



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/policies or by calling 1-888-319-5999.

Important Questions	Answers	Why this Matters:
<p>What is the overall deductible?</p>	<p>For participating providers: \$1,250 per individual / \$2,500 per family.</p> <p>For non-participating providers: \$2,500 per individual / \$5,000 per family.</p> <p>The Calendar Year Medical Deductible does not apply to breast pump, chiropractic benefits, initial prenatal and preconception physician office visit, hospice services, mental health and substance use disorder outpatient office visits, outpatient prescription drug benefits, participating physician and specialist office visits, preventive health benefits, pediatric vision benefits at participating providers, and urgent care.</p> <p>Includes medical care cost-shares; in a family, a member only needs to satisfy the individual deductible, not the entire family deductible, prior to receiving plan 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 4 for how much you pay for covered services after you meet the deductible.</p>
<p>Are there other deductibles for specific</p>	<p>Yes. \$250 per individual / \$500 per</p>	<p>You must pay all of the costs for these services up to the specific deductible amount before this plan begins to pay for these services.</p>

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If you aren't clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary at www.dol.gov/ebsa/healthreform or call 1-866-444-3272 to request a copy.

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Important Questions	Answers	Why this Matters:
services?	<p>family calendar year deductible for outpatient prescription drug coverage.</p> <p>Pharmacy deductible is separate from and does not accrue to calendar year medical deductible.</p> <p>Applicable to all covered drugs not in Tier 1.</p> <p>Does not apply to contraceptive drugs and devices.</p> <p>There are no other specific deductibles.</p>	
Is there an <u>out-of-pocket limit</u> on my expenses?	<p>Yes. For participating providers: \$6,500 per individual / \$13,000 per family.</p> <p>For non-participating providers: \$10,000 per individual / \$20,000 per family.</p> <p>Annual Out-of-Pocket Maximums (Copayments for covered services from participating providers accrue to both the participating and non-participating provider calendar year out-of-pocket maximums.); includes calendar year medical deductible and pharmacy deductible, physician office dollar copay & prescription drug copays; for an individual on family coverage plan, a member can receive 100% benefits for covered services once the individual out-of-pocket maximum is met.</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>

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What is not included in the <u>out-of-pocket limit</u> ?	Premiums, balance-billed charges, chiropractic benefits, some copayments, charges in excess of specified benefit maximums, and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u> .
Is there an overall annual limit on what the plan pays?	No.	The chart starting on page 4 describes any limits on what the plan will pay for <i>specific</i> covered services, such as office visits.
Does this plan use a <u>network of providers</u> ?	Yes. This health plan uses the Full PPO Provider Network. See www.blueshieldca.com or call 1-888-319-5999 for a list of participating providers.	If you use an in-network doctor or other health care <u>provider</u> , this plan will pay some or all of the costs of covered services. Be aware, your <u>in-network</u> doctor or hospital may use an out-of-network <u>provider</u> for some services. Plans use the term in-network, <u>preferred</u> , or participating for <u>providers</u> in their <u>network</u> . See the chart starting on page 4 for how this plan pays different kinds of <u>providers</u> .
Do I need a referral to see a <u>specialist</u> ?	No.	You can see the <u>specialist</u> 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 13. See your policy or plan document for additional information about <u>excluded services</u> .



- **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 a non-participating **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if a non-participating 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
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If you visit a health care <u>provider's</u> office or clinic	Primary care visit to treat an injury or illness	\$40 copayment / visit	50% coinsurance	For other services received during the office visit, additional member cost-share may apply. Not subject at calendar-year medical deductible at participating providers.
	Specialist visit	\$50 copayment / visit	50% coinsurance	For other services received during the office visit, additional member cost-share may apply. Not subject at calendar-year medical deductible at participating providers.
	Other practitioner office visit	<u>Chiropractic</u> : 50% coinsurance <u>Acupuncture</u> : \$25 copayment / visit	<u>Chiropractic</u> : 50% coinsurance <u>Acupuncture</u> : 50% coinsurance	Coverage for chiropractic services is limited to 12 visits per calendar year. Chiropractic services not subject to calendar-year medical deductible. 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. Not subject to the calendar-year medical deductible.

