EIA Health/County of Imperial
ASO PPO 1500 Actives and Early Retirees

Benefit Summary (For groups of 300 and above)
(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]	Non-Participating Providers[2]
Calendar Year Medical Deductible (4th quarter carryover applies)	$1,500 per individual / $3,000 per family	
Calendar Year Out-of-Pocket Maximum (includes the calendar year medical deductible. 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)	$6,000 per individual / $12,000 per family	$12,000 per individual / $24,000 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%	40%[4]
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; prior authorization is required)	20%	40%
Teladoc medical consultation	$10 per consult (not subject to the calendar year medical deductible)	Not Covered
Allergy Testing and Treatment Benefits		
Allergy testing, treatment and serum injections (separate office visit copayment may apply)	20%	40%
Preventive Health Benefits[10]		
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%	40% up to $3,000 per day[3]
Outpatient surgery performed in a hospital or a hospital affiliated ambulatory surgery center	20%	40% up to $3,000 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 $3,000 per day[3]
Outpatient diagnostic x-ray, imaging, pathology, laboratory and other testing services	20%	40% up to $3,000 per day[3]
Radiological and nuclear imaging (CT scans, MRIs, MRAs, PET scans and cardiac diagnostic procedures utilizing nuclear medicine; prior authorization is required)	20%	40% up to $3,000 per day[3]
Bariatric surgery	Not Covered	Not Covered
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 day up to 3 days maximum + 20%	$250 per day up to 3 days maximum + 40% up to $3,000 per day[5]
Bariatric surgery	Not Covered	Not Covered
Inpatient Skilled Nursing Benefits[6] (combined maximum of up to 120 days per calendar year; 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 $3,000 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)	$250 per day up to 3 days maximum + 20%	$250 per day up to 3 days maximum + 20%
Emergency room physician services	20%	20%
AMBULANCE SERVICES		
Emergency or authorized transport (ground or air)	20%	20%
PRESCRIPTION DRUG COVERAGE		
Outpatient Prescription Drug Benefits	Administered by Express Scripts	
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		
Other durable medical equipment	20%	40%
MENTAL HEALTH SERVICES[8]		
Inpatient hospital services	$250 per day up to 3 days maximum + 20%	$250 per day up to 3 days maximum + 40% up to $3,000 per day[5]
Residential care	$250 per day up to 3 days maximum + 20%	$250 per day up to 3 days maximum + 40% up to $3,000 per day[5]
Inpatient physician services	No Charge	No Charge
Routine outpatient mental health services (includes professional/physician visits)	20%	40%
Non-routine outpatient mental health services (includes electroconvulsive therapy, intensive outpatient programs, partial hospitalization program, psychological testing and transcranial magnetic stimulation)	20%	40%
Teledoc Behavorial Health consultations	20% per consult	Not Covered
HOME HEALTH SERVICES		
Home health care agency services[6] (up to 60 visits per calendar year)	No Charge	No Charge[9] with prior authorization
Home infusion/home injectable therapy and infusion nursing visits provided by a home infusion agency	No Charge	No Charge[9] with prior authorization
HOSPICE PROGRAM BENEFITS		
Routine home care	No Charge	No Charge[9] with prior authorization
Inpatient respite care	Not Covered	Not Covered
24-hour continuous home care	No Charge	No Charge[9] with prior authorization
Short-term inpatient care for pain and symptom management	No Charge	No Charge[9] with prior authorization
CHIROPRACTIC BENEFITS		
Chiropractic spinal manipulation	Not Covered	Not Covered
ACUPUNCTURE BENEFITS		
Acupuncture services	20%	40%
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%	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 (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
Infertility services (Diagnosis and treatment of cause of infertility. Excludes in vitro fertilization, injectables for infertility, artificial insemination and GIFT)	20%	40%
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%	40%
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%

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 $3,000 per day. Members are responsible for 40% of this $3,000 per day, and all charges in excess of $3,000 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 Copayments/Coinsurance marked with this footnote do not accrue to Calendar Year copayment maximum. Copayments/Coinsurance and charges for services not accruing to the member's Calendar Year copayment maximum continue to be the member's responsibility after the Calendar Year copayment maximum is reached. This amount could be substantial. Please refer to the Plan Contract for exact terms and conditions of coverage.

5 The maximum allowed charges for non-emergency hospital services received from a non-participating hospital is $3,000 per day. Members are responsible for $250 per day up to 3 days maximum plus 40% of this $3,000 per day, and all charges in excess of $3,000 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 services are accessed through Blue Shield's participating and non-participating providers.

9 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.

10 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. No coverage is provided for preventive care well woman office visits or eye and ear screening and immunization office visits by non-participating providers.

Plan designs may be modified to ensure compliance with Federal requirements