Mendocino County Schools/Staywell Plan
Custom ASO PPO – Active Plan

Benefit Summary (For groups of 300 and above)
(Uniform Health Plan Benefits and Coverage Matrix)

Blue Shield of California

Effective: July 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.

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

	Participating Providers[1]	Non-Participating Providers[2]
Contract Year Medical Deductible (all providers combined)	$1,000 per individual / $1,000 per family	
Contract Year Out-of-Pocket Maximum (Includes the plan year medical deductible. All Providers combined accumulate toward the Contract year out-of-pocket maximum.)	$2,000 per individual / $3,000 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%	50%
Teladoc consultation	No Charge (not subject to the contract year medical deductible)	Not Covered
Outpatient diagnostic x-ray, imaging, pathology, laboratory and other testing services	20%	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[11]		
Preventive health services (as required by applicable Federal law)	No Charge (not subject to the contract year medical deductible)	50%
OUTPATIENT FACILITY SERVICES		
Outpatient surgery performed at a free-standing ambulatory surgery center	$50 per surgery + 20%	50% up to $350 per day[3]
Outpatient surgery performed in a hospital or a hospital affiliated ambulatory surgery center	$50 per surgery + 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	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)	20%	50% up to $350 per day[3]
Bariatric surgery[4] (prior authorization is required; medically necessary surgery for weight loss, for morbid obesity only)	$50 per surgery + 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)	$100 per day up to 3 days per contract year + 20%	50% up to $1,500 per day[5]
Bariatric surgery[4] (prior authorization is required; medically necessary surgery for weight loss, for morbid obesity only)	$100 per day up to 3 days per contract year + 20%	50% up to $1,500 per day[5]
Inpatient Skilled Nursing Benefits[6]		
Free-standing skilled nursing facility	20%	20%[7]
Skilled nursing unit of a hospital	20%	50% up to $1,500 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)	$100 per day up to 3 days per contract year + 20%	$100 per day up to 3 days per contract year + 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
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)	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 contract year medical deductible)	Not Covered
Other durable medical equipment	20%	50%
MENTAL HEALTH AND SUBSTANCE ABUSE SERVICES[8,9]		
Inpatient hospital services	$100 per day up to 3 days per contract year + 20%	50% up to $1,500 per day [5]
Residential care	$100 per day up to 3 days per contract year + 20%	50% up to $1,500 per day [5]
Inpatient physician services	No Charge	50%
Routine outpatient mental health and substance abuse services (includes professional/physician visits)	20%	50%
Non-routine outpatient mental health and substance abuse services (includes behavioral health treatment, electroconvulsive therapy, intensive outpatient programs, office-based opioid treatment, partial hospitalization program, psychological testing and transcranial magnetic stimulation)	No Charge	50%
HOME HEALTH SERVICES		
Home health care agency services[6] Coverage limited to 100 visits per contract year.	20%	Not Covered[10]
Home infusion/home injectable therapy and infusion nursing visits provided by a home infusion agency	20%	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 limited to 25 visits per contract year	20%	50%
ACUPUNCTURE BENEFITS[6]		
Acupuncture services Coverage limited to 24 visits per contract year	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[6]		
Office location (an additional facility copayment may apply when services are rendered in a hospital or skilled nursing facility) (up to 23 visits per contract year)	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%	50%

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 contract year medical deductible)	50%
Tubal ligation	No Charge (not subject to the contract year medical deductible)	50%
Vasectomy (an additional facility copayment may apply when services are rendered in a hospital or outpatient surgery center)	20%	50%
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 SERVICES		
Hearing aids (1 every 36 months up to a maximum of $2,000)	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 Contract 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 Contract 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 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 Contract year out-of-pocket maximum and continue to be the member's financial responsibility after the Contract 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 $1,500 per day. Members are responsible for 50% of this $1,500 per day, and all charges in excess of $1,500 per day. Amounts that exceed the benefit maximum do not count toward the Contract year out-of-pocket maximum and continue to be the member's responsibility after the Contract year maximums are reached.

