

# CSEBA

## Trio ACO HMO 15 Plan 2 – \$0 Admit

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 EVIDENCE OF COVERAGE AND 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

This plan is available only in certain California counties and cities "Service Area" as described in the *Evidence of Coverage*. You must live and/or work in this select Service Area in order to enroll in this plan.

This HMO plan also utilizes an Accountable Care Organization (ACO) for its provider network. Except for Emergency Services, Urgent Services when the Member is out of the Service Area, or when prior authorized, all services must be obtained through the Member's Personal Physician and within the ACO provider network to be covered.

This health plan uses the ACO HMO provider network.

<b>Calendar Year Medical Deductible</b>	None
<b>Calendar Year Out-of-Pocket Maximum</b>	\$500 per individual / \$1,500 per family
<b>Lifetime Benefit Maximum</b>	None
<b>Covered Services</b>	<b>Member Copayment</b>
<b>OUTPATIENT PROFESSIONAL SERVICES</b>	
<b>Professional (Physician) Benefits</b>	
Physician and specialist office visits (note: a woman may self-refer to an OB/GYN or family practice physician in her personal physician's medical group or IPA for OB/GYN services)	\$15 per visit
Teladoc consultation	\$5 per consultation
Outpatient diagnostic x-ray, imaging, pathology, laboratory and other testing services	No Charge
Radiological and nuclear imaging (CT scans, MRIs, MRAs, PET scans and cardiac diagnostic procedures utilizing nuclear medicine)	No Charge
<b>Allergy Testing and Treatment Benefits</b>	
Allergy testing, treatment and serum injections	\$15 per visit
<b>Access+ Specialist<sup>SM</sup> Benefits<sup>1</sup></b>	
Office visit, examination or other consultation (self-referred office visits and consultations only)	\$25 per visit
<b>Preventive Health Benefits</b>	
Preventive health services (as required by applicable Federal and California law)	No Charge
<b>OUTPATIENT FACILITY SERVICES</b>	
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	No Charge
Radiological and nuclear imaging (CT scans, MRIs, MRAs, PET scans and cardiac diagnostic procedures utilizing nuclear medicine)	No Charge
<b>HOSPITALIZATION SERVICES</b>	
<b>Hospital Benefits (Facility Services)</b>	
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
<b>Inpatient Skilled Nursing Benefits<sup>2, 3</sup></b> (combined maximum of up to 100 days per benefit period; prior authorization is required; semi-private accommodations)	
Free-standing skilled nursing facility	No Charge
Skilled nursing unit of a hospital	No Charge
<b>EMERGENCY HEALTH COVERAGE</b>	
Emergency room services not resulting in admission (copayment does not apply if the member is directly admitted to the hospital for inpatient services)	\$50 per visit
Emergency room physician services	No Charge

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**AMBULANCE SERVICES**

Emergency or authorized transport (ground or air)	No Charge
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**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 Member Services number on your identification card.

**PROSTHETICS/ORTHOTICS**

Prosthetic equipment and devices (separate office visit copayment may apply)	No Charge
Orthotic equipment and devices (separate office visit copayment may apply)	No Charge

**DURABLE MEDICAL EQUIPMENT**

Breast pump	No Charge
Other durable medical equipment (member share is based on allowed charges)	No Charge

**MENTAL HEALTH AND SUBSTANCE USE DISORDER SERVICES<sup>4, 5</sup>**

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)	\$15 per visit
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 programs, psychological testing and transcranial magnetic stimulation)	No Charge

**HOME HEALTH SERVICES**

Home health care agency services <sup>2</sup> Coverage limited to 100 visits per member per calendar year.	\$15 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

**PREGNANCY AND MATERNITY CARE BENEFITS**

Prenatal and postnatal physician office visits (may be billed as part of global maternity fee including hospital inpatient delivery services)	\$15 per visit
Abortion services (an additional facility copayment may apply when services are rendered in a hospital or outpatient surgery center)	No Charge

**FAMILY PLANNING AND INFERTILITY BENEFITS**

Counseling, consulting, and education (Includes insertion of IUD, as well as injectable and implantable contraceptives for women)	No Charge
Infertility services (member cost share is based upon allowed charges) (diagnosis and treatment of cause of infertility. Excludes in vitro fertilization, injectables for infertility, artificial insemination and GIFT)	50%
Tubal ligation	No Charge
Vasectomy (an additional facility copayment may apply when services are rendered in a hospital or outpatient surgery center)	\$50 per surgery

**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)	\$15 per visit
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**SPEECH THERAPY BENEFITS**

Office location (an additional facility copayment may apply when services are rendered in a hospital or skilled nursing facility)	\$15 per visit
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**DIABETES CARE BENEFITS**

Devices, equipment, and non-testing supplies (member share is based upon allowed charges; for testing supplies see Outpatient Prescription Drug Benefits)	No Charge
Diabetes self-management training	\$15 per visit

**URGENT CARE BENEFITS**

Urgent care services outside your personal physician service area within California	\$15 per visit
Urgent care services outside of California (BlueCard® Program)	\$15 per visit

**OPTIONAL BENEFITS**

Optional dental, vision, hearing aid, infertility, chiropractic or acupuncture benefits are available. If your employer purchased any of these benefits, a description of the benefit is provided separately.

- 1 To use this option, members must select a personal physician who is affiliated with a medical group or IPA that is an Access+ provider group, which offers the Access+ Specialist feature. Members should then select a specialist within that medical group or IPA.
- 2 For Plans with a facility deductible amount, services with a day or visit limit accrue to the calendar year day or visit limit maximum regardless of whether the plan deductible has been met.
- 3 Inpatient skilled nursing services are limited to 100 preauthorized days during a benefit period except when received through a hospice program provided by a participating hospice agency. This 100 preauthorized day maximum on inpatient skilled nursing services is a combined maximum between skilled nursing services provided in a hospital unit and skilled nursing services provided in a skilled nursing facility (SNF).

- 4 Mental health and substance use disorder services are accessed through Blue Shield's Mental Health Service Administrator (MHA) - using MHA participating providers.
- 5 Inpatient services for acute detoxification are covered under the medical benefit; see the Hospital Benefits (Facility Services) section of the *Evidence of Coverage* for benefit details. Services for acute medical detoxification are accessed through Blue Shield using Blue Shield's participating providers.

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

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