North Coast Schools' Medical Insurance Group

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.

Maple Plan
Blue Shield of California
Custom ASO PPO 5000 70/50
Benefit Summary (For groups of 300 and above)
(Uniform Health Plan Benefits and Coverage Matrix)

Effective: July 1, 2014

	Preferred Providers[1]	Non-Preferred Providers[1]
Calendar Year Medical Deductible (All providers combined; 4th quarter carryover applies)	$5,000 per individual / $10,000 per family	
Calendar Year Copayment Maximum[2] (Includes the plan deductible) (Copayments/Coinsurance for Preferred Providers accrue to both Preferred and Non-Preferred Provider Calendar-year Copayment Maximum amounts.)	$6,350 per individual / $12,700 per family	$10,000 per individual / $20,000 per family
LIFETIME BENEFIT MAXIMUM	None	

Covered Services	**Member Copayment**	
PROFESSIONAL SERVICES	**Preferred Providers[1]**	**Non-Preferred Providers[1]**
Professional (Physician) Benefits		
• Physician office visits (Includes OB/GYN, Pediatrician, Internal Medicine, Family Practice, General Practice)[5]	$60 per visit[7]	50%
• Specialist office visits (Includes all other provider designations)[5]	$70 per visit	50%
• CT scans, MRIs, MRAs, PET scans, and cardiac diagnostic procedures utilizing nuclear medicine (prior authorization is required)[3]	30%	50%
• Other outpatient X-ray, pathology and laboratory (Diagnostic testing by providers other than outpatient laboratory, pathology, and imaging departments of hospitals/facilities)[3]	30%	50%
Allergy Testing and Treatment Benefits		
• Office visits (includes visits for allergy serum injections)	30%	50%
Preventive Health Benefits		
• Preventive Health Services (As required by applicable federal law.)	No Charge (Not subject to the Calendar Year Deductible)	50%
OUTPATIENT SERVICES		
Hospital Benefits (Facility Services)		
• Outpatient surgery performed at an Ambulatory Surgery Center[4]	30%	50%
• Outpatient surgery in a hospital	30%	50%
• Outpatient Services for treatment of illness or injury and necessary supplies (Except as described under "Rehabilitation Benefits")	30%	50%
• CT scans, MRIs, MRAs, PET scans, and cardiac diagnostic procedures utilizing nuclear medicine performed in a hospital (prior authorization is required)[3]	30%	50%
• Other outpatient X-ray, pathology and laboratory performed in a hospital[3]	30%	50%
• Bariatric Surgery (prior authorization required by the Plan; medically necessary surgery for weight loss, for morbid obesity only)	30%	50%
HOSPITALIZATION SERVICES		
Hospital Benefits (Facility Services)		
• Inpatient Physician Services	30%	50%
• Inpatient Non-emergency Facility Services (Semi-private room and board, and medically-necessary Services and supplies, including Subacute Care)	30%	50%
• Bariatric Surgery (prior authorization required by the Plan; medically necessary surgery for weight loss, for morbid obesity only)	30%	50%

