

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

(Uniform Health Plan Benefits and Coverage Matrix)

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.

Blue Shield of California

Effective January 1, 2010

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| DEDUCTIBLES¹ (All providers combined) | Preferred Providers² |
| Calendar year medical deductible | \$0 per individual \$0 per family |
| Calendar year Copayment Maximum¹ | \$1,500 per individual \$3,000 per family |
| LIFETIME MAXIMUM | Unlimited |
| Covered Services | Member Copayment |
| PROFESSIONAL SERVICES | Preferred Providers² |
| Professional (physician) benefits | |
| • Physician and specialist office visit | \$20/visit ¹ |
| • Diagnostic testing | No charge |
| • Outpatient X-ray, pathology and laboratory | No charge |
| Allergy testing and treatment benefits¹¹ | |
| • Office visits (includes visits for allergy serum injections) | \$20/visit ¹ |
| Preventive care benefits | |
| • Annual routine physical examination, vision and hearing screening and immunizations | \$20/visit ¹ |
| • Routine laboratory services, including annual mammography, Papanicolaou test, or cervical cancer and human papillomavirus (HPV) screening (One per calendar year) | No charge |
| • Well baby care (Includes: eye/ear screenings, immunizations, vaccinations) | \$20/visit ¹ |
| • Well baby laboratory | No charge |
| OUTPATIENT SERVICES | |
| Hospital benefits (facility services) | |
| • Outpatient surgery performed in a Participating Ambulatory Surgery Center (ASC) ³ | No charge |
| • Outpatient surgery in a hospital | No charge |
| • Outpatient services for treatment of illness or injury and necessary supplies (Except as described under "Rehabilitation services") | No charge |
| • Bariatric surgery (pre-authorization required; medically necessary surgery for weight loss, only for morbid obesity) ⁵ | No charge |
| HOSPITALIZATION SERVICES | |
| Hospital benefits (facility services) | |
| • Inpatient physician benefits | No charge |
| • Semi-private room and board, medically necessary services and supplies | \$250/admission + 20% |
| • Bariatric surgery (pre-authorization required; medically necessary surgery for weight loss, only for morbid obesity) ⁵ | \$250/admission + 20% |
| Skilled nursing facility benefits⁶ (Combined maximum of up to 100 preauthorized days per calendar year; semi-private accommodations) | |
| • Skilled nursing free standing facility | 20% |
| • Skilled nursing facility unit of a hospital | 20% |
| EMERGENCY HEALTH COVERAGE | |
| • Emergency room services not resulting in admission (If ER services do not result in a direct admission) | \$100/visit ¹ |
| • Emergency room services resulting in admission (when the member is admitted directly from the ER) | \$250/admission + 20% |
| • Emergency room physician services | No charge |
| AMBULANCE SERVICES | |
| • 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 services | 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 facility services | \$250/admission + 20% |
| • Outpatient mental health services | \$20/visit ¹ |
| CHEMICAL DEPENDENCY SERVICES (SUBSTANCE ABUSE)⁹ | |
| • Inpatient hospital facility services | \$250/admission + 20% |
| • Outpatient chemical dependency services | \$20/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 (Up to 30 visits per calendar year) | \$20/visit ¹ |
| Acupuncture benefits | |
| • Acupuncture services (Up to 12 visits per calendar year; \$50/visit plan payment maximum) | \$20/visit ¹ |
| Rehabilitation services (physical, occupational and respiratory therapy) | |
| • In an office location | \$20/visit ¹ |
| Speech therapy benefits | |
| • In an office location (Speech therapy services by a licensed speech pathologist or certified speech therapist) | \$20/visit ¹ |
| Pregnancy and maternity care | |
| • Prenatal and postnatal physician office visits (For inpatient hospital services, see "Hospitalization Services.") | No charge |
| Family planning benefits | |
| • Counseling and consulting | \$20/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/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/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 pre-authorized 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.

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

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