

CSAC/EIA Santa Barbara Superior Courts
 Custom Shield Spectrum PPO 500-80/60
 Benefit Summary

(Uniform Health Plan Benefits and Coverage Matrix)

Blue Shield of California

Effective January 1, 2011

THIS MATRIX IS INTENDED TO BE USED TO HELP YOU COMPARE COVERAGE BENEFITS AND IS A SUMMARY ONLY. PLAN CONTRACT SHOULD BE CONSULTED FOR A DETAILED DESCRIPTION OF COVERAGE BENEFITS AND LIMITATIONS.

	Preferred Providers ²	Non-Preferred Providers ²
Calendar year Medical Deductible¹ (All providers combined)		\$500 per individual/ \$1,500 per family
Calendar year Copayment Maximum¹ (Copayments for Preferred Providers accrue to both Preferred and Non-Preferred Provider Calendar-year Copayment Maximum amounts.)	\$4,000 per individual/ \$8,000 per family	\$6,000 per individual/ \$12,000 per family

LIFETIME BENEFIT MAXIMUM

None

Covered Services

Member Copayment

PROFESSIONAL SERVICES

Professional (physician) benefits

- Physician and specialist office visits

\$30 per visit¹
(Not subject to the
Calendar-Year Deductible)

40%

- Diagnostic testing
- Outpatient X-ray, pathology and laboratory

20% 40%

Allergy testing and treatment benefits

- Office visits (includes visits for allergy serum injections)

20% 40%

Preventive care benefits

- Annual routine physical examination, vision and hearing screening and immunizations

\$30 per visit¹
(Not subject to the Calendar-Year
Deductible)

40%

- Routine laboratory services, including annual mammography, Papanicolaou test, or cervical cancer and human papillomavirus (HPV) screening (One per calendar year)

No charge
(Not subject to the
Calendar-Year Deductible)

40%

- Well baby care (Includes: eye/ear screenings, immunizations, vaccinations)

\$30 per visit¹
(Not subject to the Calendar-Year
Deductible)

40%

- Well baby laboratory

No charge
(Not subject to the
Calendar-Year Deductible)

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.

- Outpatient surgery performed in an Ambulatory Surgery Center³
- 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

20% 40%

20% 40%

20% 40%

20% 40%

HOSPITALIZATION SERVICES

Hospital benefits (facility services)

- 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

20% 40%

\$250 per admission +
20% 40%⁴

\$250 per admission +
20% 40%⁴

Skilled nursing facility benefits

(Combined maximum of up to 100 preauthorized days per calendar year; semi-private accommodations)

- Services by a free-standing skilled nursing facility
- Skilled nursing facility unit of a hospital

20% 20% with prior
authorization⁶

20% 40%⁴

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EMERGENCY HEALTH COVERAGE		
• Emergency room services not resulting in admission (If ER services do not result in a direct admission the Calendar-Year Deductible does not apply)	\$75 ¹ per visit + 20%	\$75 ¹ per visit + 20%
• Emergency room services resulting in admission (when the member is admitted directly from the ER)	\$250 per admission + 20%	\$250 per admission + 20%
• Emergency room physician services	20%	20%
AMBULANCE SERVICES		
• Emergency or authorized transport	20%	20%
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)⁷		
• Inpatient hospital services	\$250 per admission + 20%	40% ⁴
• Outpatient mental health services	\$30 per visit ¹ (Not subject to the Calendar-Year Deductible)	40%
CHEMICAL DEPENDENCY SERVICES (SUBSTANCE ABUSE)^{7,9}		
• Inpatient hospital services	\$250 per admission + 20%	40% ⁴
• Outpatient chemical dependency services	\$30 per visit ¹ (Not subject to the Calendar-Year Deductible)	40%
HOME HEALTH SERVICES¹⁰		
• Home health care agency services (Maximum of 100 prior authorized visits per calendar year)	20%	Not covered ¹⁰
• Home infusion/Home injectable therapy provided by a home infusion agency	20%	Not covered ¹⁰
OTHER		
Hospice program benefits¹⁰		
• Routine home care	No charge (After deductible)	Not covered ¹⁰
• Inpatient respite care	No charge (After deductible)	Not covered ¹⁰
• 24-hour continuous home care	20%	Not covered ¹⁰
• General inpatient care	20%	Not covered ¹⁰
Chiropractic benefits⁸		
• Chiropractic services – provided by a chiropractor (Up to 12 visits per calendar year)	\$30 per visit ¹ (Not subject to the Calendar-Year Deductible)	Not covered
Acupuncture benefits⁸		
• Acupuncture (Up to 12 visits per calendar year; plan payment up to \$50 per visit)	20%	20%
Rehabilitation benefits (physical, occupational and respiratory therapy)		
• Office location	20%	40%
Speech therapy benefits		
• Office location	20%	40%
Pregnancy and maternity care benefits		
• Prenatal and postnatal physician office visits (For inpatient hospital services, see "Hospitalization Services.")	20%	40%
Family planning benefits		
• Counseling and consulting	\$30 per visit ¹ (Not subject to the Calendar-Year Deductible)	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	\$30 per visit ¹ (Not subject to the Calendar-Year Deductible)	Not covered
• Elective abortion ¹¹	20%	40%
• Tubal ligation ¹¹	20%	40%
• Vasectomy ¹¹	20%	40%

Diabetes care benefits

• Devices, equipment, and non-testing supplies	20%	40%
• Diabetes self-management training (If billed by your provider, you will also be responsible for the office visit copayment)	\$30 per visit ¹ (Not subject to the Calendar-Year Deductible)	40%

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	See Applicable Benefit
• Outside of US: BlueCard Worldwide	See Applicable Benefit	See Applicable Benefit

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- 1 Deductible and 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. Deductible does not apply toward the calendar-year maximum. 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. 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 above the allowable amount do not count toward the calendar-year deductible or copayment maximum.
 - 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 The maximum allowed charges 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.
 - 5 Bariatric surgery is covered when pre-authorized by Blue Shield.
 - 6 Services may require prior authorization by Blue Shield. When these services are prior authorized, members pay the preferred or participating provider amount.
 - 7 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.
 - 8 All outpatient chiropractic visits accrue to the calendar-year visit maximum regardless of whether the plan deductible has been met.
 - 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 or non-preferred providers.
 - 10 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.
 - 11 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.

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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