

CSAC/EIA Health Santa Barbara Superior Courts
 Custom High Deductible Health Plan
 PPO Shield SavingsSM Plus 1500
 Benefit Summary

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.

(Uniform Health Plan Benefits and Coverage Matrix)

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

Effective January 1, 2011

DEDUCTIBLES	Preferred Providers¹	Non-Preferred Providers¹
Calendar year Medical Deductible (All providers combined) (Note: 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 maximum¹ (Includes the plan deductible) (Note: 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.)		\$4,500 per individual/ \$9,000 per family
LIFETIME MAXIMUM		None
Covered Services	Member Copayment	
PROFESSIONAL SERVICES	Preferred Providers¹	Non-Preferred Providers¹
Professional (physician) benefits <ul style="list-style-type: none"> Physician and specialist office visits Outpatient X-ray, pathology and laboratory 	20% No charge (After deductible)	40% 40%
Allergy testing and treatment benefits <ul style="list-style-type: none"> Office visits (includes visits for allergy serum injections) 	20%	40%
Preventive health benefits <ul style="list-style-type: none"> Annual routine physical examination, vision and hearing screening and immunizations Routine laboratory services, including annual mammography, Papanicolaou test, or cervical cancer and human papillomavirus (HPV) screening (One per calendar year) Well baby care (Includes: eye/ear screenings, immunizations, vaccinations) Well baby laboratory 	No charge (Not subject to the Calendar-Year Deductible) No charge (Not subject to the Calendar-Year Deductible) No charge (Not subject to the Calendar-Year Deductible) No charge (Not subject to the Calendar-Year Deductible)	40% 40% 40%
OUTPATIENT SERVICES		
Hospital benefits (facility services) The maximum allowed charges for non-emergency surgery and services performed in a non-participating Ambulatory Surgery Center or outpatient unit of a non-preferred hospital is \$350 per day. Members are responsible for 40% of this \$350 per day, plus all charges in excess of \$350.		
<ul style="list-style-type: none"> Outpatient surgery performed in an ambulatory surgery center² Outpatient surgery in a hospital Outpatient services for treatment of illness or injury and necessary supplies (Except as described under "Rehabilitation benefits") Bariatric surgery⁴ (pre-authorization required; medically necessary surgery for weight loss, only for morbid obesity) 	20% 20% 20% 20%	40% 40% 40% 40%
HOSPITALIZATION SERVICES		
Hospital benefits (facility services) <ul style="list-style-type: none"> Inpatient physician benefits Inpatient non-emergency facility services (semi-private room and board, medically necessary services and supplies) Bariatric surgery⁴ (pre-authorization required; medically necessary surgery for weight loss, only for morbid obesity) 	20% 20% 20%	40% 40% ³ 40% ³
Skilled nursing facility benefits⁵ (Combined maximum of up to 100 preauthorized days per calendar year; semi-private accommodations)		
<ul style="list-style-type: none"> Services by a free-standing skilled nursing facility Skilled nursing facility unit of a hospital 	20% 20%	20% with prior authorization ⁵ 40% ³

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EMERGENCY HEALTH COVERAGE		
• Emergency room services not resulting in admission (ER Facility copay does not apply if the member is admitted directly from the ER for inpatient services.)	20%	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	20%	20%
PRESCRIPTION DRUG COVERAGE ^{6,7, 8, 9, 10, 11, 12}		
(Subject to deductible; includes oral contraceptives, diaphragms, and covered diabetic drugs and testing supplies)		
Outpatient Prescription Drug Benefits	Participating Pharmacy	Non-Participating Pharmacy
Retail prescriptions (For up to a 30-day supply)		
• Formulary generic drugs	20%	20%
• Formulary brand name drugs	20%	20%
• Non-formulary brand name drugs	20%	20%
Mail service prescriptions (For up to a 90-day supply)		
• Formulary generic drugs	20%	Not covered
• Formulary brand name drugs	20%	Not covered
• Non-formulary brand name drugs	20%	Not covered
Specialty Pharmacies		
• Specialty drugs	20% up to \$100 out-of-pocket member copayment max per prescription	Not covered
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		
• Durable medical equipment	20%	40%
Hearing Aid		
• Hearing Aid Instrument and ancillary equipment (Up to a maximum of \$700 per member every 24 months for the hearing aid and ancillary equipment)	20%	20%
MENTAL HEALTH SERVICES (PSYCHIATRIC) ¹³		
• Inpatient hospital services	20%	40% ³
• Outpatient mental health services	20%	40%
CHEMICAL DEPENDENCY SERVICES (SUBSTANCE ABUSE) ^{13,16}		
• Inpatient hospital services	20%	40% ³
• Outpatient chemical dependency services	20%	40%
HOME HEALTH SERVICES ¹⁷		
• Home health care agency services (Up to 100 prior authorized visit maximum per calendar year)	20%	Not covered ¹⁷
• Home infusion/home injectable therapy provided by a home infusion agency	20%	Not covered ¹⁷
OTHER		
Hospice program benefits ¹⁷		
• Routine home care	No charge (After deductible)	Not covered ¹⁷
• Inpatient respite care	No charge (After deductible)	Not covered ¹⁷
• 24 hour continuous home care	20%	Not covered ¹⁷
• General inpatient care	20%	Not covered ¹⁷
Chiropractic benefits ¹⁵		
• Chiropractic services – provided by a chiropractor (Up to 20 visits per calendar year)	20%	40%
Acupuncture benefits ¹⁵		
• Acupuncture (Up to 12 visits per calendar year)	20%	20%
Rehabilitation benefits (physical, occupational and respiratory therapy)		
• Office location	20%	Not covered
Speech therapy benefits		
• Office location	20%	40%

