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.

Spruce Plan

Blue Shield of California

Custom ASO PPO 500 – 80/60

Benefit Summary (For groups of 300 and above)

(Uniform Health Plan Benefits and Coverage Matrix)

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

Effective: July 1, 2014

	Preferred Providers[1]	Non-Preferred Providers[1]
Calendar Year Medical Deductible (All providers combined. 4th quarter carryover applies.)	$500 per individual / $1,500 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.)	$3,000 per individual / $9,000 per family	$7,167 per individual / $21,501 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	$15 per visit (Not subject to the Calendar Year Deductible)	40%
• CT scans, MRIs, MRAs, PET scans, and cardiac diagnostic procedures utilizing nuclear medicine (prior authorization is required)[3]	20%	40%
• Other outpatient X-ray, pathology and laboratory (Diagnostic testing by providers other than outpatient laboratory, pathology, and imaging departments of hospitals/facilities)[3]	20%	40%
Allergy Testing and Treatment Benefits		
• Office visits (includes visits for allergy serum injections)	20%	40%
Preventive Health Benefits		
• Preventive Health Services (As required by applicable federal law.)	No Charge (Not subject to the Calendar Year Deductible)	40% (Not subject to the Calendar Year Deductible)
OUTPATIENT SERVICES		
Hospital Benefits (Facility Services)		
• Outpatient surgery performed at an Ambulatory Surgery Center[4]	20%	40%
• Outpatient surgery in a hospital	20%	40%
• Outpatient Services for treatment of illness or injury and necessary supplies (Except as described under "Rehabilitation Benefits")	20%	40%
• CT scans, MRIs, MRAs, PET scans, and cardiac diagnostic procedures utilizing nuclear medicine performed in a hospital (prior authorization is required)[3]	20%	40%
• Other outpatient X-ray, pathology and laboratory performed in a hospital[3]	20%	40%
• Bariatric Surgery (prior authorization required by the Plan; medically necessary surgery for weight loss, for morbid obesity only)	20%	40%
HOSPITALIZATION SERVICES		
Hospital Benefits (Facility Services)		
• Inpatient Physician Services	20%	40%
• Inpatient Non-emergency Facility Services (Semi-private room and board, and medically-necessary Services and supplies, including Subacute Care)	20%	$500 per admission + 40%

• Bariatric Surgery (prior authorization required by the Plan; medically necessary surgery for weight loss, for morbid obesity only)	20%	$500 per admission + 40%
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	20%	20% [9]
• Skilled Nursing Unit of a Hospital	20%	$500 per admission + 40%
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	40%	40%
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)	20%	40%
• Orthotic equipment and devices (Separate office visit copay may apply)	20%	40%
DURABLE MEDICAL EQUIPMENT		
• Breast pump	No Charge (Not subject to the Calendar Year Deductible)	Not Covered
• Other Durable Medical Equipment	20%	40%
MENTAL HEALTH SERVICES (PSYCHIATRIC)[10]		
• Inpatient Hospital Services / Residential Treatment	20%	$500 per admission + 40%
• Outpatient Mental Health Services	$15 per visit (Not subject to the Calendar Year Deductible)	40%
CHEMICAL DEPENDENCY SERVICES (SUBSTANCE ABUSE)[10, 11]		
• Inpatient Hospital Services / Residential Treatment	20%	$500 per admission + 40%
• Outpatient Chemical dependency and substance abuse services	$15 per visit (Not subject to the Calendar Year Deductible)	40%
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]	20%	Not Covered [7]
• Home infusion/home intravenous injectable therapy and infusion nursing visits provided by a Home Infusion Agency	20%	Not Covered [7]
OTHER		
Hospice Program Benefits		
• Routine home care	No Charge	Not Covered [7]
• Inpatient Respite Care	No Charge	Not Covered [7]
• 24-hour Continuous Home Care	20%	Not Covered [7]
• General Inpatient care	20%	Not Covered [7]
Chiropractic Benefits[8]		
• Chiropractic Services - (provided by a chiropractor) Covers up to 12 visits per calendar year combined with rehabilitation services;	20%	40% (plan payment maximum up to $25 per visit)
Acupuncture Benefits[8]		
• 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 24 Up to [AMT} visits per calendar year combined with Occupational Therapy and Chiropractic Services[8]	20%	40% (plan payment maximum up to $25 per visit)
Speech Therapy Benefits		

• Office visit	20%	40%
Pregnancy and Maternity Care Benefits		
• Prenatal and postnatal Physician office visits (For inpatient hospital services, see "Hospitalization Services.")	$15 per visit (Not subject to the Calendar Year Deductible)	40%
Family Planning Benefits		
• Counseling and consulting[6]	No Charge (Not subject to the Calendar Year Deductible)	40%
• Elective abortion[5]	20%	40%
• Tubal ligation	No Charge (Not subject to the Calendar Year Deductible)	40%
• Vasectomy[5]	20%	40%
Diabetes Care Benefits		
• Devices, equipment, and non-testing supplies (for testing supplies see Outpatient Prescription Drug Benefits.)	20%	40%
• 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)	40%
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 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 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.

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

7 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.

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.

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

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