Long Beach Unified School District ASO
Preferred Savings Plus
Aggregate Deductible 1500/3000

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

Blue Shield of California

Effective: January 1, 2016 – June 30, 2016

THIS MATRIX IS INTENDED TO BE USED TO HELP YOU COMPARE 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 (All providers combined) For family coverage, the full family deductible must be met before the enrollee or covered dependents can receive benefits for covered services.	$1,500 per individual / $3,000 per family	
Calendar Year Out-of-Pocket Maximum (includes the calendar year medical deductible) For family coverage, the full family out-of-pocket maximum must be met before the enrollee or covered dependents can receive 100% benefits for covered services.	$3,275 per individual / $6,550 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%
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[16]		
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	10%	40%[3]
Outpatient surgery performed in a hospital or hospital affiliated ambulatory surgery center	10%	40%[3]
Outpatient services for treatment of illness or injury and necessary supplies (except as described under "Rehabilitation Benefits" and "Speech Therapy Benefits")	10%	40%[3]
Outpatient diagnostic x-ray, imaging, pathology, laboratory and other testing services	$25 per visit + 10%	40%[3]
Radiological and nuclear imaging (CT scans, MRIs, MRAs, PET scans and cardiac diagnostic procedures utilizing nuclear medicine)	$100 per visit + 10%	40%[3]
Bariatric surgery[4] (prior authorization is required; medically necessary surgery for weight loss, for morbid obesity only)	10%	40%[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%[5]
Bariatric surgery[4] (prior authorization is required; medically necessary surgery for weight loss, for morbid obesity only)	10%	40%[5]

Inpatient Skilled Nursing Benefits[6] (combined maximum of up to 100 days per benefit period; prior authorization is required; semi-private accommodations)		
Free-standing skilled nursing facility	10%	10%[7]
Skilled nursing unit of a hospital	10%	40%[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 + 10%	$100 per visit + 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)	10%	10%
PRESCRIPTION DRUG COVERAGE[9,10,11,12,13,14, 15] (subject to deductible)	**Participating Pharmacy**	**Non-Participating Pharmacy**
Outpatient Prescription Drug Benefits		
Retail Prescriptions (up to a 30-day supply)		
Contraceptive drugs and devices[14]	No Charge	Not Covered
Formulary generic drugs	$5 per prescription	Not Covered
Formulary brand drugs	$10 per prescription	Not Covered
Non-Formulary brand drugs	$35 per prescription	Not Covered
Mail Service Prescriptions (up to a 90-day supply)		
Contraceptive drugs and devices[14]	No Charge	Not Covered
Formulary generic drugs	$5 per prescription	Not Covered
Formulary brand drugs	$10 per prescription	Not Covered
Non-Formulary brand drugs	$35 per prescription	Not Covered
Specialty Pharmacies[11,13] (up to a 30-day supply)		
Specialty drugs (includes orally administered anti-cancer medications)	20% up to $100 maximum per prescription	Not Covered
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 ABUSE SERVICES[17,18]		
Inpatient hospital services	10%	40%[5]
Residential care	10%	40%[5]
Inpatient physician services	10%	40%
Routine outpatient mental health and substance abuse services (includes professional/physician visits)	10%	40%
Non-routine outpatient mental health and substance abuse services (includes electroconvulsive therapy, intensive outpatient programs, office-based opioid treatment, partial hospitalization program, psychological testing and transcranial magnetic stimulation)	10%	40%
HOME HEALTH SERVICES	**Participating Providers**[1]	**Non-Participating Providers**[2]
Home health care agency services (up to 100 visits per calendar year)[6]	10%	Not Covered[8]
Home infusion/home injectable therapy and infusion nursing visits provided by a home infusion agency	10%	Not Covered[8]
HOSPICE PROGRAM BENEFITS[8]		
Routine home care	No Charge	Not Covered[8]
Inpatient respite care	No Charge	Not Covered[8]
24-hour continuous home care	10%	Not Covered[8]
Short-term inpatient care for pain and symptom management	10%	Not Covered[8]
CHIROPRACTIC BENEFITS[6]		
Chiropractic spinal manipulation (up to 20 visits per calendar year)	10%	40%

ACUPUNCTURE BENEFITS		
Acupuncture services	Not Covered	Not Covered
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)	Not Covered
Tubal ligation (an additional facility copayment may apply when services are rendered in a hospital or outpatient surgery center)	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)	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 a copayment/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 medical 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 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.

9 If the member requests a brand drug when a generic drug equivalent is available, the member is responsible for paying the difference in cost between the brand drug and its generic drug equivalent, in addition to the generic drug copayment. The difference in cost that the member must pay does not accrue to any calendar year medical or brand drug deductible and is not included in the calendar year out-of-pocket maximum responsibility calculations. Refer to the Plan Contract for details.

10 Please note that if you switch from another plan, your prescription drug deductible credit from the previous plan during the calendar year, if applicable, will not carry forward to your new plan.

11 Specialty drugs are available from a Network Specialty Pharmacy. A Network Specialty Pharmacy provides specialty drugs by mail or upon member request, at an associated retail store for pickup.

12 Select formulary and non-formulary drugs require prior authorization by Blue Shield for Medical Necessity, or when effective, lower cost alternatives are available.

13 Specialty Drugs are Drugs requiring coordination of care, close monitoring, or extensive patient training that generally cannot be met by a retail pharmacy and are available at a Network Specialty Pharmacy. Specialty Drugs may also require special handling or manufacturing processes, restriction to certain Physicians or pharmacies, or reporting of certain clinical events to the FDA. Specialty Drugs are generally high cost.

[14] Contraceptive drugs and devices covered under the outpatient prescription drug benefits do not require a copayment and are not subject to the calendar year medical deductible when obtained from a participating pharmacy. However, if a brand contraceptive is requested when a generic equivalent is available, the member is responsible for paying the difference between the cost to Blue Shield for the brand contraceptive and its generic drug equivalent. The difference in cost that the member must pay does not accrue to any calendar year medical or brand drug deductible and is not included in the calendar year out-of-pocket maximum calculation. In addition, select contraceptives may need prior authorization to be covered without a copayment.

[15] Blue Shield's Short-Cycle Specialty Drug Program allows initial prescriptions for select specialty drugs to be dispensed for a 15-day trial supply, as further described in the Plan Contract. In such circumstances, the applicable specialty drug copayment or coinsurance will be pro-rated.

[16] Preventive Health Services, including an annual preventive care or well-baby care office visit, are not subject to the calendar year medical deductible when received from a Participating Provider. Other covered non-preventive services received during, or in connection with, the preventive care or well-baby care office visit may be subject to the calendar year medical deductible and applicable member copayment/coinsurance.

[17] Mental Health and Substance Abuse services are accessed through Blue Shield's Participating and Non-Participating providers.

[18] 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.

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