

hello.

Welcome to the benefits of Blue Shield – the quality health coverage you need, when you need it.

There's more to Blue Shield of California health plans than broad healthcare benefits. Blue Shield brings County of Santa Barbara one of the largest statewide networks of doctors, specialists, and hospitals, as well as a wide variety of health resources to help make it easier to manage your family's health.

Extensive provider network

Blue Shield's network is one of the largest in California with more than 31,000 physicians and 280 hospitals in our HMO network, and 63,000 physicians and 351 hospitals in our PPO network, including Goleta Valley Cottage Hospital and Santa Barbara Cottage Hospital.

On-call nurse and counselor support for life's challenges

You can talk with registered nurses and master's-level counselors, day or night, for information and support on issues affecting your physical and emotional health.

Health management programs

These programs give members with certain conditions the tools, knowledge, and support they need to better manage their health and wellness. Programs include prenatal education, assistance in managing asthma, diabetes, coronary artery disease, and heart failure.

Discounts on chiropractic, massage therapy, and acupuncture

We offer you access to alternative health and wellness services at a generous reduction in cost – at least 25% off published fees for chiropractic, acupuncture, and massage therapy from participating practitioners.*

blueshieldca.com

Our award-winning Web site provides round-the-clock health resources and wellness information at your fingertips. Look up your plan benefits, learn about copayments, check claims, download forms, and more.

Overview of County of Santa Barbara and Santa Barbara County Superior Court plans

Your Blue Shield health plan options for 2007-2008 include the Access+ HMO Low, Access+ HMO High, Blue Shield PPO, and the High Deductible Health Plan.

Access+ HMO Low

With Access+ HMO, you'll have no annual deductibles or claim forms with only affordable copayments each time you see a physician. You'll need to select your Personal Physician who is responsible for the overall coordination of your care. As an Access + HMO member, you also have the option to visit a specialist within your Personal Physician's medical group or IPA without a referral for a higher copay.**

Access+ HMO High

Like the standard Access+ HMO, you'll have affordable copayments for services, no annual deductibles or claim forms, and the ability to self-refer to a specialist.** The only difference is, you pay slightly more out-of-pocket for more comprehensive benefit coverage.

Blue Shield PPO

Your Blue Shield PPO plan lets you choose, each time you need care, between network providers who offer their services at negotiated rates and non-network providers who are not in Blue Shield's network. You pay less when you see a network provider. You are responsible for paying a certain amount of covered expenses (deductible) before the plan pays most benefits, and you also can seek services from a specialist without a referral.

* The Alternative Health Services Discount Program is an exclusive offer to Blue Shield members, made available through an arrangement with American Specialty Health Networks of California Inc. (ASH Networks), and is not a covered service of any Blue Shield health plan. ASH Networks credentials and manages the program's practitioners. None of the terms and conditions of Blue Shield health plans applies. Blue Shield of California and ASH Networks do not review the program's practitioner services and products for medical necessity or efficacy, and make no representations, claims, or guarantees regarding their services or products. Members who use the discount program are responsible for the payment of services provided by participating network practitioners, including payment for cancelled or missed appointments. Members who are not satisfied with services received from the program's practitioners may use the Blue Shield grievance process. Blue Shield reserves the right to terminate this program without notice.

** Please note: Not all types of specialist visits are through the Access+ Specialist option. For more information, please refer to the *Evidence of Coverage and Disclosure Form* (EOC), or call our dedicated Blue Shield Member Services representatives. Access+ Specialist office visits are available only to members whose Personal Physicians belong to a medical group or Independent Practice Association (IPA) that participates as an Access+ provider. These providers are noted in the Physicians and Hospitals Directory and in the *Find a Provider* section of blueshieldca.com.

Overview (continued)

High Deductible Health Plan

The High Deductible Health Plan is compatible with health savings accounts (HSAs) with specific tax benefits for qualified members. Like the Shield Spectrum PPO plan, you are responsible for paying a deductible before the plan pays most benefits. You get affordable monthly dues, access to Blue Shield's extensive provider network, preventive care benefits when you use a network doctor, and a calendar-year deductible that accumulates toward the calendar-year out-of-pocket maximum.

Blue Shield POS Plan

The Blue Shield POS plan gives you the choice of using either the HMO or PPO network whenever you need care. You will need to select a Personal Physician from Blue Shield's HMO network. For regular physician care, you'll have the highest level of benefits when you access care through your Personal Physician. However, you always have the choice to seek care with any physician through the PPO option, which includes seeing any licensed physician or hospital. Using network doctors affords you a higher level of benefit, but the choice is yours.

We're here to help

If you have any questions, visit blueshieldca.com or call your dedicated Member Services team at (800) 642-6155 from 7 a.m. to 7 p.m., Monday through Friday.

Benefit plan changes for 2007-2008 plan year

High Deductible Health Plan

No changes

Blue Shield PPO

Prescription drug copayment:
\$15/25/40 retail
\$30/50/80 mail

Rx \$50 annual non-formulary deductible

Access+ HMO High

\$15 office visit copayment
\$100/admit hospital copayment
\$50 ER copayment

Prescription drug copayment:
\$10/30/45 retail
\$20/60/90 mail

\$50 annual non-formulary prescription drug deductible

Access+ HMO Low

\$20 office visit copayment
\$100 ER copayment

Prescription drug copayment:
\$10/35/50 retail
\$20/70/100 mail

\$50 annual non-formulary prescription drug deductible

Blue Shield POS

\$15 office visit copayment
\$50 emergency room copayment

Hospital copayments:

Tier I: \$200/admit
Tier II: \$200/admit + 10%
Tier III: 20% plan maximum \$600 per day

Prescription drug copayment:

\$10/20/35 retail
\$20/40/70 mail

County of Santa Barbara and Santa Barbara County Superior Court

Access + HMO Low Benefit Summary

Blue Shield of California

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 *Evidence of Coverage* and the Group Policy should be consulted for a detailed description of the coverage benefits and limitations.