6 For plans with a Contract year medical deductible amount, services with a day or visit limit accrue to the Contract year day or visit limit maximum regardless of whether the Contract 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 Abuse 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 Contract 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 Contract year medical deductible and applicable member copayment/coinsurance

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

Notice Informing Individuals about Nondiscrimination and Accessibility Requirements

Discrimination is against the law

Blue Shield of California complies with applicable federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability or sex. Blue Shield of California does not exclude people or treat them differently because of race, color, national origin, age, disability or sex.

Blue Shield of California:

- Provides aids and services at no cost to people with disabilities to communicate effectively with us such as:
  - Qualified sign language interpreters
  - Written information in other formats (including large print, audio, accessible electronic formats and other formats)
- Provides language services at no cost to people whose primary language is not English such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, contact the Blue Shield of California Civil Rights Coordinator.

If you believe that Blue Shield of California has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability or sex, you can file a grievance with:

Blue Shield of California
Civil Rights Coordinator
P.O. Box 629007
El Dorado Hills, CA 95762-9007

Phone: (844) 831-4133 (TTY: 711)
Fax: (916) 350-7405
Email: BlueShieldCivilRightsCoordinator@blueshieldca.com

You can file a grievance in person or by mail, fax or email. If you need help filing a grievance, our Civil Rights Coordinator is available to help you.

Blue Shield of California is an independent member of the Blue Shield Association A49939 (01/17)

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

U.S. Department of Health and Human
Services 200 Independence Avenue SW.
Room 509F, HHH Building
Washington, DC 20201
(800) 368-1019; TTY: (800) 537-7697

Complaint forms are available at www.hhs.gov/ocr/office/file/index.html.

Language Access Services

English: For assistance in English at no cost, call 1-866-346-7198

Spanish (Español): Para obtener asistencia en Español sin cargo, llame al 1-866-346-7198.

Tagalog (Tagalog): Kung kailanganninyo ang libreng tulongsa Tagalog tumawag sa 1-866-346-7198.

Chinese（中文）：如果需要中文的免费帮助，请拨打这个号码 1-866-346-7198.

Navajo (Dine): Diné k'ehjí doo bąąh ílínígó shíka' at'oowoł nínízingo, kwiįį' hodíílnih 1-866-346-7198.

Vietnamese (Tiếng Việt): Đểđược hỗ trợ miễn phí tiếng Việt, vui lòng gọi đến số 1-866-346-7198.

Korean (한국어): 한국어도움이필요하시면, 1-866-346-7198 무료전화 로전화하십시오.

Armenian (Հայերեն): Հայերենլեզվովանվճարօգնությունստանալուհամարխնդրում ենքզանգահարել 1-866-346-7198.

Russian (Русский): если нужна бесплатная помощь на русском языке, то позвоните 1-866-346-7198.

Japanese (日本語): 日本語支援が必要な場合、1-866-346-7198 に電話をかけてください。無料で提供します。

Persian (فارسی): برای دریافت کمک رایگان زبان فارسی،لطفاً با شماره تلفن 1-866-346-7198 تماس بگیرید.

Punjabi(پنجابی): پنجابی وچ مدد لئی مہربانی کر کے 1-866-346-7198 تے مفت کال کرو۔

Khmer (ភាសាខ្មែរ): សូមជំនួយជាភាសាអង់គ្លេសដោយឥតគិតថ្លៃ សូមទាក់ទងមកលេខ 1-866-346-7198.

Arabic(العربية): لحصول على المساعدة في اللغة العربية مجانا ، تفضل باتصال على هذا الرقم: 1-866-346-7198.

Hmong (Hnoob): Xav tau kev pab dawb lub Hmoob, thov hu rau 1-866-346-7198.

Hindi (हिन्दी): हिन्दीमेंबिना खर्च केसहायताकेलिए, 1-866-346-7198 परकॉलकरें।.

Thai (ไทย): สำหรับความช่วยเหลือเป็นภาษาไทยโดยไม่มีค่าใช้จ่ายโปรดโทร 1-866-346-7198.

An independent member of the Blue Shield Association