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If you have a test	Diagnostic test (x-ray, blood work)	<u>Lab & Path at Free Standing Location:</u> 40% coinsurance <u>X-ray & Imaging at Free Standing Radiology Center:</u> 40% coinsurance <u>Other Diagnostic Examination at Free Standing Location:</u> 40% coinsurance <u>Other Diagnostic Examination at Outpatient Hospital:</u> 40% coinsurance	<u>Lab & Path at Free Standing Location:</u> 50% coinsurance <u>X-ray & Imaging at Free Standing Radiology Center:</u> 50% coinsurance <u>Other Diagnostic Examination at Free Standing Location:</u> 50% coinsurance <u>Other Diagnostic Examination at Outpatient Hospital:</u> 50% coinsurance	Benefits in this section are for diagnostic, non-preventive health services. <u>Other Diagnostic Examination at Outpatient Hospital:</u> The maximum allowed amount for non-participating providers is \$350 per day. Members are responsible for 50% of this \$350 per day, plus all charges in excess of \$350.
	Imaging (CT/PET scans, MRIs)	<u>Radiological & Nuclear Imaging at Free Standing Radiology Center:</u> 40% coinsurance <u>Radiological & Nuclear Imaging at Outpatient Hospital:</u> \$100 copayment / visit + 40% coinsurance	<u>Radiological & Nuclear Imaging at Free Standing Radiology Center:</u> 50% coinsurance <u>Radiological & Nuclear Imaging at Outpatient Hospital:</u> 50% coinsurance	Benefits in this section are for diagnostic, non-preventive health services. Pre-authorization is required. <u>Radiological & Nuclear Imaging at Outpatient Hospital:</u> The maximum allowed amount for non-participating providers is \$350 per day. Members are responsible for 50% of this \$350 per day, plus all charges in excess of \$350.

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<p>If you need drugs to treat your illness or condition</p> <p>More information about prescription drug coverage is available at www.blueshieldca.com/bsca/pharmacy</p>	Tier 1 Drugs	<u>Retail Pharmacies</u> : \$15 copayment / prescription <u>Mail Service Pharmacies</u> : \$30 copayment / prescription	Not Covered	Tier 1 Drugs are not subject to calendar year medical or pharmacy deductible.
	Tier 2 Drugs	<u>Retail Pharmacies</u> : \$50 copayment / prescription <u>Mail Service Pharmacies</u> : \$100 copayment / prescription	Not Covered	<u>Retail Pharmacies</u> : Covers up to a 30-day supply. <u>Mail Service Pharmacies</u> : Covers up to a 90-day supply, except Specialty Drugs.
	Tier 3 Drugs	<u>Retail Pharmacies</u> : \$75 copayment / prescription <u>Mail Service Pharmacies</u> : \$150 copayment / prescription	Not Covered	Select formulary and non-formulary drugs require Prior Authorization.
	Tier 4 Drugs	<u>Network Specialty Pharmacies and Retail Pharmacies</u> : 30% coinsurance up to \$250 / prescription <u>Mail Service Pharmacies</u> : 30% coinsurance up to \$500 / prescription	Not Covered	Blue Shield's Short Cycle Specialty Drug Program allows initial prescriptions for select Tier 4 Drugs to be dispensed for a 15-day trial supply. In such circumstances the Tier 4 cost share will be pro-rated. Prior Authorization is required.
<p>If you have outpatient surgery</p>	Facility fee (e.g., ambulatory surgery center)	40% coinsurance	50% coinsurance	The maximum allowed amount for non-participating providers is \$350 per day. Members are responsible for 50% of this \$350 per day, plus all charges in excess of \$350.
	Physician/surgeon fees	40% coinsurance	50% coinsurance	-----None-----