Effective July 1, 2007

Deductibles¹

Calendar-year Medical Deductible	None
Calendar-year copayment maximum¹ (for many covered services)	\$1,500 per individual/ \$3,000 per 2-party/\$4,500 per family
Lifetime maximums	None

Covered services

Member copayment

Professional services

Physician Services – outpatient

Physician and authorized specialist office visits <small>Note: A woman may self-refer to an OB/GYN or family practice physician in her Personal Physician's medical group or IPA for OB/GYN services.</small>	\$20/visit
Allergy testing or treatment	\$20/visit
Access+ <i>Specialist</i> SM (self-referred office visits or consultations only) ^{1,2}	\$30/visit
Laboratory, X-ray, and diagnostic tests	No charge

Preventive care

Scheduled routine physical exams

Routine physical exam, eye/ear screenings, and immunizations according to age schedule <small>Note: A woman may self-refer to an OB/GYN or family practice physician in her Personal Physician's medical group or IPA for OB/GYN services.</small>	\$20/visit
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Outpatient services

Non-emergency

Outpatient surgery performed in a participating ambulatory surgery center ³ (ASC)	No charge
Outpatient surgery in hospital/facility	No charge
Outpatient treatment (except as described under "Rehabilitative Therapy Services"), and necessary supplies	No charge

Hospitalization services

Inpatient physician services, including pregnancy and maternity care	No charge
Semi-private room and board, medically necessary services, and supplies	\$250/admission + 20%
Skilled nursing facility (SNF) services ⁴	\$50/day

Emergency health coverage

Waived if the member is directly admitted to the hospital for inpatient services	\$100/visit
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Ambulance services

\$50

Covered services

Member copayment

Prescription drug coverage ^{9, 10} PENDING REGULATORY REVIEW (includes oral contraceptives, diaphragms, and covered diabetic drugs and testing supplies)	Participating pharmacy (for up to a 30-day supply)	Mail service prescriptions (for up to a 90-day supply)
Calendar-year brand-name drug deductible	\$50 per member per calendar year—applies to covered non-formulary brand-name medications	
Generic drugs	\$10/prescription	\$20/prescription
Formulary brand-name drugs	\$35/prescription	\$70/prescription
Non-formulary brand-name drugs	\$50/prescription	\$100/prescription
Home self-administered injectable medications (may require prior authorization from Blue Shield Pharmacy Services)	20% (up to \$100 copayment maximum per prescription) ¹⁰	Not covered
Durable medical equipment ¹ (plan payment up to \$2,000 maximum per calendar year)	20% of allowed charges	
Prosthetics/orthotics	\$20/visit	
Mental health services (psychiatric) ⁵		
Inpatient hospital facility services	\$250/admission + 20%	
Outpatient visits for severe mental health conditions	\$20/visit	
Outpatient visits for non-severe mental health conditions ¹ (up to 20 visits per calendar year combined with outpatient chemical dependency visits)	\$25/visit	
Chemical dependency services (substance abuse) ^{5, 6}		
Inpatient services for medical acute detoxification	See "hospitalization services"	
Outpatient visits ¹ (up to 20 visits per calendar year combined with outpatient non-severe mental health visits)	\$25/visit	
Home health services		
Agency visits (up to 100 visits per plan year)	\$20/visit	
Medical supplies/IV solutions (for home self-administered injectable medications, see "Prescription Drug Coverage")	No charge	
Other		
Hospice		
Routine home care and inpatient respite care	No charge	
24-hour continuous home care and general inpatient care	\$75/day	
Pregnancy and maternity care		
Prenatal and postnatal professional (physician) services (for all necessary inpatient hospital services, see "Hospitalization Services.")	No charge	
Family planning and infertility services		
Family planning counseling	\$20/visit	
Diagnosis and treatment of causes of infertility (excludes in vitro fertilization, injectables for infertility, artificial insemination, and GIFT)	50% of allowed charges	
Tubal ligation ^{7, 8} and elective abortion ^{7, 8}	\$100	
Vasectomy ⁸	\$75	
Rehabilitative therapy services		
Outpatient visits (copayment applies to all places of service, including professional and facility settings)	\$20/visit	
Urgent care outside service area (BlueCard® Program)	\$50/visit	
Diabetes care		
Equipment, devices, and non-testing supplies (for testing supplies, see "Prescription Drug Coverage.")	20% of allowed charges	
Self-management training and education	\$20/visit	
Optional benefits ¹		
Optional dental, vision, chiropractic, chiropractic, and acupuncture or infertility benefits are available. If your employer purchased any of these benefits, a description of the benefit is provided separately.		

County of Santa Barbara and Santa Barbara County Superior Court

Access + HMO Low Benefit Summary (continued)

