



The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately. This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, visit [blueshieldca.com/policies](https://blueshieldca.com/policies) or call 1-855-256-9404. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms see the Glossary. You can view the Glossary at [healthcare.gov/sbc-glossary](https://healthcare.gov/sbc-glossary) or call 1-866-444-3272 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall <u>deductible</u> ?	\$750 per individual / \$1,500 per family for <u>participating providers</u> , \$1,500 per individual / \$3,000 per family for <u>non-participating providers</u> .	Generally, you must pay all of the costs from <u>providers</u> up to the <u>deductible</u> amount before this <u>plan</u> begins to pay. If you have other family members on the <u>plan</u> , each family member must meet their own individual <u>deductible</u> until the total amount of <u>deductible</u> expenses paid by all family members meets the overall family <u>deductible</u> .
Are there services covered before you meet your <u>deductible</u> ?	Yes. <u>Preventive care</u> and other services listed in your complete terms of coverage.	This <u>plan</u> covers some items and services even if you haven't yet met the <u>deductible</u> amount. But a <u>copayment</u> or <u>coinsurance</u> may apply. For example, this <u>plan</u> covers certain <u>preventive services</u> without <u>cost-sharing</u> and before you meet your <u>deductible</u> . See a list of covered <u>preventive services</u> at <a href="https://healthcare.gov/coverage/preventive-care-benefits/">healthcare.gov/coverage/preventive-care-benefits/</a> .
Are there other <u>deductibles</u> for specific services?	No.	You don't have to meet <u>deductibles</u> for specific services.
What is the <u>out-of-pocket</u> limit for this plan?	\$4,750 per individual / \$9,500 per family for <u>participating providers</u> , \$9,500 per individual / \$19,000 per family for <u>non-participating providers</u> .	If you have other family members in this <u>plan</u> , the overall family <u>out-of-pocket limit</u> must be met. 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.
What is not included in the <u>out-of-pocket limit</u> ?	<u>Copayments</u> for certain services, <u>premiums</u> , <u>balance-billing</u> charges, and health care this <u>plan</u> doesn't cover.	Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u> .
Will you pay less if you use a <u>network provider</u> ?	Yes. See <a href="https://blueshieldca.com/fap">blueshieldca.com/fap</a> or call 1-855-256-9404 for a list of participating providers.	This <u>plan</u> uses a <u>provider network</u> . You will pay less if you use a <u>provider</u> in the <u>plan's network</u> . You will pay the most if you use an <u>out-of-network provider</u> , and you might receive a bill from a provider for the difference between the <u>provider's charge</u> and what your <u>plan</u> pays ( <u>balance billing</u> ). Be aware, your <u>network provider</u> might use an <u>out-of-network provider</u> for some services (such as lab work). Check with your <u>provider</u> before you get services.
Do you need a <u>referral</u> to see a <u>specialist</u> ?	No.	You can see the <u>specialist</u> you choose without a <u>referral</u> .

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All copayment and coinsurance costs shown in this chart are after your deductible has been met, if a deductible applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Participating Provider (You will pay the least)	Non-Participating Provider (You will pay the most)	
If you visit a health care <u>provide r's</u> office or clinic	Primary care visit to treat an injury or illness	\$25/visit	40% <u>coinsurance</u>	-----None-----  You may have to pay for services that aren't preventive. Ask your <u>provider</u> if the services needed are <u>preventive</u> . Then check what your plan will pay for.
	<u>Specialist</u> visit	\$25/visit	40% <u>coinsurance</u>	
	Preventive care/ screening/ immunization	No charge	Not covered	
If you have a test	<u>Diagnostic test</u> (x-ray, blood work)	\$25/visit	40% <u>coinsurance</u> up to \$350/day plus 100% of additional charges	The services listed are at a free standing location.
	Imaging (CT/PET scans, MRIs)	20% <u>coinsurance</u>	40% <u>coinsurance</u> up to \$350/day plus 100% of additional charges	Preauthorization is required. Failure to obtain preauthorization may result in reduction or non-payment of benefits.
If you need drugs to treat your illness or condition More information about <u>prescription drug coverage</u> is available at <a href="http://blueshieldca.com/formulary">blueshieldca.com/formulary</a>	Tier 1	<i>Retail:</i> \$10/prescription <i>Mail Service:</i> \$20/prescription	<i>Retail:</i> 25% <u>coinsurance</u> of the billed amount + \$10/prescription <i>Mail Service:</i> Not covered	<u>Preauthorization</u> is required for select formulary and non-formulary drugs. Failure to obtain <u>preauthorization</u> may result in reduction or non-payment of benefits. <i>Retail:</i> Covers up to a 30-day supply; <i>Mail Service:</i> Covers up to a 90-day supply.
	Tier 2	<i>Retail:</i> \$30/prescription <i>Mail Service:</i> \$60/prescription	<i>Retail:</i> 25% <u>coinsurance</u> of the billed amount + \$30/prescription <i>Mail Service:</i> Not covered	
	Tier 3	<i>Retail:</i> \$50/prescription <i>Mail Service:</i> \$100/prescription	<i>Retail:</i> 25% <u>coinsurance</u> of the billed amount + \$50/prescription <i>Mail Service:</i> Not covered	
	Tier 4 (excluding Specialty drugs)	<i>Retail:</i> 30% <u>coinsurance</u> up to \$200 maximum/ prescription <i>Mail Service:</i> 30% <u>coinsurance</u> up to \$400 maximum/prescription	<i>Retail:</i> 25% of purchase price +30% <u>coinsurance</u> up to \$200 maximum/prescription <i>Mail Service:</i> Not covered	Preauthorization is required for select drugs. Failure to obtain <u>preauthorization</u> may result in reduction or non-payment of benefits.

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Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Participating Provider (You will pay the least)	Non-Participating Provider (You will pay the most)	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% <u>coinsurance</u>	40% <u>coinsurance</u> up to \$350/day plus 100% of additional charges	-----None-----
	Physician/surgeon fees	20% <u>coinsurance</u>	40% <u>coinsurance</u>	
If you need immediate medical attention	<u>Emergency room care</u>	<i>Facility Fee:</i> \$100/visit + 20% <u>coinsurance</u> <i>Physician Fee:</i> 20% <u>coinsurance</u>	<i>Facility Fee:</i> \$100/visit + 20% <u>coinsurance</u> <i>Physician Fee:</i> 20% <u>coinsurance</u>	Calendar year medical <u>deductible</u> does not apply.
	Emergency medical transportation	20% <u>coinsurance</u>	20% <u>coinsurance</u>	-----None-----
	<u>Urgent care</u>	\$25/visit	40% <u>coinsurance</u>	
If you have a hospital stay	Facility fee (e.g., hospital room)	\$100/admission + 20% <u>coinsurance</u>	40% <u>coinsurance</u> up to \$600 per day plus 100% of additional charges	Preauthorization is required. Failure to obtain preauthorization may result in reduction or non-payment of benefits.
	Physician/surgeon fees	20% <u>coinsurance</u>	40% <u>coinsurance</u>	-----None-----
If you need mental health, behavioral health, or substance abuse services	Outpatient services	<i>Office Visit:</i> \$25/visit <i>Outpatient Services:</i> 20% <u>coinsurance</u> <i>Partial Hospitalization:</i> 20% <u>coinsurance</u> <i>Psychological Testing:</i> 20% <u>coinsurance</u>	40% <u>coinsurance</u> up to \$350/day plus 100% of additional charges	Calendar year medical <u>deductible</u> does not apply. Preauthorization is required except for office visits. