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.

Pine Plan

Blue Shield of California

Custom ASO PPO Savings Plus 1500

Benefit Summary (For groups of 300 and above)

(Uniform Health Plan Benefits and Coverage Matrix)

Highlights: $1,500 individual coverage deductible or $3,000 family coverage deductible

Effective: July 1, 2014

	Preferred Providers[1]	Non-Preferred Providers[1]
Calendar Year Deductible (All providers combined) (Note: For individual on family coverage plan, enrollee can receive benefits for covered services once individual deductible is met.)	$1,500 per individual / $3,000 per family	
Calendar Year Out-of-Pocket Maximum[1] (Includes the plan deductible) (For individual on family coverage, enrollee can receive 100% benefits for covered services once individual out-of-pocket maximum is met.)	$4,000 per individual / $8,000 per family	$5,786 per individual / $11,572 per family
LIFETIME BENEFIT MAXIMUM	None	

Covered Services	Member Copayment	
PROFESSIONAL SERVICES	**Preferred Providers[1]**	**Non-Preferred Providers[1]**
Professional (Physician) Benefits		
• Physician and specialist office visits	No Charge	30%
• CT scans, MRIs, MRAs, PET scans, and cardiac diagnostic procedures utilizing nuclear medicine (prior authorization is required)[2]	20%	30%
• Other outpatient X-ray, pathology and laboratory (Diagnostic testing by providers other than outpatient laboratory, pathology, and imaging departments of hospitals/facilities)[2]	20%	30%
Allergy Testing and Treatment Benefits		
• Office visits (includes visits for allergy serum injections)	20%	30%
Preventive Health Benefits		
• Preventive Health Services (As required by applicable federal law.)	No Charge (Not subject to the Calendar Year Deductible)	30% (Not subject to the Calendar Year Deductible)
OUTPATIENT SERVICES		
Hospital Benefits (Facility Services)		
• Outpatient surgery performed at an Ambulatory Surgery Center[3]	20%	30%
• Outpatient surgery in a hospital	20%	30%
• Outpatient Services for treatment of illness or injury and necessary supplies (Except as described under "Rehabilitation Benefits")	20%	30%
• CT scans, MRIs, MRAs, PET scans, and cardiac diagnostic procedures utilizing nuclear medicine performed in a hospital (prior authorization is required)[2]	20%	30%
• Other outpatient X-ray, pathology and laboratory performed in a hospital[2]	20%	30%
• Bariatric Surgery (prior authorization required by the Plan; medically necessary surgery for weight loss, for morbid obesity only)	20%	30%

HOSPITALIZATION SERVICES		
Hospital Benefits (Facility Services)		
• Inpatient Physician Services	20%	30%
• Inpatient Non-emergency Facility Services (Semi-private room and board, and medically-necessary Services and supplies, including Subacute Care)	20%	30%
• Bariatric Surgery (prior authorization required by the Plan; medically necessary surgery for weight loss, for morbid obesity only)	20%	30%
Skilled Nursing Facility Benefits[7] Covers up to 120 days per calendar year combined with Hospital Skilled Nursing Facility Unit.		
• Services by a free-standing Skilled Nursing Facility	20%	20%[8]
• Skilled Nursing Unit of a Hospital	20%	30%
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)	$25 per visit + 20%	$25 per visit + 20%
• Emergency room Services resulting in admission (when the member is admitted directly from the ER)	20%	20%
• Emergency room Physician Services	20%	20%
AMBULANCE SERVICES		
• Emergency or authorized transport	30%	30%
PRESCRIPTION DRUG COVERAGE[10, 11, 12, 13, 14, 15] (Subject to deductible)	**Participating Pharmacy**	**Non-Participating Pharmacy**
Outpatient Prescription Drug Benefits		
Retail Prescriptions (For up to a 30-day supply)		
• Contraceptive Drugs and Devices[16]	No Charge	Applicable Retail Drug Tier Applies
• Formulary Generic Drugs	$10 per prescription	25%+ $10 per prescription
• Formulary Brand Name Drugs	$30 per prescription	25%+ $30 per prescription
• Non-Formulary Brand Name Drugs	$40 per prescription	25%+ $40 per prescription
Mail Service Prescriptions (For up to a 90-day supply)		
• Contraceptive Drugs and Devices[16]	No Charge	Not Covered
• Formulary Generic Drugs	$15 per prescription	Not Covered
• Formulary Brand Name Drugs	$45 per prescription	Not Covered
• Non-Formulary Brand Name Drugs	$80 per prescription	Not Covered
Specialty Pharmacies (up to a 30-day supply)		
• Specialty Drugs	30% up to $150 maximum per prescription	Not Covered
PROSTHETICS/ORTHOTICS		
• Prosthetic equipment and devices (Separate office visit copay may apply)	20%	30%
• Orthotic equipment and devices (Separate office visit copay may apply)	20%	30%
DURABLE MEDICAL EQUIPMENT		
• Breast pump	No Charge (Not subject to the Calendar Year Deductible)	Not Covered
• Other Durable Medical Equipment	20%	30%
MENTAL HEALTH SERVICES (PSYCHIATRIC)[17]		
• Inpatient Hospital Services / Residential Treatment	20%	30%
• Outpatient Mental Health Services	No Charge	30%
CHEMICAL DEPENDENCY SERVICES (SUBSTANCE ABUSE)[17,5]		
• Inpatient Hospital Services / Residential Treatment	20%	30%
• Outpatient Chemical dependency and substance abuse services	No Charge	30%
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.[7]	20%	Not Covered[6]
• Home infusion/home intravenous injectable therapy and infusion nursing visits provided by a Home Infusion Agency	20%	Not Covered[6]