- 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 *Evidence of Coverage and Disclosure Form* and the Plan Contract for exact terms and conditions of coverage.
- 2 To use this option, members must select a Personal Physician who is affiliated with a medical group or IPA that is an Access+ provider group, which offers the Access+ *Specialist* feature. Members should then select a specialist within that medical group or IPA. Access+ *Specialist* visits for mental health or substance abuse services must be provided by an MHSA network participating provider. Access+ *Specialist* visits for mental health services for non-severe mental illness, or non-serious emotional disturbances of a child, or substance abuse will accrue toward the 20-visit per calendar-year 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 Skilled nursing services are limited to 100 pre-authorized days during a calendar-year except when received through a hospice program provided by a participating hospice agency. This pre-authorized 100-day maximum on skilled nursing services is a combined maximum between SNF in a hospital unit and skilled nursing facilities.
- 5 Mental health and chemical dependency services, other than medical acute detoxification, are accessed through the mental health services administrator (MHSA)—U.S. Behavioral Health Plan, California (USBHPC)—using MHSA participating providers. Services for medical acute detoxification are accessed through Blue Shield using Blue Shield HMO providers. For a listing of severe mental illnesses, including serious emotional disturbances of a child, and other benefit details, please refer to the *Evidence of Coverage* or Plan Contract.
- 6 Optional inpatient substance abuse treatment benefits are available. If your employer purchased these benefits, a description of the benefit is attached hereto as "Additional Substance Abuse Treatment Benefits."
- 7 Copayment waived when procedure is performed in conjunction with delivery or abdominal surgery.
- 8 Physician services copayment in the office or outpatient hospital facility only. If procedure is performed in a hospital facility setting, additional hospital services copayment may apply.
- 9 If the member requests a brand-name drug and a generic drug equivalent is available, the member is responsible for paying the difference between the cost to Blue Shield of California of the brand-name drug and its generic drug equivalent, as well as the applicable generic drug copayment. Home self-administered injectable drugs are covered only when dispensed by select participating pharmacies in the Specialty Pharmacy Network. Drugs from non-participating pharmacies are not covered except in emergency and urgent situations.
- 10 Copayments and charges for these covered services are not included in the calculation of the member's medical calendar-year copayment maximum and continue to be the member's responsibility after the calendar-year copayment maximum is reached. Please refer to the *Evidence of Coverage* and the Plan Contract for exact terms and conditions of coverage. Please note that if you switch to another Blue Shield of California or Blue Shield of California Life & Health Insurance Company plan, the prescription drug deductible credit from the previous plan during the calendar year, if applicable, will not carry forward to the new plan.

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

Note: 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 Part D premiums.

County of Santa Barbara and Santa Barbara County Superior Court
Access+ HMO High Benefit Summary

Blue Shield of California

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 *Evidence of Coverage* and the Group Policy should be consulted for a detailed description of the coverage benefits and limitations.

Effective July 1, 2007

Deductibles¹

Calendar-year deductible	None
Calendar-year copayment maximum¹ (for most covered services)	\$1,500 per individual/\$3,000 per 2-party/\$4,500 per family
Lifetime maximums	None

Covered services

Member copayment

Professional services

Physician Services – outpatient

Physician and authorized specialist office visits <small>Note: A woman may self-refer to an OB/GYN or family practice physician in her Personal Physician's medical group or IPA for OB/GYN services.</small>	\$15/visit
Allergy testing or treatment	\$15/visit
Access+ <i>Specialist</i> (self-referred office visits or consultations only) ^{1,2}	\$30/visit
Laboratory, X-ray, and diagnostic tests	No charge

Preventive care

Scheduled routine physical exams

Routine physical exam, eye/ear screenings, and immunizations according to age schedule <small>Note: A woman may self-refer to an OB/GYN or family practice physician in her Personal Physician's medical group or IPA for OB/GYN services.</small>	\$15/visit
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Outpatient services

Non-emergency

Outpatient surgery performed in a participating ambulatory surgery center ³ (ASC)	No charge
Outpatient surgery in hospital/facility	No charge
Outpatient treatment (except as described under "Rehabilitative therapy services"), and necessary supplies	No charge

Hospitalization services

Inpatient physician services, including pregnancy and maternity care	No charge
Semi-private room and board, medically necessary services and supplies	\$100/admission
Skilled nursing facility (SNF) services ⁴	No charge

Emergency health coverage

Waived if the member is directly admitted to the hospital for inpatient services	\$50/visit
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Ambulance services

\$50

County of Santa Barbara and Santa Barbara County Superior Court
 Access+ HMO High Benefit Summary (continued)

Covered services

Member copayment

Prescription drug coverage ^{9, 10} PENDING REGULATORY REVIEW (includes oral contraceptives, diaphragms, and covered diabetic drugs and testing supplies)	Participating pharmacy (for up to a 30-day supply)	Mail service prescriptions (for up to a 90-day supply)
Calendar-year brand-name drug deductible	\$50 per member per calendar year—applies to covered non-formulary brand-name medications	
Generic drugs	\$10/prescription	\$20/prescription
Formulary brand-name drugs	\$30/prescription	\$60/prescription
Non-formulary brand-name drugs	\$45/prescription	\$90/prescription
Home self-administered injectable medications (may require prior authorization from Blue Shield Pharmacy Services)	20% (up to \$100 copayment maximum per prescription) ¹	Not covered
Durable medical equipment ¹ (plan payment up to \$2,000 maximum per calendar year)	No charge	
Prosthetics/orthotics	\$15/visit	
Mental health services (psychiatric) ⁵		
Inpatient hospital facility services	\$100/admission	
Outpatient visits for severe mental health conditions	\$15/visit	
Outpatient visits for non-severe mental health conditions ¹ (up to 20 visits per calendar year combined with outpatient chemical dependency visits)	\$20/visit	
Chemical dependency services (substance abuse) ^{5, 6}		
Inpatient services for medical acute detoxification	See "Hospitalization Services"	
Outpatient visits ¹ (up to 20 visits per calendar year combined with outpatient non-severe mental health visits)	\$20/visit	
Home health services		
Agency visits (up to 100 visits per calendar year)	\$15/visit	
Medical supplies/IV solutions (for home self-administered injectable medications, see "Prescription Drug Coverage")	No charge	
Other		
Hospice		
Routine home care and inpatient respite care	No charge	
24-hour continuous home care and general inpatient care	No charge	
Pregnancy and maternity care		
Prenatal and postnatal professional (physician) services (for all necessary inpatient hospital services, see "Hospitalization Services.")	No charge	
Family planning and infertility services		
Family planning counseling	\$15/visit	
Diagnosis and treatment of causes of infertility (excludes in vitro fertilization, injectables for infertility, artificial insemination, and GIFT)	50% of allowed charges	
Tubal ligation ^{7, 8} and elective abortion ^{7, 8}	\$100	
Vasectomy ⁸	\$75	
Rehabilitative therapy services		
Outpatient visits (copayment applies to all places of service, including professional and facility settings)	\$15/visit	
Urgent care outside service area (BlueCard Program)	\$50/visit	
Diabetes care		
Equipment, devices, and non-testing supplies (for testing supplies, see "Prescription Drug Coverage.")	No charge	
Self-management training and education	\$15/visit	

