



This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at www.blueshieldca.com or by calling 1-800-642-6155.

Important Questions	Answers	Why this Matters:
<p>What is the overall <u>deductible</u>?</p>	<p>\$250 per individual / \$500 per family. Does not apply to emergency room facility services not resulting in admission, participating physician and specialist office visits, breast pump, preventive health services and outpatient prescription drug benefits.</p>	<p>You must pay all the costs up to the deductible amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the deductible starts over (usually, but not always, January 1st). See the chart starting on page 2 for how much you pay for covered services after you meet the deductible.</p>
<p>Are there other <u>deductibles</u> for specific services?</p>	<p>No.</p>	<p>You don't have to meet deductibles for specific services, but see the chart starting on page 2 for other costs for services this plan covers.</p>
<p>Is there an <u>out-of-pocket limit</u> on my expenses?</p>	<p>Yes. For participating providers: \$1,750 per individual / \$3,500 per family. For non-participating providers: \$2,250 per individual / \$4,500 per family.</p>	<p>The out-of-pocket limit is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.</p>
<p>What is not included in the <u>out-of-pocket limit</u>?</p>	<p>Premiums, balance-billed charges, some cost sharing, and health care this plan doesn't cover.</p>	<p>Even though you pay these expenses, they don't count toward the out-of-pocket limit.</p>
<p>Is there an overall annual limit on what the plan pays?</p>	<p>No.</p>	<p>The chart starting on page 2 describes any limits on what the plan will pay for <i>specific</i> covered services, such as office visits.</p>
<p>Does this plan use a <u>network of providers</u>?</p>	<p>Yes. See www.blueshieldca.com or call 1-800-642-6155 for a list of participating providers.</p>	<p>If you use an in-network doctor or other health care provider, this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network provider for some services. Plans use the term in-network, preferred, or participating for providers in their network. See the chart starting on</p>

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If you aren't clear about any of the underlined terms used in this form, see the Glossary.

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Important Questions	Answers	Why this Matters:
		page 2 for how this plan pays different kinds of providers .
Do I need a referral to see a specialist ?	No.	You can see the specialist you choose without permission from this plan.
Are there services this plan doesn't cover?	Yes.	Some of the services this plan doesn't cover are listed on page 11. See your policy or plan document for additional information about excluded services .



- **Copayments** are fixed dollar amounts (for example, \$15) you pay for covered health care, usually when you receive the service.
- **Coinsurance** is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is \$1,000, your **coinsurance** payment of 20% would be \$200. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges \$1,500 for an overnight stay and the **allowed amount** is \$1,000, you may have to pay the \$500 difference. (This is called **balance billing**.)
- This plan may encourage you to use participating **providers** by charging you lower **deductibles**, **copayments** and **coinsurance** amounts.

Common Medical Event	Services You May Need	Your Cost If You Use a Participating Provider	Your Cost If You Use a Non-Participating Provider	Limitations & Exceptions
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	\$10 copayment / visit	30% coinsurance	For other services received during the office visit, additional member cost-share may apply. Not subject to the calendar-year medical deductible at participating providers.
	Specialist visit	\$10 copayment / visit	30% coinsurance	For other services received during the office visit, additional member cost-share may apply. Not subject to the calendar-year medical deductible at participating providers.

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	Other practitioner office visit	<u>Chiropractic:</u> 20% coinsurance <u>Acupuncture:</u> 20% coinsurance	<u>Chiropractic:</u> 30% coinsurance <u>Acupuncture:</u> 20% coinsurance	Coverage for chiropractic services is limited to 30 visits per calendar year. Coverage for acupuncture services is limited to 20 visits per calendar year. Additional member cost-share applies for covered X-ray services received in conjunction with the office visit.
	Preventive care/screening /immunization	No Charge	Not Covered	Preventive health services are only covered when provided by participating providers. Coverage for services consistent with ACA requirements and California laws. Please refer to your plan contract for details.
If you have a test	Diagnostic test (x-ray, blood work)	<u>Lab & Path at Free Standing Location:</u> 20% coinsurance <u>X-Ray & Imaging at Free Standing Radiology Center:</u> 20% coinsurance <u>Other Diagnostic Examination at Free Standing Location:</u> 20% coinsurance <u>X-Ray, Lab & Other Examination at Outpatient Hospital:</u> 20% coinsurance	<u>Lab & Path at Free Standing Location:</u> 30% coinsurance <u>X-Ray & Imaging at Free Standing Radiology Center:</u> 30% coinsurance <u>Other Diagnostic Examination at Free Standing Location:</u> 30% coinsurance <u>X-Ray, Lab & Other Examination at Outpatient Hospital:</u> 30% coinsurance	Benefits in this section are for diagnostic, non-preventive health services.

