

CSAC/EIA Santa Barbara Superior Courts Custom EPO – Low Option Benefit Summary

(Uniform Health Plan Benefits and Coverage Matrix)

Blue Shield of California

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.

Effective January 1, 2011

Calendar year Medical Deductible¹ (all providers combined)	Preferred Providers² \$0 per individual/ \$0 per family
Calendar year Copayment Maximum¹ (Copayments for Preferred Providers accrue to both Preferred and Non-Preferred Provider Calendar-year Copayment Maximum amounts.)	\$1,500 per individual/ \$3,000 per family
LIFETIME BENEFIT MAXIMUM	None
Covered Services	Member Copayment
PROFESSIONAL SERVICES	Preferred Providers²
Professional (physician) benefits	
<ul style="list-style-type: none"> Physician and specialist office visits Diagnostic testing Outpatient X-ray, pathology and laboratory 	\$20 per visit ¹ No charge No charge
Allergy testing and treatment benefits	
<ul style="list-style-type: none"> Office visits (includes visits for allergy serum injections) 	\$20 per visit ¹
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 	\$20 per visit ¹ No charge \$20 per visit ¹ No charge
OUTPATIENT SERVICES	
Hospital benefits (facility services)	
<ul style="list-style-type: none"> Outpatient surgery performed in an ambulatory surgery center Outpatient surgery in a hospital Outpatient services for treatment of illness or injury and necessary supplies (Except as described under "Rehabilitation benefits") Bariatric surgery (pre-authorization required; medically necessary surgery for weight loss, only for morbid obesity)⁵ 	No charge No charge No charge No charge
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 surgery (pre-authorization required; medically necessary surgery for weight loss, only for morbid obesity)⁵ 	No charge \$250 per admission + 20% \$250 per admission + 20%
Skilled nursing facility benefits⁶ (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%
EMERGENCY HEALTH COVERAGE	
<ul style="list-style-type: none"> Emergency room services not resulting in admission (If ER services do not result in a direct admission the Calendar-Year Deductible does not apply) Emergency room services resulting in admission (when the member is admitted directly from the ER) Emergency room physician services 	\$100 per visit ¹ \$250 per admission + 20% No charge
AMBULANCE SERVICES	
<ul style="list-style-type: none"> Emergency or authorized transport 	\$50 ¹

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PROSTHETICS/ORTHOTICS	
• Prosthetic equipment and devices (Separate office visit copay may apply)	20%
• Orthotic equipment and devices (Separate office visit copay may apply)	20%
DURABLE MEDICAL EQUIPMENT	
• Durable medical equipment	20%
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)	No charge
MENTAL HEALTH SERVICES (PSYCHIATRIC)⁷	
• Inpatient hospital services	\$250 per admission + 20%
• Outpatient mental health services	\$20 per visit ¹
CHEMICAL DEPENDENCY SERVICES (SUBSTANCE ABUSE)^{7,9}	
• Inpatient hospital services	\$250 per admission + 20%
• Outpatient chemical dependency services	\$20 per visit ¹
HOME HEALTH SERVICES⁴	
• Home health care agency services (Maximum of 100 prior authorized visits per calendar year)	20%
• Home infusion/Home injectable therapy provided by a home infusion agency	20%
OTHER	
Hospice program benefits⁴	
• Routine home care	No charge
• Inpatient respite care	No charge
• 24-hour continuous home care	20%
• General inpatient care	20%
Chiropractic benefits	
• Chiropractic services – provided by a chiropractor (Up to 30 visits per calendar year)	\$20 per visit ¹
Acupuncture benefits	
• Acupuncture (Up to 12 visits per calendar year; \$50 per visit plan payment maximum)	\$20 per visit ¹
Rehabilitation benefits (physical, occupational and respiratory therapy)	
• Office location	\$20 per visit ¹
Speech therapy benefits	
• Office location	\$20 per visit ¹
Pregnancy and maternity care benefits	
• Prenatal and postnatal physician office visits (For inpatient hospital services, see "Hospitalization Services.")	No charge
Family planning benefits	
• Counseling and consulting	\$20 per visit ¹
• Infertility services (Diagnosis and treatment of causes of infertility. Excludes in vitro fertilization, injectables for infertility, artificial insemination and GIFT)	50% of allowed charges
• Intrauterine device (IUD)	\$20 ¹
• Insertion/removal of intrauterine device	\$20 per visit ¹
• Elective abortion ⁸	\$100
• Tubal ligation ⁸	\$100
• Vasectomy ⁸	\$75
Diabetes care benefits	
• Devices, equipment, and non-testing supplies	20%
• Diabetes self-management training (If billed by your provider, you will also be responsible for the office visit copayment)	\$20 per visit ¹
Care Outside of Plan Service Area 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.	
• Within US: BlueCard Program	See Applicable Benefit
• Outside of US: BlueCard Worldwide	See Applicable Benefit

¹ Copayments marked with a (1) do not accrue to calendar-year copayment maximum. Copayments 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. Please refer to the Plan Contract for exact terms and conditions of coverage.

² Member is responsible for copayment in addition to any charges above allowable amounts. The copayment percentage indicated is a percentage of allowable amounts. Preferred providers accept Blue Shield's allowable amount as full payment for covered services.

³ 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.

⁴ Home health care, home infusion and hospice services require prior authorization.

5 Bariatric surgery is covered when preauthorized by Blue Shield.

6 Services may require prior authorization by Blue Shield.

7 Mental health services are accessed through Blue Shield using Blue Shield's 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.

8 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.

9 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.

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

A17264 (10/10) ME_092310_GF-ASO