County of Santa Barbara and Santa Barbara County Superior Court Access+ HMO High Benefit Summary (continued)

- 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 *Evidence of Coverage and Disclosure Form* and the Plan Contract for exact terms and conditions of coverage.
- 2 To use this option, members must select a personal physician who is affiliated with a medical group or IPA that is an Access+ provider group, which offers the Access+ *Specialist* feature. Members should then select a specialist within that medical group or IPA. Access+ *Specialist* visits for mental health or substance abuse services must be provided by an MHSA network participating provider. Access+ *Specialist* visits for mental health services for non-severe mental illness, or non-serious emotional disturbances of a child, or substance abuse will accrue toward the 20-visit per calendar-year 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 Skilled nursing services are limited to 100 days during a calendar year except when received through a hospice program provided by a participating hospice agency. This 100-day maximum on skilled nursing services is a combined maximum between SNF in a hospital unit and skilled nursing facilities.
- 5 Mental health and chemical dependency services, other than medical acute detoxification, are accessed through the mental health services administrator (MHSA)—U.S. Behavioral Health Plan, California (USBHPC)—using MHSA participating providers. Services for medical acute detoxification are accessed through Blue Shield using Blue Shield HMO providers. For a listing of severe mental illnesses, including serious emotional disturbances of a child, and other benefit details, please refer to the *Evidence of Coverage* or Plan Contract.
- 6 Optional inpatient substance abuse treatment benefits are available. If your employer purchased these benefits, a description of the benefit is attached hereto as "Additional Substance Abuse Treatment Benefits."
- 7 Copayment waived when procedure is performed in conjunction with delivery or abdominal surgery.
- 8 Physician services copayment in the office or outpatient hospital facility only. If procedure is performed in a hospital facility setting, additional hospital services copayment may apply.
- 9 If the member requests a brand-name drug and a generic drug equivalent is available, the member is responsible for paying the difference between the cost to Blue Shield of California of the brand-name drug and its generic drug equivalent, as well as the applicable generic drug copayment. Home self-administered injectable drugs are covered only when dispensed by select participating pharmacies in the Specialty Pharmacy Network. Drugs from non-participating pharmacies are not covered except in emergency and urgent situations.
- 10 Copayments and charges for these covered services are not included in the calculation of the member's medical calendar-year copayment maximum and continue to be the member's responsibility after the calendar-year copayment maximum is reached. Please refer to the *Evidence of Coverage* and the Plan Contract for exact terms and conditions of coverage. Please note that if you switch to another Blue Shield of California or Blue Shield of California Life & Health Insurance Company plan, the prescription drug deductible credit from the previous plan during the calendar year, if applicable, will not carry forward to the new plan.

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

Note: 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 Part D premiums.

County of Santa Barbara and Santa Barbara County Superior Court
Blue Shield PPO Benefit Summary

Blue Shield of California

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 *Evidence of Coverage* and the Group Policy should be consulted for a detailed description of the coverage benefits and limitations.

Effective July 1, 2007

Deductibles¹

All providers combined	Preferred providers ²	Non-preferred providers ²
Calendar-year deductible	\$500 per individual/\$1,500 per family	
Calendar-year copayment maximum¹ (for most covered services)	\$4,000 per individual/ \$8,000 per family	\$6,000 per individual/ \$18,000 per family
Lifetime maximums	\$6,000,000	

Covered services

Member copayment

Professional services

Physician services	Preferred providers ²	Non-preferred providers ²
Physician and specialist office visits	\$30/visit (deductible waived)	40% ¹
Laboratory and X-rays	20%	40%
Allergy testing or treatment	20%	40%
Diagnostic testing	20%	40%

Preventive care

Annual routine physical exam, eye/ear screenings and immunizations	\$30/visit (deductible waived)	Not covered
Laboratory, including mammogram and Pap test screening or other FDA-approved cervical cancer screening tests (one per calendar year)	\$30/visit (deductible waived)	Not covered

Well-baby care

Office visits and consultations Includes: eye/ear screenings, immunizations, vaccinations	\$30/visit (deductible waived)	Not covered
Laboratory	\$30/visit	Not covered

Outpatient 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 a participating ambulatory surgery center ³ (ASC)	20%	40% ¹
Outpatient surgery in hospital/facility	\$250/surgery + 20%	40% ¹
Outpatient treatment and necessary supplies	20%	40% ¹

Hospitalization services

Inpatient services – non-emergency

Inpatient physician services, including pregnancy and maternity care	20%	40% ¹
Semi-private room and board, medically necessary services and supplies	\$250/admission + 20%	40% ^{1,4}

Bariatric surgery

(pre-authorization required; medically necessary surgery for weight loss, only for morbid obesity)⁵

Inpatient services	\$250/admission + 20%	40% ^{1,4}
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Skilled nursing facility (SNF) services⁶

(combined maximum of up to 100 pre-authorized days per calendar year; semi-private accommodations)

Freestanding SNF	20%	20% with prior authorization ⁶
Hospital SNF unit	20%	40% ^{1,4}

Emergency health coverage

Facility services (waived if the member is directly admitted to the hospital for inpatient services)	\$75 ¹ + 20% /visit	\$75 ¹ + 20% /visit
Facility services	\$250/admission + 20%	\$250/admission + 20%
Emergency room physician services	20%	20%