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	Imaging (CT/PET scans, MRIs)	<u>Radiological & Nuclear Imaging at Free Standing Radiology Center:</u> 20% coinsurance <u>Radiological & Nuclear Imaging at Outpatient Hospital:</u> 20% coinsurance	<u>Radiological & Nuclear Imaging at Free Standing Radiology Center:</u> 30% coinsurance <u>Radiological & Nuclear Imaging at Outpatient Hospital:</u> 30% coinsurance	Benefits in this section are for diagnostic, non-preventive health services. Pre-authorization is required.
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.blueshieldca.com .	Generic drugs	<u>Retail:</u> \$15 copayment / prescription <u>Mail Order:</u> \$30 copayment / prescription	<u>Retail:</u> 25% of billed amount + \$15 copayment / prescription <u>Mail Order:</u> Not Covered	<u>Retail:</u> Covers up to a 30-day supply; <u>Mail Order:</u> Covers up to a 90-day supply. Select formulary and non-formulary drugs require pre-authorization.
	Brand Formulary Drugs	<u>Retail:</u> \$30 copayment / prescription <u>Mail Order:</u> \$60 copayment / prescription	<u>Retail:</u> 25% of billed amount + \$30 copayment / prescription <u>Mail Order:</u> Not Covered	
	Brand Non-Formulary Drugs	<u>Retail:</u> \$30 copayment / prescription <u>Mail Order:</u> \$60 copayment / prescription	<u>Retail:</u> 25% of billed amount + \$30 copayment / prescription <u>Mail Order:</u> Not Covered	

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	Specialty drugs	\$15 copayment / prescription	Not Covered	Covers up to a 30-day supply. Coverage limited to drugs dispensed by select pharmacies in the Specialty Pharmacy Network unless medically necessary for a covered emergency. Pre-authorization is required.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance	30% coinsurance	-----None-----
	Physician/surgeon fees	20% coinsurance	30% coinsurance	-----None-----
If you need immediate medical attention	Emergency room services	\$50 copayment / visit + 20% coinsurance	\$50 copayment / visit + 20% coinsurance	Copayment waived if admitted; standard inpatient hospital facility benefits apply. Not subject to the calendar-year medical deductible. This is for the hospital/facility charge only. The ER physician charge is separate. Coverage outside of California under BlueCard.
	Emergency medical transportation	20% coinsurance	20% coinsurance	-----None-----
	Urgent care	\$10 copayment / visit at freestanding urgent care center	30% coinsurance at freestanding urgent care center	-----None-----
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance	30% coinsurance	Pre-authorization is required for all services. Failure to obtain pre-authorization for special transplant services may result in non-payment of benefits.
	Physician/surgeon fee	20% coinsurance	30% coinsurance	-----None-----

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<p>If you have mental health, behavioral health, or substance abuse needs</p>	<p>Mental/Behavioral health outpatient services</p>	<p><u>Mental Health Routine Outpatient Services:</u> No Charge / visits 1-3, then \$10 copayment / visit</p> <p><u>Mental Health Non-Routine Outpatient Services:</u> No Charge</p>	<p><u>Mental Health Routine Outpatient Services:</u> 30% coinsurance</p> <p><u>Mental Health Non-Routine Outpatient Services:</u> 30% coinsurance</p>	<p><u>Mental Health Routine Outpatient Services:</u> Services include professional /physician office visits. Not subject to the calendar-year medical deductible at participating providers.</p> <p><u>Mental Health Non-Routine Outpatient Services:</u> Services include behavioral health treatment, electroconvulsive therapy, intensive outpatient programs, partial hospitalization programs, and transcranial magnetic stimulation. Higher copayment and facility charges per episode of care may apply for partial hospitalization programs. Pre-authorization from Mental Health Service Administrator (MHSA) is required for non-routine outpatient mental health services.</p>
	<p>Mental/Behavioral health inpatient services</p>	<p><u>Mental Health Inpatient Hospital Services:</u> 20% coinsurance</p> <p><u>Mental Health Residential Services:</u> 20% coinsurance</p> <p><u>Mental Health Inpatient Physician Services:</u> 20% coinsurance</p>	<p><u>Mental Health Inpatient Hospital Services:</u> 30% coinsurance</p> <p><u>Mental Health Residential Services:</u> 30% coinsurance</p> <p><u>Mental Health Inpatient Physician Services:</u> 30% coinsurance</p>	<p>Pre-authorization from Mental Health Service Administrator (MHSA) is required.</p>