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If you need immediate medical attention	Emergency room services	<u>ER Facility Fee:</u> \$150 copayment / visit + 40% coinsurance <u>ER Physician Fee:</u> 40% coinsurance	<u>ER Facility Fee:</u> \$150 copayment / visit + 40% coinsurance <u>ER Physician Fee:</u> 40% coinsurance	Copayment waived if admitted; standard inpatient hospital facility benefits apply. This is for the hospital/facility charge only. The ER physician charge is separate. Coverage outside of California under BlueCard.
	Emergency medical transportation	40% coinsurance	40% coinsurance	-----None-----
	Urgent care	\$40 copayment / visit at freestanding urgent care center	Not Covered	-----None-----
If you have a hospital stay	Facility fee (e.g., hospital room)	40% coinsurance	50% coinsurance	The maximum allowed amount for non-participating providers is \$2,000 per day. Members are responsible for 50% of this \$2,000 per day, plus all charges in excess of \$2,000. 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	40% coinsurance	50% 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> \$40 copayment / visit</p> <p><u>Mental Health Non-Routine Outpatient Services:</u> 40% coinsurance</p>	<p><u>Mental Health Routine Outpatient Services:</u> 50% coinsurance</p> <p><u>Mental Health Non-Routine Outpatient Services:</u> 50% coinsurance</p>	<p><u>Mental Health Routine Outpatient Services:</u> Services include professional/physician office visits. Not subject at 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, post-discharge ancillary care services, partial hospitalization programs, and transcranial magnetic stimulation. Higher copayment and facility charges per episode of care may apply for partial hospitalization programs.</p> <p>Pre-authorization from Mental Health Service Administrator (MHSA) is required for non-routine outpatient mental health services.</p>

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	Mental/Behavioral health inpatient services	<u>Mental Health Inpatient Hospital Services:</u> 40% coinsurance <u>Mental Health Residential Services:</u> 40% coinsurance <u>Mental Health Inpatient Physician Services:</u> 40% coinsurance	<u>Mental Health Inpatient Hospital Services:</u> 50% coinsurance <u>Mental Health Residential Services:</u> 50% coinsurance <u>Mental Health Inpatient Physician Services:</u> 50% coinsurance	<p>The maximum allowed charges for non-participating providers is \$2,000 per day. Members are responsible for 50% of this \$2,000 per day, plus all charges in excess of \$2,000.</p> <p>Pre-authorization from Mental Health Service Administrator (MHSA) is required.</p>

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	Substance use disorder outpatient services	<p><u>Substance Use Disorder Routine Outpatient Services:</u> \$40 copayment / visit</p> <p><u>Substance Use Disorder Non-Routine Outpatient Services:</u> 40% coinsurance</p>	<p><u>Substance Use Disorder Routine Outpatient Services:</u> 50% coinsurance</p> <p><u>Substance Use Disorder Non-Routine Outpatient Services:</u> 50% coinsurance</p>	<p><u>Substance Use Disorder Routine Outpatient Services:</u> Services include professional/physician office visits. Not subject at calendar-year medical deductible at participating providers.</p> <p><u>Substance Use Disorder Non-Routine Outpatient Services:</u> Services include partial hospitalization program, intensive outpatient program, post-discharge ancillary care services, 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 use disorder services.</p>

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	Substance use disorder inpatient services	<u>Substance Use Disorder Inpatient Hospital Services:</u> 40% coinsurance <u>Substance Use Disorder Residential Services:</u> 40% coinsurance <u>Substance Use Disorder Inpatient Physician Services:</u> 40% coinsurance	<u>Substance Use Disorder Inpatient Hospital Services:</u> 50% coinsurance <u>Substance Use Disorder Residential Services:</u> 50% coinsurance <u>Substance Use Disorder Inpatient Physician Services:</u> 50% coinsurance	<p>The maximum allowed charges for non-participating providers is \$2,000 per day. Members are responsible for 50% of this \$2,000 per day, plus all charges in excess of \$2,000.</p> <p>Pre-authorization from Mental Health Service Administrator (MHSA) is required.</p>
If you are pregnant	Prenatal and postnatal care	<u>Prenatal:</u> 40% coinsurance <u>Postnatal:</u> 40% coinsurance	<u>Prenatal:</u> 50% coinsurance <u>Postnatal:</u> 50% coinsurance	<u>Prenatal:</u> No Charge for initial visit only at participating providers.
	Delivery and all inpatient services	40% coinsurance	50% coinsurance	<p>The maximum allowed charges for non-participating providers is \$2,000 per day. Members are responsible for 50% of this \$2,000 per day, plus all charges in excess of \$2,000.</p>