Skilled Nursing Facility Benefits[8] Covers up to 120 days per calendar year combined with Hospital Skilled Nursing Facility Unit.		
• Services by a free-standing Skilled Nursing Facility	30%	30% [9]
• Skilled Nursing Unit of a Hospital	30%	50%
EMERGENCY HEALTH COVERAGE		
• Emergency room Services not resulting in admission (The ER copayment does not apply if the member is directly admitted to the hospital for inpatient services)	30%	30%
• Emergency room Services resulting in admission (when the member is admitted directly from the ER)	30%	30%
• Emergency room Physician Services	30%	30%
AMBULANCE SERVICES		
• Emergency or authorized transport	$300 per transport	$300 per transport
PRESCRIPTION DRUG COVERAGE		
Outpatient Prescription Drug Benefits	**Prescription drugs are carved out to CVS/Caremark 866-260-4646 (7am – 7pm CST)**	
PROSTHETICS/ORTHOTICS		
• Prosthetic equipment and devices (Separate office visit copay may apply)	30%	Not Covered
• Orthotic equipment and devices (Separate office visit copay may apply)	30%	Not Covered
DURABLE MEDICAL EQUIPMENT		
• Breast pump	No Charge (Not subject to the Calendar Year Deductible)	Not Covered
• Other Durable Medical Equipment	30%	Not Covered
MENTAL HEALTH SERVICES (PSYCHIATRIC)[10]		
• Inpatient Hospital Services / Residential Treatment	30%	50%
• Outpatient Mental Health Services	$60 per visit [7]	50%
CHEMICAL DEPENDENCY SERVICES (SUBSTANCE ABUSE)[10, 11]		
• Inpatient Hospital Services / Residential Treatment	30%	50%
• Outpatient Chemical dependency and substance abuse services	$60 per visit [7]	50%
HOME HEALTH SERVICES		
• Home health care agency Services Covers up to 120 visits per calendar year. Non-preferred home health care and home infusion are not covered unless pre-authorized. When these services are pre-authorized, you pay the preferred provider copayment.[8]	30%	Not Covered [12]
• Home infusion/home intravenous injectable therapy and infusion nursing visits provided by a Home Infusion Agency	30%	Not Covered [12]
OTHER		
Hospice Program Benefits		
• Routine home care	No Charge	Not Covered [12]
• Inpatient Respite Care	No Charge	Not Covered [12]
• 24-hour Continuous Home Care	No Charge	Not Covered [12]
• General Inpatient care	No Charge	Not Covered [12]
Chiropractic Benefits[8]		
• Chiropractic Services - (provided by a chiropractor) Covers up to 24 visits per calendar year combined with rehabilitation services;	30%	50% (up to a plan payment maximum of $25 per visit)
Acupuncture Benefits		
• Acupuncture by a certificated acupuncturist	$60 per visit	$60 per visit
Rehabilitation Benefits (Physical, Occupational and Respiratory Therapy)		
• Office location Physical and occupational therapy up to 24 visits per calendar year combined with chiropractic services.[8]	30%	50% (up to a plan payment maximum of $25 per visit)
Speech Therapy Benefits		
• Office visit	30%	50%
Pregnancy and Maternity Care Benefits		
• Prenatal and postnatal Physician office visits (For inpatient hospital services, see "Hospitalization Services.")	$60 per visit [7]	50%

Family Planning Benefits		
• Counseling and consulting[13]	No Charge (Not subject to the Calendar Year Deductible)	50%
• Elective abortion[6]	30%	Not Covered
• Tubal ligation	No Charge (Not subject to the Calendar Year Deductible)	50%
• Vasectomy[6]	30%	Not Covered
Diabetes Care Benefits		
• Devices, equipment, and non-testing supplies (for testing supplies see Outpatient Prescription Drug Benefits.)	30%	Not Covered
• Diabetes self-management training (by a registered dietician or registered nurse that are certified diabetes educators)	$60 per visit [7]	50%
Hearing Aid (Up to a maximum of $5,000 per member every 24 months)		
• Hearing Aid Instrument and ancillary equipment	30%	30%
• Audiological evaluations	30%	30%
Care Outside of Plan Service Area (Benefits provided through the BlueCard® Program for out-of-state emergency and non-emergency care are provided at the preferred level of the local Blue Plan allowable amount when you use a Blue Cross/Blue Shield provider)		
• 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. Preferred providers agree to accept Blue Shield's allowable amount plus the plan's and any applicable member's payment as full payment for covered Services. Non-preferred providers can charge more than these amounts. When members use non-preferred 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 copayment maximum.

2 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.

3 Participating non Hospital based ("freestanding") laboratory or radiology centers may not be available in all areas. Laboratory and radiology Services may also be obtained from a Hospital or from a laboratory and radiology center that is affiliated with a Hospital, and paid according to the benefit under your health plan's Hospital Benefits.

4 Participating Ambulatory Surgery Centers may not be available in all areas. Outpatient surgery Services may also be obtained from a Hospital or from an ambulatory surgery center that is affiliated with a Hospital, and paid according to the benefit under your health plan's Hospital Benefits.

5 When services are provided by a Preferred Specialist a $70 copayment per visit applies.

6 Copayment shown is for physician's services. If the procedure is performed in a facility setting (hospital or outpatient surgery center), an additional facility copayment may apply. Services from non-participating providers and non-preferred facilities are not covered under this benefit.

7 3 office visits before the deductible applies. The 3 office visits before the deductible is for any combination of Physician, Postnatal, Urgent Care, Outpatient Mental/Behavioral Health and Substance Abuse office visit services.

8 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 plan medical deductible has been met.

9 Services may require prior authorization by the Plan. When services are prior authorized, members pay the preferred or participating provider amount.

10 Mental health services are accessed through Blue Shield's participating and non-participating providers.

11 Inpatient Services which are Medically Necessary to treat the acute medical complications of detoxification are covered under the medical benefits; see hospitalization services for benefit details. Services for acute medical complications of detoxification are accessed through Blue Shield using Blue Shield's preferred providers or with non-preferred providers.

12 Out of network home health care, home infusion and hospice services are not covered unless pre-authorized. When these services are pre-authorized, the member pays the Preferred Provider copayment.

13 Includes insertion of IUD as well as injectable and implantable contraceptives for women.

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

ASO (1/14)