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Common Medical Event	Services You May Need	Your Cost If You Use a Participating Provider	Your Cost If You Use a Non-Participating Provider	Limitations & Exceptions
	Substance use disorder outpatient services	<p><u>Substance Abuse Routine Outpatient Services:</u> No Charge / visits 1-3, then \$10 copayment / visit</p> <p><u>Substance Abuse Non-Routine Outpatient Services:</u> No Charge</p>	<p><u>Substance Abuse Routine Outpatient Services:</u> 30% coinsurance</p> <p><u>Substance Abuse Non-Routine Outpatient Services:</u> 30% coinsurance</p>	<p><u>Substance Abuse Routine Outpatient Services:</u> Services include professional/physician office visits. Not subject to the calendar-year medical deductible at participating providers.</p> <p><u>Substance Abuse Non-Routine Outpatient Services:</u> Services include partial hospitalization program, intensive outpatient program, and office-based opioid treatment. Higher copayment and facility charges per episode of care may apply for partial hospitalization programs. Pre-authorization from Mental Health Service Administrator (MHSA) is required for non-routine outpatient substance abuse services.</p>
	Substance use disorder inpatient services	<p><u>Substance Abuse Inpatient Hospital Services:</u> 20% coinsurance</p> <p><u>Substance Abuse Residential Services:</u> 20% coinsurance</p> <p><u>Substance Abuse Inpatient Physician Services:</u> 20% coinsurance</p>	<p><u>Substance Abuse Inpatient Hospital Services:</u> 30% coinsurance</p> <p><u>Substance Abuse Residential Services:</u> 30% coinsurance</p> <p><u>Substance Abuse Inpatient Physician Services:</u> 30% coinsurance</p>	Pre-authorization from Mental Health Service Administrator (MHSA) is required.

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If you are pregnant	Prenatal and postnatal care	<u>Prenatal:</u> 20% coinsurance <u>Postnatal:</u> 20% coinsurance	30% coinsurance	-----None-----
	Delivery and all inpatient services	20% coinsurance	30% coinsurance	-----None-----

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If you need help recovering or have other special health needs	Home health care	20% coinsurance	Not Covered	Covers up to 100 visits per calendar year. Non-preferred home health care and home infusion are not covered unless pre-authorized. When these services are pre-authorized, you pay the preferred provider copayment. Pre-authorization is required.
	Rehabilitation services	<u>Office visit:</u> 20% coinsurance <u>Outpatient hospital:</u> 20% coinsurance	<u>Office visit:</u> 30% coinsurance <u>Outpatient hospital:</u> 30% coinsurance	Coverage for physical, occupational and respiratory therapy services. Not subject to the calendar-year medical deductible at participating providers in an office setting.
	Habilitation services	<u>Office visit:</u> 20% coinsurance <u>Outpatient hospital:</u> 20% coinsurance	<u>Office visit:</u> 30% coinsurance <u>Outpatient hospital:</u> 30% coinsurance	
	Skilled nursing care	20% coinsurance at freestanding skilled nursing facility	20% coinsurance at freestanding skilled nursing facility	Coverage limited to 100 days per member per benefit period combined with hospital/free-standing skilled nursing facility. Pre-authorization is required.
	Durable medical equipment	20% coinsurance	30% coinsurance	Pre-authorization is required.

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	Hospice service	No Charge	Not Covered	20% applies to 24-hour Continuous Home Care and General Inpatient Care hospice services. All Hospice Program Benefits must be pre-authorized by the Plan. (With the exception of Pre-hospice consultation.) Failure to obtain pre-authorization may result in non-payment of benefits.
If your child needs dental or eye care	Eye exam	20% coinsurance	20% coinsurance	Coverage limited to one self-referred comprehensive eye exam per 12 consecutive months (no age limit) for services provided by Vision Plan Administrator's providers. For visits by non-participating providers the maximum plan reimbursement for Ophthalmologic exam is \$60 or \$50 if the member has an Optometric exam.
	Glasses	Not Covered	Not Covered	-----None-----
	Dental check-up	Not Covered	Not Covered	-----None-----

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Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy or plan document for other excluded services.)