OTHER		
Hospice Program Benefits		
• Routine home Care	No Charge	Not Covered [6]
• Inpatient Respite Care	No Charge	Not Covered [6]
• 24-hour Continuous Home Care	20%	Not Covered [6]
• General Inpatient Care	20%	Not Covered [6]
Chiropractic Benefits[7]		
• Chiropractic Services (provided by a chiropractor) Covers up to 24 visits per calendar year combined with rehabilitation services;	20%	30% (plan payment maximum up to $25 per visit)
Acupuncture Benefits[7]		
• Acupuncture by a certificated acupuncturist Covers up to 24 visits per calendar year for acupuncture.	20%	20%
Rehabilitation Benefits (Physical, Occupational and Respiratory Therapy)		
• Office location Physical and occupational therapy up to 24 visits per calendar year combined with chiropractic services.[7]	20%	30% (plan payment maximum up to $25 per visit)
Speech Therapy Benefits		
• Office visit	20%	30%
Pregnancy and Maternity Care Benefits		
• Prenatal and postnatal Physician office visits (For inpatient hospital services, see "Hospitalization Services.")	No Charge	30%
Family Planning Benefits		
• Counseling and consulting[4]	No Charge (Not subject to the Calendar Year Deductible)	30%
• Tubal ligation	No Charge (Not subject to the Calendar Year Deductible)	30%
• Elective abortion[9]	20%	30%
• Vasectomy[9]	20%	30%
Diabetes Care Benefits		
• Devices, equipment, and non-testing supplies (for testing supplies see Outpatient Prescription Drug Benefits.)	20%	30%
• Diabetes self-management training (by a registered dietician or registered nurse that are certified diabetes educators)	$15 per visit (Not subject to the Calendar Year Deductible)	30%
Hearing Aid (Up to a maximum if $5,000 per member every 24 months)		
• Hearing Aid Instrument and ancillary equipment	20%	20%
• Audiological evaluations	20%	20%
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 in excess of the allowable amount do not count toward the Calendar Year deductible or out-of-pocket maximum. Payments applied to your Calendar Year deductible accrue towards the out-of-pocket maximum.

2 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.

3 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.

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

5 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.

6 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.

7 For plans with a Calendar Year 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.

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

9 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.

10 If the member requests a brand-name drug when a generic drug equivalent is available, the member is responsible for paying the difference between the cost to Blue Shield for the brand-name Drug and its generic drug equivalent, as well as the applicable generic drug Copayment. This difference in cost that the member must pay is not applied to their Calendar Year deductible and is not included in the Calendar Year out-of-pocket maximum responsibility calculations.

11 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.

[12] For the Outpatient Prescription Drugs Benefit, covered Drugs obtained from Non-Participating Pharmacies will be subject to and accrue to the Calendar Year Deductible and the Calendar Year Out-of-Pocket Maximum for Preferred Providers.

[13] Specialty drugs are covered only when dispensed by select pharmacies in the Specialty Pharmacy Network unless Medically Necessary for a covered emergency.

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

[15] Specialty Drugs are specific Drugs used to treat complex or chronic conditions which usually require close monitoring such as multiple sclerosis, hepatitis, rheumatoid arthritis, cancers, and other conditions that are difficult to treat with traditional therapies. Specialty Drugs are listed in the Blue Shield Outpatient Drug Formulary. Specialty Drugs may be self-administered in the home by injection by the patient or family member (subcutaneously or intramuscularly), by inhalation, orally or topically. Specialty Drugs may also require special handling, special manufacturing processes, and may have limited prescribing or limited pharmacy availability. Specialty Drugs must be considered safe for self-administration by Blue Shield's Pharmacy & Therapeutics Committee, be obtained from a Blue Shield Specialty Pharmacy and may require prior authorization for Medical Necessity by Blue Shield. Infused or Intravenous (IV) medications are not included as Specialty Drugs.

[16] Contraceptive Drugs and Devices covered under the outpatient prescription drug benefits will not be subject to the Calendar Year deductible. If a brand-name contraceptive is requested when a generic equivalent is available, the member will be responsible for paying the difference between the cost to Blue Shield for the brand-name contraceptive and its generic drug equivalent. In addition, select contraceptives may need prior authorization to be covered without a copayment.

[17] Mental health services are accessed through Blue Shield's participating and non-participating providers

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

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