Ambulance services

	20%	20%
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Covered services

Member copayment

Prescription drug coverage^{11, 12} PENDING REGULATORY REVIEW

(includes oral contraceptives, diaphragms, and covered diabetic drugs and testing supplies)

Pharmacy

Non-participating pharmacy

Member pays 25% of allowable amount plus a copayment of:

Calendar-year brand-name drug deductible

\$50 per member per calendar year; applies to covered non-formulary brand-name medications

Retail prescriptions (for up to a 30-day supply)

Generic	\$15/prescription	\$15/prescription
Formulary brand-name	\$25/prescription	\$25/prescription
Non-formulary brand-name	\$40/prescription	\$40/prescription

Mail service prescriptions (for up to a 90-day supply)

Generic	\$30/prescription	Not covered
Formulary brand-name	\$50/prescription	Not covered
Non-formulary brand-name	\$80/prescription	Not covered

Home self-administered injectable medications (may require prior authorization from Blue Shield Pharmacy Services—not covered through mail service benefit)

30% (up to \$150 copayment maximum per prescription)¹

Not covered

Durable medical equipment

Plan payment up to \$2,000 maximum per calendar year	20%	40%
Prosthetics/orthotics	20%	40%

Mental health services (psychiatric)⁷

MHSA

Participating providers²

MHSA

Non-participating providers²

Inpatient hospital facility services	\$250/admission + 20%	40% ^{1,4}
Outpatient visits for severe mental health conditions	\$30/visit (deductible waived)	40% ¹
Outpatient visits for non-severe mental health conditions (up to 20 visits per calendar year combined with outpatient chemical dependency visits) ⁸	20% ¹	40%

Chemical dependency services (substance abuse)^{7,9}

Inpatient services for medical acute detoxification	See "Hospitalization Services"	See "Hospitalization Services"
Outpatient visits (up to 20 visits per calendar year combined with outpatient non-severe mental health visits) ⁸	20% ¹	40% ¹

Home health services⁶ (combined maximum of 100 prior authorized visits per calendar year)

Preferred providers²

Preferred providers²

Home health and home infusion care (see "Prescription Drug Coverage" for home self-administered injectables)	20%	20% with prior authorization
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Other

Hospice⁴

Routine home care and inpatient respite care	No charge	No charge with prior authorization
24-hour continuous home care and general inpatient care	20%	20% with prior authorization

Alternative care⁸

Chiropractic services (up to 12 visits per calendar year)	\$25/visit	Not covered
Acupuncture services	Not covered	Not covered

Rehabilitative therapy services

Outpatient visits	20%	40%
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Pregnancy and maternity care

Prenatal and postnatal professional (physician) services (for all necessary inpatient hospital services, see "Hospitalization Services")	20%	40% ¹
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Family planning

Family planning counseling	\$35/visit (deductible waived)	Not covered
Elective abortion, tubal ligation, vasectomy ¹⁰	20%	Not covered

Covered out-of-state benefits

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.

20% or \$30 copay

40%

Diabetes care

Equipment, devices, and non-testing supplies (for testing supplies, see "Prescription Drug Coverage.")	20%	40%
Self-management training and education (if billed by your provider, you will also be responsible for the office visit copayment)	\$30/visit	40%

County of Santa Barbara and Santa Barbara County Superior Court Blue Shield PPO Benefit Summary (continued)

- 1 Deductible and copayments marked with a (1) do not accrue to calendar-year copayment maximum, except for the percentage copay for the outpatient surgery in hospital/facility benefit which does accrue to the 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 *Evidence of Coverage and Disclosure Form* and 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% of this \$600 per day, plus all charges in excess of \$600.
- 5 Bariatric surgery is covered when pre-authorized by Blue Shield. However, for members residing in Imperial, Kern, Los Angeles, Orange, Riverside, San Bernardino, San Diego, Santa Barbara, and Ventura counties ("designated counties"), bariatric surgery services are covered only when performed at designated contracting bariatric surgery facilities and by designated contracting surgeons; coverage is not available for bariatric services from any other preferred provider, and there is no coverage for bariatric services from non-preferred providers. In addition, if prior authorized by Blue Shield of California, a member in a designated county who is required to travel more than 50 miles to a designated bariatric surgery facility will be eligible for limited reimbursement for specified travel expenses for the member and one companion. Refer to the *Evidence of Coverage* for further benefit details.
- 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, other than medical acute detoxification, are accessed through the mental health services administrator (MHSA)—U.S. Behavioral Health Plan, California (USBHPC—using MHSA participating and non-participating providers. MHSA non-participating providers are not administered by USBHPC. Services for medical acute detoxification are accessed through Blue Shield using Blue Shield's preferred providers or non-preferred providers. For a listing of severe mental illnesses, including serious emotional disturbances of a child, and other benefit details, please refer to the *Evidence of Coverage* or Plan Contract.
- 8 All outpatient non-severe mental health, outpatient substance abuse and chiropractic visits accrue to the calendar-year visit maximum regardless of whether the plan deductible has been met.
- 9 Optional inpatient substance abuse treatment benefits are available. If your employer purchased these benefits, a description of the benefit is attached hereto as "Additional Substance Abuse Treatment Benefits."
- 10 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.
- 11 If the member requests a brand-name drug and a generic drug equivalent is available, the member is responsible for paying the difference between the cost to Blue Shield of California of the brand-name drug and its generic drug equivalent, as well as the applicable generic drug copayment. Home self-administered injectable drugs are covered only when dispensed by select participating pharmacies in the Specialty Pharmacy Network.
- 12 Copayments and charges for these covered services are not included in the calculation of the member's medical calendar-year copayment maximum and continue to be the member's responsibility after the calendar-year copayment maximum is reached. Please refer to the *Evidence of Coverage* and the Plan Contract for exact terms and conditions of coverage. Please note that if you switch to another Blue Shield of California or Blue Shield of California Life & Health Insurance Company plan, the prescription drug deductible credit from the previous plan during the calendar year, if applicable, will not carry forward to the new plan.

