Santa Barbara IBEW
Custom PPO℠ 250 - 90/70

Benefit Summary (For groups of 300 and above)

(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 *EVIDENCE OF COVERAGE, DISCLOSURE FORM* AND PLAN CONTRACT SHOULD BE CONSULTED FOR A DETAILED DESCRIPTION OF COVERAGE BENEFITS AND LIMITATIONS.

Highlights: A description of the prescription drug coverage is provided separately

Effective June 1, 2008 through December 31, 2008

DEDUCTIBLES[1] (All providers combined)	**Preferred Providers**[2]	**Non-Preferred Providers**[2]
Calendar-year medical deductible	$250 per individual/$500 per family	
Calendar-year Copayment Maximum[1]	$2,000 per individual/ $4,000 per family	$10,000 per individual/ $20,000 per family
LIFETIME MAXIMUM	$6,000,000	

Covered Services	**Member Copayment**	
PROFESSIONAL SERVICES	**Preferred Providers**[2]	**Non-Preferred Providers**[2]
Physician services		
• Physician and specialist office visits	$15/visit (Deductible waived)	30%
• Laboratory and X-rays	$15/visit	30%
• Allergy testing or treatment	10%	30%
• Diagnostic testing	10%	30%
Preventive care		
• Annual routine physical exam, eye/ear screenings and immunizations	$15/visit (Deductible waived)	Not covered
• Laboratory, including mammogram and Pap test screening or other FDA-approved cervical cancer screening tests (One per calendar year)	$15/visit (Deductible waived)	Not covered
Well-baby care		
• Office visits and consultations Includes: eye/ear screenings, immunizations, vaccinations	$15/visit (Deductible waived)	Not covered
• Laboratory	$15/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 30% of this $350 per day, plus all charges in excess of $350.		
• Outpatient surgery performed in a Participating Ambulatory Surgery Center[3] (ASC)	10%	30%
• Outpatient surgery in hospital/facility	10%	30%
• Outpatient treatment and necessary supplies	10%	30%
HOSPITALIZATION SERVICES		
Inpatient services – non-emergency		
• Inpatient physician services (Including pregnancy and maternity care)	10%	30%
• Semi-private room and board, medically necessary services and supplies	10%	30%[4]
• Bariatric surgery (pre-authorization required; medically necessary surgery for weight loss, only for morbid obesity)[5]	10%	30%[4]
Skilled nursing facility (SNF) services[6] (Combined maximum of up to 100 preauthorized days per calendar year; semi-private accommodations)		
• Freestanding SNF	10%	10% with prior authorization[6]
• Hospital SNF unit	10%	30%[4]
EMERGENCY HEALTH COVERAGE		
• ER facility services (Deductible and coinsurance waived if the member is admitted directly from the ER for inpatient services)	$50[1]+10%	
• Inpatient facility services (when the member is admitted directly from the ER)	10%	10%
• Emergency room physician visits	10%	10%
AMBULANCE SERVICES	10%	10%
PRESCRIPTION DRUG COVERAGE	A description of your outpatient prescription drug coverage is provided separately. If you do not have the separate drug sheet that goes with this benefit summary, please contact your benefits administrator or call Customer Services at **(800) 200-3242.**	
PROSTHETICS/ORTHOTICS (Equipment and devices only)	10%	30%

DURABLE MEDICAL EQUIPMENT (Plan payment up to $2000 maximum per calendar year.)	10%	30%
MENTAL HEALTH SERVICES (PSYCHIATRIC)[7]	**MHSA Participating Providers**[2]	**MHSA Non-Participating Providers**[2]
• Inpatient hospital facility services	10%	30%[4]
• Outpatient visits for severe mental health conditions	$15/visit (Deductible waived)	30%
• Outpatient visits for non-severe mental health conditions (Up to 20 visits per calendar year combined with outpatient chemical dependency visits)[8]	$25/visit[1]	Not covered
CHEMICAL DEPENDENCY SERVICES (SUBSTANCE ABUSE)[7] **Please see footnote 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]	$25/visit[1]	Not covered
HOME HEALTH SERVICES[10] (Combined maximum of 100 prior authorized visits per calendar year)	**Preferred Providers**[2]	**Non-Preferred Providers**[2]
• Home health and home infusion care (See "Prescription Drug Coverage" for home self-administered injectables.)	10%	10% with prior authorization
OTHER		
Hospice[10]		
• Routine home care and inpatient respite care	No charge	No charge with prior authorization
• 24 hour continuous home care and general inpatient care	10%	10% charge with prior authorization
Alternative care[6]		
• Chiropractic services (Up to 12 visits per calendar year)	$25/visit	30%
• Acupuncture services (Up to 20 visits per calendar year)	$25/visit	$25/visit
Rehabilitative therapy services		
• Outpatient visits	$25/visit	30%
Pregnancy and maternity care		
• Prenatal and postnatal professional (physician) services (For all necessary inpatient hospital services, see "Hospitalization Services.")	10%	30%
Family planning		
• Family planning counseling	$15/visit (Deductible waived)	Not covered
• Elective abortion, tubal ligation, vasectomy[11]	10%	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.	See Applicable Benefit Line	See Applicable Benefit Line
Diabetes care		
• Equipment, devices and non-testing supplies (For testing supplies, see "Prescription Drug Coverage.")	10%	30%
• Self-management training and education (If billed by your provider, you will also be responsible for the office visit copayment)	$15/visit	30%

