CSEBA
ASO PPO Plan 5 – 300/600 90/60
Benefit Summary (For groups of 300 and above)
(Uniform Health Plan Benefits and Coverage Matrix)

Blue Shield of California

Effective: July 1, 2017

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.

Highlights: A description of the prescription drug coverage is provided separately

	Participating Providers[1]	**Non-Participating Providers[2]**
Calendar Year Medical Deductible (Covered services from Participating providers and Non Participating providers deductible amounts cross apply)	$300 per individual / $600 per family	$600 per individual / $1,200 per family
Calendar Year Out-of-Pocket Maximum (Includes the Calendar Year medical deductible. Copayments or coinsurance for covered services from Participating and Non-participating provider out-of-pocket maximum amounts cross apply)	$2,000 per individual / $4,000 per family	$5,000 per individual / $10,000 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	10%	40%
Teladoc consultation	$5 per consultation (not subject to the Calendar Year medical deductible)	Not Covered
Outpatient diagnostic x-ray, imaging, pathology, laboratory and other testing services	10%	40%
Radiological and nuclear imaging (CT scans, MRIs, MRAs, PET scans and cardiac diagnostic procedures utilizing nuclear medicine)	10%	40%
Allergy Testing and Treatment Benefits		
Allergy testing, treatment and serum injections (separate office visit copayment may apply)	10%	40%
Preventive Health Benefits[11]		
Preventive health services (as required by applicable Federal law)	No Charge (not subject to the Calendar Year medical deductible)	40%[12]
OUTPATIENT FACILITY SERVICES		
Outpatient surgery performed at a free-standing ambulatory surgery center	10%	40% up to $350 per day[3]
Outpatient surgery performed in a hospital or a hospital affiliated ambulatory surgery center	10%	40% 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")	10%	40% up to $350 per day[3]
Outpatient diagnostic x-ray, imaging, pathology, laboratory and other testing services	10%	40% up to $350 per day[3]
Radiological and nuclear imaging (CT scans, MRIs, MRAs, PET scans and cardiac diagnostic procedures utilizing nuclear medicine)	10%	40% up to $350 per day[3]
Bariatric surgery (prior authorization is required; medically necessary surgery for weight loss, for morbid obesity only)[4]	10%	40% up to $350 per day[3]
HOSPITALIZATION SERVICES		
Hospital Benefits (Facility Services)		
Inpatient physician services	10%	40%
Inpatient non-emergency facility services (semi-private room and board, and medically necessary services and supplies, including subacute care)	10%	40% up to $600 per day[5]
Bariatric surgery (prior authorization is required; medically necessary surgery for weight loss, for morbid obesity only)[4]	10%	40% up to $600 per day[5]

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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	10%	10%[7]
Skilled nursing unit of a hospital	10%	40% 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)	10%	10%
Emergency room services resulting in admission (when the member is admitted directly from the ER)	10%	10%
Emergency room physician services	10%	10%
AMBULANCE SERVICES		
Emergency or authorized transport (ground or air)	20%	20%
PRESCRIPTION DRUG COVERAGE		
Outpatient Prescription Drug Benefits A description of your outpatient prescription drug coverage is provided separately. If you do not have the separate drug summary that goes with this benefit summary, please contact your benefits administrator or call the Customer Service number on your identification card.		
PROSTHETICS/ORTHOTICS		
Prosthetic equipment and devices (separate office visit copayment may apply)	10%	40%
Orthotic equipment and devices (separate office visit copayment may apply)	10%	40%
DURABLE MEDICAL EQUIPMENT		
Breast pump	No Charge (not subject to the Calendar Year medical deductible)	Not Covered
Other durable medical equipment	10%	40%
MENTAL HEALTH AND SUBSTANCE USE DISORDER SERVICES[8, 9]		
Inpatient hospital services	10%	40% up to $600 per day[5]
Residential care	10%	40% up to $600 per day[5]
Inpatient physician services	10%	40%
Routine outpatient mental health and substance use disorder services (includes professional/physician visits)	10%	40%
Non-routine outpatient mental health and substance use disorder services (includes behavioral health treatment, electroconvulsive therapy, intensive outpatient programs, office-based opioid treatment, partial hospitalization program, psychological testing and transcranial magnetic stimulation)	10%	40%
HOME HEALTH SERVICES		
Home health care agency services[6] (Coverage limited to 100 visits per member per calendar year)	10%	Not Covered[10]
Home infusion/home injectable therapy and infusion nursing visits provided by a home infusion agency	10%	Not Covered[10]
HOSPICE PROGRAM BENEFITS		
Routine home care	20%	Not Covered[10]
Inpatient respite care	20%	Not Covered[10]
24-hour continuous home care	20%	Not Covered[10]
Short-term inpatient care for pain and symptom management	20%	Not Covered[10]
CHIROPRACTIC BENEFITS[6]		
Chiropractic spinal manipulation (Coverage is limited to 24 visits per calendar year.)	10%	40%
ACUPUNCTURE BENEFITS[6]		
Acupuncture services (Coverage is limited to 12 visits per calendar year.)	10%	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)	10%	40%
SPEECH THERAPY BENEFITS		
Office location (an additional facility copayment may apply when services are rendered in a hospital or skilled nursing facility)	10%	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)	10%	40%
Abortion services (an additional facility copayment may apply when services are rendered in a hospital or outpatient surgery center)	10%	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)	40%
Tubal ligation	No Charge (not subject to the Calendar Year medical deductible)	40%
Vasectomy (an additional facility copayment may apply when services are rendered in a hospital or outpatient surgery center)	10%	40%
DIABETES CARE BENEFITS		
Devices, equipment, and non-testing supplies (for testing supplies see Outpatient Prescription Drug Benefits)	10%	40%
Diabetes self-management training	10%	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 $350 per day. Members are responsible for 40% 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 40% 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 use disorder 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 non-participating providers.

10 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.

11 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.

12 Non-participating adult preventive services including mammograms, pap smears, prostate cancer screenings and colorectal cancer screenings are not subject to the calendar year deductible,

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