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

Note: 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 Part D premiums.

County of Santa Barbara and Santa Barbara County Superior Court High Deductible Health Plan Benefit Summary

Plan underwritten by Blue Shield of California Life & Health Insurance Company

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 *Evidence of Coverage* and the Group Policy should be consulted for a detailed description of the coverage benefits and limitations.

Effective July 1, 2007

Deductibles

(All providers combined)	Preferred providers ¹	Non-preferred providers ¹
Calendar-year deductible (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 deductible must be met before the enrollee or covered dependents can receive benefits for covered services)	\$4,500 per individual/\$9,000 per family	
Lifetime maximums	\$6,000,000	

Covered services

Member copayment

Professional services

Physician services	Preferred providers ¹	Non-preferred providers ¹
Physician and specialist office visits	20%	40% ¹
Allergy testing or treatment	20%	40%
Laboratory, X-rays, and diagnostics	20%	40%

Preventive care (not subject to the plan's calendar-year deductible)

Annual physical exam office visit (one per calendar year, age 3 and older) immunizations and vaccinations	\$20 ²	Not covered
Laboratory, including mammogram and Pap test screening or other FDA-approved cervical cancer screening tests	20%	Not covered

Outpatient 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 a participating ambulatory surgery center ³ (ASC)	20%	40%
Outpatient surgery in hospital/facility	20%	40%
Outpatient treatment and necessary supplies	20%	40%

Hospitalization services

Inpatient services – non-emergency

Inpatient physician services	20%	40%
Semi-private room and board, medically necessary services and supplies	20%	40% ⁴
Bariatric surgery⁵ (pre-authorization required; medically necessary surgery for weight loss, for morbid obesity only)	20%	40% ⁴

Skilled nursing facility (SNF) services⁶

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

Freestanding SNF	20%	20% with prior authorization ⁶
Hospital SNF unit	20%	40% ⁴

Emergency health coverage

Members must meet an additional \$50 copayment per emergency room visit before benefits apply. This copayment is waived if the member is directly admitted to the hospital for inpatient services.

Ambulance services	20%	20%
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County of Santa Barbara and Santa Barbara County Superior Court
High Deductible Health Plan Benefit Summary (continued)

Covered services

Member copayment

	Preferred providers ¹	Non-preferred providers ¹
Prescription drug coverage ^{7,8} (subject to deductible, includes oral contraceptives and diaphragms)		
Retail pharmacy and mail service prescriptions	20%	20%
Durable medical equipment		
Plan payment up to \$2,000 maximum per calendar year	20%	40%
Prosthetics/orthotics	20%	40%
Mental health services (psychiatric) ⁹		
	MHSA Participating providers¹	MHSA Non-participating providers¹
Inpatient hospital facility services	20%	40% ⁴
Outpatient visits for severe mental health conditions	20%	40%
Outpatient visits for non-severe mental health conditions (up to 20 visits per calendar year combined with outpatient chemical dependency visits) ¹⁰	50%	Not covered
Chemical dependency services (substance abuse) ^{9,11}		
Inpatient services for medical acute detoxification	See "Hospitalization Services"	See "Hospitalization Services"
Outpatient visits (up to 20 visits per calendar year combined with outpatient non-severe mental health visits) ¹⁰	50%	Not covered
Home health services ⁶		
	Preferred providers¹	Non-preferred providers¹
Home health and home infusion care, home injectable treatment (up to 100 combined prior authorized visit maximum per calendar year)	20%	20% with prior authorization ⁶
Other		
Hospice		
Routine home care and inpatient respite care	No charge	No charge with prior authorization ⁶
24-hour continuous home care and general inpatient care	20%	20% with prior authorization ⁶
Pregnancy and maternity care		
Prenatal and postnatal professional (physician) services (for all necessary inpatient hospital services, see "Hospitalization Services")	20%	40%
Well-baby care		
Office visits and consultations	\$20 ²	Not covered
Immunizations	20%	Not covered
Laboratory screenings	20%	Not covered
Family planning		
Family planning counseling	20%	Not covered
Elective abortion, tubal ligation, vasectomy ¹²	20%	Not covered
Rehabilitative therapy services		
Outpatient visits	20%	40%
Acupuncture services		
	Not covered	Not covered
Chiropractic services (up to 20 visits per calendar year) ¹⁰		
Chiropractic services provided by a chiropractor	20%	40%
Covered out-of-state benefits 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.		
	20%	40%
Diabetes care		
Equipment, devices, and non-testing supplies	20%	40%
Self-management training and education (if billed by your provider, you will also be responsible for the office visit copayment)	20%	40%

County of Santa Barbara and Santa Barbara County Superior Court High Deductible Health Plan Benefit Summary (continued)