Optional Benefits Optional dental, vision, inpatient substance abuse treatment, infertility and hearing aid 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. Deductible does not apply toward the calendar-year maximum. 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.

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-plan provider-hospital is $600 per day. Members are responsible for 30 percent 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, acupuncture 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 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.

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

Santa Barbara IBEW
Shield Spectrum PPO℠ Plans
Outpatient Prescription Drug Coverage

June 1, 2008 through December 31, 2008

THIS DRUG SUMMARY IS INTENDED TO BE USED WITH THE SHIELD SPECTRUM PPO PLANS UNIFORM HEALTH PLAN BENEFITS AND COVERAGE MATRIX. THE *EVIDENCE OF COVERAGE, DISCLOSURE FORM* AND PLAN CONTRACT SHOULD BE CONSULTED FOR A DETAILED DESCRIPTION OF COVERAGE BENEFITS AND LIMITATIONS.

Highlight: 3-Tier/Incentive Formulary
No Calendar-Year Brand-Name Drug Deductible
$10 Generic/$20 Formulary Brand-Name/$35 Non-Formulary Brand-Name Drugs – Retail Pharmacy
$20 Generic/$40 Formulary Brand-Name/$60 Non-Formulary Brand-Name Drugs – Mail Service

Covered Services	Member Copayment	
DEDUCTIBLES (Prescription drug coverage benefits are not subject to the medical plan deductible.)		
Calendar-year brand-name drug deductible	None	
PRESCRIPTION DRUG COVERAGE*# (Includes oral contraceptives, diaphragms, and covered diabetic drugs and testing supplies)	**Participating Pharmacy**	**Non-Participating Pharmacy**
		Member pays 25% of allowable amount plus a copayment of:
• Retail prescriptions (For up to a 30-day supply)	$10/Generic	$10/Generic
	$20/Formulary Brand	$20/Formulary Brand
	$35/Non-Formulary Brand	$35/Non-Formulary Brand
• Mail service prescriptions (For up to a 90-day supply)	$20/Generic	Not Covered
	$40/Formulary Brand	Not Covered
	$60/Non-Formulary Brand	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)*	Not Covered

* 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.

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 Group Health Service Contract for exact terms and conditions of coverage.

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.

Important Prescription Drug Information

You can find details about your drug coverage three ways:

1. Check your *Evidence of Coverage*.
2. Go to **blueshieldca.com** and log onto My Health Plan from the home page.
3. Call Member Services at the number listed on your Blue Shield member ID card.

At Blue Shield of California, we're dedicated to providing you with valuable resources for managing your drug coverage. Go online to the *Pharmacy* section of **blueshieldca.com** and select the *Drug Database and Formulary* to access a variety of useful drug information that can affect your out-of-pocket expenses, such as:

- Look up drugs with generic equivalents;
- Look up drugs that require prior authorization;
- Find specifics about your prescription copayments;
- Find local network pharmacies to fill your prescriptions.

TIPS!
Using our convenient mail order service with Express Scripts can save you time and money. If you take a consistent dose of a covered maintenance drug for a chronic condition, such as diabetes or high blood pressure, you can receive a 90-day supply through Express Scripts with a reduced copayment. Call Express Scripts at (800) 544-6962 or TTY: (800) 972-4348

Benefits are subject to modification for subsequently enacted state or federal legislation