EIA Health/Small Group Program
ASO EPO Plan

Benefit Summary
(Uniform Health Plan Benefits and Coverage Matrix)

Blue Shield of California

Effective: January 1, 2019

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 (4th quarter carryover applies; Calendar Year Deductible applies to all services, including where member copayment is stated as No Charge, unless next to service it explicitly states deductible is waived)	$300 per individual / $600 per family
Calendar Year Out-of-Pocket Maximum	$1,300 per individual / $2,600 per family
Lifetime Benefit Maximum	None
Covered Services	**Member Copayment**
OUTPATIENT PROFESSIONAL SERVICES	**Participating Providers[1]**
Professional (Physician) Benefits	
Physician and specialist office visits	$30 per visit (not subject to the Calendar Year medical deductible)
Teladoc consultation	$30 per consultation (not subject to the Calendar Year medical deductible)
Outpatient diagnostic x-ray, imaging, pathology, laboratory and other testing services	No Charge (not subject to the Calendar Year medical deductible)
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)	No Charge
Preventive Health Benefits[7]	
Preventive health services (as required by applicable Federal law)	No Charge (not subject to the Calendar Year medical deductible)
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	$25 per visit
Radiological and nuclear imaging (CT scans, MRIs, MRAs, PET scans and cardiac diagnostic procedures utilizing nuclear medicine)	$100 per visit
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)	No Charge
Bariatric surgery (prior authorization is required; medically necessary surgery for weight loss, for morbid obesity only)[2]	No Charge
Inpatient Skilled Nursing Benefits[3,4] (Coverage limited to 100 days per member per benefit period combined with hospital/free-standing skilled nursing facility)	
Free-standing skilled nursing facility	No Charge
Skilled nursing unit of a hospital	No Charge

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
Emergency room services resulting in admission (when the member is admitted directly from the ER)	No Charge
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)	20%
Orthotic equipment and devices (separate office visit copayment may apply)	20%
DURABLE MEDICAL EQUIPMENT	
Breast pump	No Charge
Other durable medical equipment	20%
MENTAL HEALTH AND SUBSTANCE USE DISORDER SERVICES[5, 6]	
Inpatient hospital services	No Charge
Residential care	No Charge
Inpatient physician services	No Charge
Routine outpatient mental health and substance use disorder services (includes professional/physician visits)	$30 per visit (not subject to the Calendar Year medical deductible)
Non-routine outpatient mental health and substance use disorder 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[3] (Coverage limited to 100 visits per member per calendar year.)	$30 per visit
Home infusion/home injectable therapy and infusion nursing visits provided by a home infusion agency	No Charge
HOSPICE PROGRAM BENEFITS	
Routine home care	No Charge
Inpatient respite care	No Charge
24-hour continuous home care	No Charge
Short-term inpatient care for pain and symptom management	No Charge
CHIROPRACTIC BENEFITS[3]	
Chiropractic spinal manipulation (up to 26 visits per Calendar Year combined with Acupuncture services)	$30 per visit
ACUPUNCTURE BENEFITS[3]	
Acupuncture services (up to 26 visits per Calendar Year combined with Chiropractic services)	$30 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)	$30 per visit
SPEECH THERAPY BENEFITS	
Office location (an additional facility copayment may apply when services are rendered in a hospital or skilled nursing facility)	$30 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)	No Charge
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)
Tubal ligation	No Charge (not subject to the Calendar Year medical deductible)
Vasectomy (an additional facility copayment may apply when services are rendered in a hospital or outpatient surgery center)	No Charge
DIABETES CARE BENEFITS	
Devices, equipment, and non-testing supplies (for testing supplies see Outpatient Prescription Drug Benefits)	No Charge
Diabetes self-management training	$30 per visit (not subject to the Calendar Year medical deductible)

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 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.

3 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.

4 Services may require prior authorization.

5 Mental health and substance use disorder 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.

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