

Santa Barbara Superior Courts Medical Benefits Chart - Blue Shield

This comparison chart shows a brief summary of the medical benefits available. The health plan contracts must be consulted to determine the exact terms and conditions of coverage.

Insurance Carrier Plan Name	Option 1 Blue Shield	Option 2 Blue Shield High EPO	Option 3 Blue Shield PPO		Option 4 Blue Shield HDHP	
			In-Network	Out-of-Network**	In-Network	Out-of-Network**
Deductibles						
Calendar Year Deductible	\$0 Individual/\$0 Family	\$0 Individual/\$0 Family	\$500 Individual/\$1,500 Family		\$1,500 Individual/\$3,000 Family	
Calendar Year Copay Maximum	\$1,500 Individual/\$3,000 Family	\$1,500 Individual/\$3,000 Family	\$4,000 Individual \$8,000 Family	\$6,000 Individual \$12,000 Family	\$4,500 Individual \$9,000 Family	
Lifetime Maximum	Unlimited	Unlimited	Unlimited		Unlimited	
Doctor Visits (Co-payment)						
Physician/Specialist/Urgent Care	\$20/visit*	\$15/visit*	\$30/visit*	40%	20%	40%
Diagnostic Testing	No Charge	No Charge	20%	40%	No Charge	40%
Allergy Testing & Treatment	\$20/visit*	\$15/visit*	20%	40%	20%	40%
Hospitalization						
Inpatient Physician Services	No Charge	No Charge	20%	40%	20%	40%
Inpatient Hospital	\$250/admission + 20%	\$100/admission	\$250/admission + 20%	40%	20%	40%
Emergency	\$100/visit * (waived if admitted) Hospital Copay Applies if Admitted	\$50/visit * (waived if admitted) Hospital Copay Applies if Admitted	\$75* + 20% (waived if admitted) Hospital Copay Applies if Admitted	\$75* + 20% (waived if admitted) Hospital Copay Applies if Admitted	20%	20%
Ambulance	\$50*	\$50*	20%	20%	20%	20%
Preventive Care						
Annual Exam/Vision/Hearing	No Charge	No Charge	No Charge	40%	No Charge***	40%
Immunizations	No Charge	No Charge	No Charge	40%	No Charge***	40%
Mammogram	No Charge	No Charge	No Charge	40%	No Charge***	40%
Pap Smears	No Charge	No Charge	No Charge	40%	No Charge***	40%
Prostate Screening	No Charge	No Charge	No Charge	40%	No Charge***	40%
Well Baby Care	No Charge	No Charge	No Charge	40%	No Charge***	40%
Outpatient Services (Co-payment)						
Surgery-Ambulatory Surgery Center (ASC)	No Charge	No Charge	20%	40%	20%	40%
Surgery-Outpatient at Hospital	No Charge	No Charge	20%	40%	20%	40%
Chiropractic Services	\$20/visit* - 30/yr max	\$15/visit* - 30/yr max	\$30/visit* - 12/yr max	Not Covered	20% - 20 visits/yr max	40%
Accupuncture Services	\$20/visit* - 12/yr max	\$15/visit* - 12/yr max	20% - 12 /yr max	20%	20% - 12 visits/yr max	20%
Pregnancy & Maternity	No Charge	No Charge	20%	40%	20%	40%
Mental Health/Substance Abuse						
Mental Health - Inpatient	\$250/admission + 20%	\$100/ admission	\$250/admission + 20%	40%	20%	40%
Mental Health - Outpatient	\$20/visit*	\$15/visit*	\$30/visit*	40%	20%	40%
Substance Abuse - Inpatient	\$250/admission + 20%	\$100/ admission	\$250/admission + 20%	40%	20%	40%
Substance Abuse - Outpatient	\$20/visit*	\$15/visit*	\$30/visit*	40%	20%	40%
Prescription Drugs						
Pharmacy Annual Deductible	\$25 Individual/\$75 Family for Brand-name drugs	\$25 Individual/\$75 Family for Brand-name drugs	\$25 Individual/\$75 Family for Brand-name drugs		Medical Deductible Applies	
Retail - Generic/Brand/Non-formulary	\$10/\$35/\$50 (30 day supply)	\$10/\$30/\$45 (30 day supply)	\$10/\$35/\$50 (30 day supply)		20% (30 day supply)	
Mail Order - Generic/Brand/Non-formulary	\$20/\$70/\$100 (90 day supply)	\$20/\$60/\$90 (90 day supply)	\$20/\$70/\$100 (90 day supply)		20% (90 day supply)	Not Covered

Notes:

* Copayment does not accrue to Calendar-Year copayment maximum.

** For the PPO and HDHP plan, out of network charges are subject to Usual and Customary. You are responsible for additional charges above the allowable charges.