- | | | |
|-----------------------------|--|--|
| • Cosmetic surgery | • Infertility treatment | • Private -duty nursing (unless enrolled in a participating hospice program) |
| • Dental care (Adult/Child) | • Long-term care | • Routine foot care (unless for treatment of diabetes) |
| • Hearing aids | • Non-emergency care when traveling outside the U.S. | • Weight loss programs |

Other Covered Services (This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)

- | | |
|--|--|
| • Acupuncture (coverage limited to 20 visits per calendar year) | • Chiropractic care (Coverage limited to 30 visits per calendar year.) |
| • Bariatric surgery (pre-authorization is required. Failure to obtain pre-authorization may result in non-payment of benefits) | • Routine eye care (Adult/Child) (coverage limited to one self-referred comprehensive eye exam per 12 consecutive months.) |

Your Rights to Continue Coverage:

If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a premium, which may be significantly higher than the **premium** you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply.

For more information on your rights to continue coverage, contact the plan at **1-800-642-6155**. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at **1-866-444-3272** or www.dol.gov/ebsa, or the U.S. Department of Health and Human Services at **1-877-267-2323 X 61565** or www.cciio.cms.gov.

Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to **appeal** or file a **grievance**. For questions about your rights, this notice, or assistance, you can contact: **1-800-642-6155** or the Department of Labor's Employee Benefits Security

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Administration at **1-866-444-EBSA (3272)** or www.dol.gov/ebsa/healthreform. Additionally, a consumer assistance program can help you file your **appeal**. Contact California Department of Managed Health Care Help at **1-888-466-2219** or visit <http://www.healthhelp.ca.gov>.

Does this Coverage Provide Minimum Essential Coverage?

The Affordable Care Act requires most people to have health care coverage that qualifies as "minimum essential coverage." **This plan or policy does provide minimum essential coverage.**

Does this Coverage Meet the Minimum Value Standard?

The Affordable Care Act establishes a minimum value standard of benefits of a health plan. The minimum value standard is 60% (actuarial value). **This health coverage does meet the minimum value standard for the benefits it provides.**

Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al 1-866-346-7198.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-866-346-7198.

Chinese (中文): 如果需要中文的帮助, 请拨打这个号码1-866-346-7198.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijigo holne' 1-866-346-7198.

—————*To see examples of how this plan might cover costs for a sample medical situation, see the next page.*—————

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About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.



This is not a cost estimator.

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

Having a baby (normal delivery)

- Amount owed to providers: \$7,540
- Plan pays \$5,720
- Patient pays \$1,820

Sample care costs:

Hospital charges (mother)	\$2,700
Routine obstetric care	\$2,100
Hospital charges (baby)	\$900
Anesthesia	\$900
Laboratory tests	\$500
Prescriptions	\$200
Radiology	\$200
Vaccines, other preventive	\$40
Total	\$7,540

Patient pays:

Deductibles	\$250
Copays	\$20
Coinsurance	\$1,400
Limits or exclusions	\$150
Total	\$1,820

Managing type 2 diabetes (routine maintenance of a well-controlled condition)

- Amount owed to providers: \$5,400
- Plan pays \$4,140
- Patient pays \$1,260

Sample care costs:

Prescriptions	\$2,900
Medical Equipment and Supplies	\$1,300
Office Visits and Procedures	\$700
Education	\$300
Laboratory tests	\$100
Vaccines, other preventive	\$100
Total	\$5,400

Patient pays:

Deductibles	\$250
Copays	\$700
Coinsurance	\$230
Limits or exclusions	\$80
Total	\$1,260

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Questions and answers about the Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

- Costs don't include **premiums**.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network **providers**. If the patient had received care from out-of-network **providers**, costs would have been higher.
- Plan and patient payments are based on a single person enrolled on the plan or policy.

What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how **deductibles**, **copayments**, and **coinsurance** can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

Does the Coverage Example predict my own care needs?

- ✗ **No.** Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

Does the Coverage Example predict my future expenses?

- ✗ **No.** Coverage Examples are **not** cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your **providers** charge, and the reimbursement your health plan allows.

Can I use Coverage Examples to compare plans?

- ✓ **Yes.** When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

Are there other costs I should consider when comparing plans?

- ✓ **Yes.** An important cost is the **premium** you pay. Generally, the lower your **premium**, the more you'll pay in out-of-pocket costs, such as **copayments**, **deductibles**, and **coinsurance**. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.

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