Blue Shield's Short-Cycle Specialty Drug Program allows initial prescriptions for select specialty drugs to be dispensed for a 15-day trial supply, as further described in the Plan Contract. In such circumstances, the applicable Tier 4 drug copayment or coinsurance will be pro-rated.

18 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 non-participating providers.

19 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.

20 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.

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