Pregnancy and maternity care benefits

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| • Prenatal and postnatal physician office visits
(For inpatient hospital services, see "Hospitalization Services.") | 20% | 40% |
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Family planning benefits

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| • Counseling and consulting | 20% | 40% |
| • Infertility services (Diagnosis and treatment of causes of infertility.
Excludes in vitro fertilization, injectables for infertility, artificial insemination and GIFT) | 50% of allowed charges | Not covered |
| • Intrauterine device (IUD) | 20% | Not covered |
| • Insertion/removal of intrauterine device | 20% | Not covered |
| • Tubal ligation ¹⁴ | 20% | 40% |
| • Elective abortion ¹⁴ | 20% | 40% |
| • Vasectomy ¹⁴ | 20% | 40% |

Diabetes care benefits

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| • Devices, equipment and non-testing supplies
(For testing supplies, see "Outpatient Prescription Drug Benefits.") | 20% | 40% |
| • Diabetes self-management training (If billed by your provider, you will also be responsible for the office visit copayment) | 20% | 40% |

Care outside of plan service area (Benefits provided through the BlueCard® Program) Benefits provided through 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.

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| • Within US: BlueCard Program | See Applicable Benefit | See Applicable Benefit |
| • Outside of US: BlueCard Worldwide | See Applicable Benefit | See Applicable Benefit |

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- 1 Member is responsible for copayment in addition to any charges above allowable amounts. The copayment percentage indicated is a percentage of allowed amounts. Preferred providers accept Blue Shield's allowable amount 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 copayment 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 Maximum Calendar Year Out-of-Pocket Responsibility.
- 2 Participating ambulatory surgery centers may not be available in all areas. Regardless of their availability, you can obtain outpatient surgery services from a hospital or an ambulatory surgery center affiliated with a hospital, with payment according to your health plan's hospital services benefits.
- 3 The maximum allowed charge for non-emergency hospital services received from a non-preferred hospital is \$600 per day. Members are responsible for 40 percent of this \$600 per day, plus all charges in excess of \$600. Payments that exceed the allowed charge do not count toward the calendar-year out-of-pocket maximum, and continue to be charged after it is reached.
- 4 Bariatric surgery is covered when pre-authorized by Blue Shield.
- 5 Services may require prior authorization by Blue Shield. When services are prior authorized, members pay the preferred or participating provider amount.
- 6 This plan's prescription drug coverage is on average equivalent to or better than the standard benefit set by the federal government for Medicare Part D (also called "creditable" coverage). Since this plan's prescription drug coverage is creditable, you do not have to enroll in Medicare Part D while you maintain this coverage; however, you should be aware that if you have a subsequent break in this coverage of 63 days or more before enrolling in Medicare Part D you could be subject to payment of higher Medicare Part D premiums.
- 7 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 of 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 the Calendar Year Deductible and is not included in the Calendar Year maximum out-of-pocket responsibility calculations.
- 8 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.
- 9 For the Outpatient Drugs benefit, covered drugs obtained from Non-Participating Pharmacies will be subject to and accrue to the deductible and the copay maximum for Preferred Providers.
- 10 Specialty drugs are covered only when dispensed by select pharmacies in the Specialty Pharmacy Network unless Medically Necessary for a covered emergency.
- 11 Selected formulary and non-formulary drugs require prior authorization by Blue Shield for Medical Necessity, and when effective, lower cost alternatives are available.
- 12 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. Infused or Intravenous (IV) medications are not included as Specialty Drugs. These 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.
- 13 Mental health and chemical dependency services are accessed through Blue Shield - using Blue Shield's participating and non-participating providers. For a listing of severe mental illnesses, including serious emotional disturbances of a child and other benefit details, please refer to the Plan Contract.
- 14 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.
- 15 Chiropractic and acupuncture visits accrue to the calendar-year visit maximum regardless of whether the plan deductible has been met.
- 16 Inpatient services for acute detoxification are covered under the medical benefit; see hospitalization services for benefit details. Services for medical acute detoxification are accessed through Blue Shield using Blue Shield's preferred providers or non-preferred providers.
- 17 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.

Blue Shield believes this plan/policy is a "grandfathered health plan" under the Patient Protection and Affordable Care Act (the Affordable Care Act). As permitted by the Affordable Care Act, a grandfathered health plan can preserve certain basic health coverage that was already in effect when that law was enacted. Being a grandfathered health plan means that your plan or policy is not required to include certain consumer protections of the Affordable Care Act that apply to other plans, for example, the requirement for the provision of preventive health services without any cost sharing. However, grandfathered health plans must comply with certain other consumer protections in the Affordable Care Act, for example, the elimination of lifetime limits on benefits. Note, even though they are not required to be included, many of the protections of the Affordable Care Act are included in your current plan/policy.

Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to Blue Shield at the telephone number on your identification card. If you obtain this plan/policy through your employer and your plan is subject to ERISA, you may also contact the Employee Benefits Security Administration, U.S. Department of Labor at 1-866-444-3272 or www.dol.gov/ebsa/healthreform. This website has a table summarizing which protections do and do not apply to grandfathered health plans. If you obtain your coverage through a nonfederal governmental employer, you may also contact the U.S. Department of Health and Human Services at www.healthreform.gov.

Plan designs may be modified to ensure compliance with state and federal requirements

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