- 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 of California Life & Health Insurance Company's (Blue Shield Life) 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 Life's allowable amount. Charges in excess of the allowable amount do not count toward the calendar-year deductible or out-of-pocket maximum.
- 2 The preventive care and well-baby care office visit are not subject to the plan deductible. Other covered services received during or in connection with the office visit are subject to the plan deductible and the applicable copayment percentage.
- 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 charge for non-emergency hospital services received from a non-preferred hospital is \$600 per day. Members are responsible for 40% 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.
- 5 Bariatric surgery is covered when pre-authorized by Blue Shield. However, for members residing in Imperial, Kern, Los Angeles, Orange, Riverside, San Bernardino, San Diego, Santa Barbara, and Ventura counties ("designated counties"), bariatric surgery services are covered only when performed at designated contracting bariatric surgery facilities and by designated contracting surgeons; coverage is not available for bariatric services from any other preferred provider, and there is no coverage for bariatric services from non-preferred providers. In addition, if prior authorized by Blue Shield Life, a member in a designated county who is required to travel more than 50 miles to a designated bariatric surgery facility will be eligible for limited reimbursement for specified travel expenses for the member and one companion. Refer to the Certificate of Insurance for further benefit details.
- 6 Services may require prior authorization by Blue Shield. When services are prior authorized, members pay 20%, the preferred provider amount.
- 7 Includes coverage for medically necessary prescription drugs. Member presents Blue Shield ID card to participating Pharmacy and pays 100% of contract rate.
- 8 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.
- 9 Mental health and chemical dependency services are accessed through the mental health services administrator (MHSA)—U.S. Behavioral Health Plan, California (USBHPC)—using MHSA participating and non-participating providers. MHSA non-participating providers are not administered by USBHPC. Services for medical acute detoxification are accessed through Blue Shield Life using Blue Shield Life's preferred providers or non-preferred providers. For a listing of severe mental illnesses, including serious emotional disturbances of a child, and other benefit details, please refer to the *Certificate of Insurance* or Group Policy.
- 10 All outpatient non-severe mental health, outpatient substance abuse, and chiropractic visits accrue to the calendar-year visit maximum regardless of whether the plan deductible has been met.
- 11 Optional inpatient substance abuse treatment benefits are available. If your employer purchased these benefits, a description of the benefit is attached hereto as "Additional Substance Abuse Treatment Benefits."
- 12 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.

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

This is an overview of the plan benefits offered by Blue Shield of California Life & Health Insurance Company.

County of Santa Barbara and Santa Barbara County Superior Court
Blue Shield POS Benefit Summary

Blue Shield of California

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 *Evidence of Coverage* and the Group Policy should be consulted for a detailed description of the coverage benefits and limitations.

Effective July 1, 2007

Deductibles¹

	LEVEL I HMO plan providers²	LEVEL II Preferred providers²	LEVEL III Non-preferred providers²
Calendar-year medical deductible	None	None	\$250 per individual/ \$750 per family
Calendar-year copayment maximum¹ (for many covered services) Per individual per 2-party/per family	\$1,500/\$3,000/\$4,500	\$2,000/\$4,000/\$6,000	\$3,000/\$6,000/\$9,000
Lifetime maximums	None		\$2,000,000

Covered services

Member copayment

Professional services

Physician services	LEVEL I HMO plan providers²	LEVEL II Preferred providers²	LEVEL III Non-preferred providers²
Physician and specialist office visits Note: For network benefits provider level, a woman may self-refer to an OB/GYN or family practice physician in her Personal Physician's medical group or IPA for OB/GYN services.	\$15/visit	10%	20%
Allergy testing or treatment	\$15/visit	\$25	20%
Laboratory, x-rays and diagnostic tests	No charge	10%	20%

Preventive care

Routine physical exam, eye/ear screenings, and immunizations according to age schedule Note: For network benefits provider level, a woman may self-refer to an OB/GYN or family practice physician in her Personal Physician's medical group or IPA for OB/GYN services.	No charge	\$25	Not covered
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Outpatient services

Non-emergency

Outpatient surgery performed in an ambulatory surgery center (ASC) ³	No charge	10%	20% ³
Outpatient surgery in hospital/facility	No charge	10%	20% ³
Outpatient treatment (except as described under "Rehabilitative therapy services") and necessary supplies	No charge	\$25/visit	20% ³

Hospitalization services

Inpatient physician services, including pregnancy and maternity care	No charge	10%	20%
Semi-private room and board, medically necessary services and supplies	\$200/admission	\$200/admission	20%
Bariatric surgery (pre-authorization required; medically necessary surgery for weight loss, only for morbid obesity) ⁵	\$200/admission	\$200/admission + 10%	20% ⁴
Skilled nursing facility (SNF) services⁶	No charge	10%	20% ⁴

Emergency health coverage

Waived if the member is directly admitted to the hospital for inpatient services	\$50/visit	\$50/visit	\$50/visit
Ambulance services	\$50	10%	10%

County of Santa Barbara and Santa Barbara County Superior Court
Blue Shield POS Benefit Summary (continued)