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If you need help recovering or have other special health needs	Home health care	40% coinsurance	Not Covered	Coverage limited to 100 visits per member per calendar year. Non-participating home health care and home infusion are not covered unless pre-authorized. When these services are pre-authorized, you pay the participating provider member cost share. Pre-authorization is required.
	Rehabilitation services	<u>Office visit:</u> 40% coinsurance	<u>Office visit:</u> 50% coinsurance	Coverage for physical, occupational and respiratory therapy services. <u>Outpatient hospital:</u> The maximum allowed amount for non-participating providers is \$350 per day. Members are responsible for 50% of this \$350 per day, plus all charges in excess of \$350.
		<u>Outpatient hospital:</u> 40% coinsurance	<u>Outpatient hospital:</u> 50% coinsurance	
	Habilitative services	<u>Office visit:</u> 40% coinsurance	<u>Office visit:</u> 50% coinsurance	Coverage limited to 100 days per member per benefit period combined with Hospital Skilled Nursing Facility Unit. Pre-authorization is required.
		<u>Outpatient hospital:</u> 40% coinsurance	<u>Outpatient hospital:</u> 50% coinsurance	
Skilled nursing care	40% coinsurance at freestanding skilled nursing facility.	40% coinsurance at freestanding skilled nursing facility.	Pre-authorization is required.	
Durable medical equipment	50% coinsurance	Not Covered	Pre-authorization is required.	

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	Hospice service	No Charge	Not Covered	All Hospice Program Benefits must be pre-authorized by the Plan. (With the exception of Pre-hospice consultation.) Services from a non-participating hospice agency are not covered unless pre-authorized. When these services are pre-authorized, you pay the participating provider member cost share.
If your child needs dental or eye care	Eye exam	No Charge	Coverage up to \$30 Maximum Allowance	Coverage limited to one comprehensive eye exam per calendar year. Services provided by Blue Shield's Vision Plan Administrator (VPA). Not subject to calendar-year medical deductible at participating providers.
	Glasses	Single vision: No Charge Lined bifocal: No Charge Lined trifocal: No Charge Lenticular: No Charge	Coverage up to a maximum allowance of: Single vision: \$25 Lined bifocal: \$35 Lined trifocal: \$45 Lenticular: \$45	Coverage limited to one pair of eyeglasses (frames and lenses) or one pair of contact lenses per calendar year. Services provided by Blue Shield's Vision Plan Administrator (VPA). Not subject to calendar-year medical deductible at participating providers.

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	Dental check-up	No Charge	20% coinsurance	Pediatric dental benefits are available for members through the end of the month in which the member turns 19. Coverage for dental check-up is limited to 2 visits in a twelve month period. Please refer to your plan contract for details

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

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	• Chiropractic care (coverage limited to 12 visits per calendar year)	• Routine eye care (Child) (one comprehensive eye exam per calendar year)
• Bariatric surgery (pre-authorization is required. Failure to obtain pre-authorization	• Dental care (Child) (Two dental check-ups in a twelve month period)	

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may result in non-payment of benefits)

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 **1-888-319-5999**. 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: **1-888-319-5999** or the Department of Labor's Employee Benefits Security 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.**

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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 \$3,720
- Patient pays \$3,820

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	\$1,250
Copays	\$20
Coinsurance	\$2,400
Limits or exclusions	\$150
Total	\$3,820

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

- Amount owed to providers: \$5,400
- Plan pays \$2,900
- Patient pays \$2,500

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	\$1,250
Copays	\$760
Coinsurance	\$410
Limits or exclusions	\$80
Total	\$2,500

Questions: Call 1-888-319-5999 or visit us at www.blueshieldca.com.

If you aren't clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary at www.dol.gov/ebsa/healthreform or call 1-866-444-3272 to request a copy

Blue Shield of California is an independent member of the Blue Shield Association.

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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