Covered services

Member copayment

Prescription drug coverage^{11, 12} (includes oral contraceptives, diaphragms, and covered diabetic drugs and testing supplies)	Participating pharmacy (for up to a 30-day supply)	Mail service prescriptions (for up to a 90-day supply)	
Generic drugs	\$10/prescription	\$20/prescription	
Formulary brand-name drugs	\$20/prescription	\$40/prescription	
Non-formulary brand-name drugs	\$35/prescription	\$70/prescription	
Home self-administered injectable medications (may require prior authorization from Blue Shield Pharmacy Services)	20% (up to \$100 copayment maximum per prescription) ¹	Not covered	
Durable medical equipment	LEVEL I HMO plan providers²	LEVEL II Preferred providers²	LEVEL III Non-preferred providers²
	50% of allowed charges ¹ (\$5,000 maximum per year)	50% (\$2,000 maximum per year)	50% (\$2,000 maximum per year)
Prosthetics/orthotics	\$15/visit	10%	20%
Mental health services (psychiatric)⁷	LEVEL I MHSA participating providers²	LEVEL II N/A except for medical acute detoxification	LEVEL III MHSA non-participating providers²
Inpatient hospital facility services	No charge	N/A	20% ⁴
Outpatient visits for severe mental health conditions	\$15/visit	N/A	20%
Outpatient visits for non-severe mental health conditions (up to 20 visits per calendar year combined with outpatient chemical dependency visits)	\$15/visit	N/A	Not covered
Chemical dependency services (substance abuse)^{7, 10}			
Inpatient services for medical acute detoxification	see "Hospitalization Services"	see "Hospitalization Services"	see "Hospitalization Services"
Outpatient visits (up to 20 visits per calendar year combined with outpatient non-severe mental health visits)	\$15/visit	N/A	Not covered
Home health services	LEVEL I HMO plan providers²	LEVEL II Preferred providers²	LEVEL III Non-preferred providers²
Agency visits (up to 100 visits per calendar year)	\$15/visit	10%	20%
Medical supplies/IV solutions (for home self-administered injectable medications, see "Prescription Drug Coverage")	No charge	10%	20%
Other			
Hospice			
Routine home care and inpatient respite care	No charge	No charge with prior authorization	No charge with prior authorization
24-hour continuous home care and general inpatient care	No charge	No charge with prior authorization	No charge with prior authorization
Pregnancy and maternity care			
Prenatal and postnatal professional (physician) services (for all necessary inpatient hospital services, see "Hospitalization Services")	No charge	10%	20%
Family planning and infertility			
Family planning counseling	No charge	Not covered	Not covered
Diagnosis and treatment of causes of infertility (excludes in vitro fertilization, injectables for infertility, artificial insemination, and GIFT)	50% of allowed charges	Not covered	Not covered
Tubal ligation ^{8, 9} and elective abortion ⁹	\$100	50%	50%
Vasectomy ⁹	\$75	50%	50%
Rehabilitative therapy services			
Outpatient visits (up to 12 visits per calendar-year combined for Levels II & III for physical therapy services)	\$15/visit	\$25/visit	20%

County of Santa Barbara and Santa Barbara County Superior Court
Blue Shield POS Benefit Summary (continued)

Covered services

Member copayment

	LEVEL I HMO plan providers²	LEVEL II Preferred providers²	LEVEL III Non-preferred providers²
Urgent care outside service area (BlueCard Program)	\$50/visit	10%	20%
Diabetes care			
Equipment, devices, and non-testing supplies ¹ (for testing supplies, please see "Prescription Drug Coverage")	50% of allowed charges	50%	50%
Self-management training and education	\$15/visit	10%	20%

Optional benefits¹

Optional dental, vision, chiropractic, chiropractic, and acupuncture or infertility benefits are available. If your employer purchased any of these benefits, a description of the benefit is provided separately.

- 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. Please refer to the *Evidence of Coverage*, the Disclosure Form and 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. Calendar-year deductible applies to the combined services of preferred and non-preferred providers.
- 3 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 20% of this \$350 per day, plus all charges in excess of \$350.
- 4 The maximum allowed charge for non-emergency hospital services received from a non-preferred hospital is \$600 per day. Members are responsible for 20% of this \$600 per day, plus all charges in excess of \$600.
- 5 Bariatric surgery is covered when pre-authorized by Blue Shield. For members residing in Imperial, Kern, Los Angeles, Orange, Riverside, San Bernardino, San Diego, Santa Barbara, and Ventura counties ("designated counties"), bariatric surgery services are covered only when performed at designated contracting bariatric surgery facilities and by designated contracting surgeons; coverage is not available for bariatric services from any other preferred provider and there is no coverage for bariatric services from non-preferred providers. In addition, if prior authorized by Blue Shield of California, a member in a designated county, who is required to travel more than 50 miles to a designated bariatric surgery facility, will be eligible for limited reimbursement for specified travel expenses for the member and one companion. Refer to the *Evidence of Coverage* for further benefit details.
- 6 Skilled Nursing services are limited to 100 pre-authorized days during any calendar-year except when received through a hospice program provided by a participating hospice agency. This 100 pre-authorized day maximum on skilled nursing services is a combined maximum between hospital and skilled nursing facilities.
- 7 Mental health and chemical dependency services, other than services for medical acute detoxification, are accessed through the mental health services administrator (MHSA)—U.S. Behavioral Health Plan, California (USBHPC)—utilizing MHSA participating (Level I) and non-participating (Level III) providers. MHSA non-participating providers are not administered by USBHPC. There are no Level II providers for mental health and chemical dependency services, other than for medical acute detoxification. Services for medical acute detoxification are accessed through Blue Shield using Blue Shield's HMO plan providers (Level I), preferred providers (Level II), or non-preferred providers (Level III). MHSA non-participating providers are not administered by USBHPC. For a listing of severe mental illnesses, including serious emotional disturbances of a child, and other benefit details, please refer to the *Evidence of Coverage* or Plan Contract.
- 8 Copayment waived when procedure is performed in conjunction with delivery or abdominal surgery.
- 9 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.
- 10 Optional inpatient substance abuse treatment benefits are available. If your employer purchased these benefits, a description of the benefit is attached hereto as "Additional Substance Abuse Treatment Benefits."
- 11 If the member requests a brand-name drug and a generic drug equivalent is available, the member is responsible for paying the difference between the cost to Blue Shield of California of the brand-name drug and its generic drug equivalent, as well as the applicable generic drug copayment. Home self-administered injectable drugs are covered only when dispensed by select participating pharmacies in the specialty pharmacy network. Drugs from non-participating pharmacies are not covered except in emergency and urgent situations.
- 12 Co-payments and charges for these covered services are not included in the calculation of the member's medical calendar-year copayment maximum and continue to be the member's responsibility after the calendar-year copayment maximum is reached. Please refer to the *Evidence of Coverage* and the Plan Contract for exact terms and conditions of coverage. Please note that if you switch to another Blue Shield of California or Blue Shield of California Life & Health Insurance Company plan, the prescription drug deductible credit from the previous plan during the calendar year, if applicable, will not carry forward to the new plan.

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

Note: 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 Part D premiums.

 works for you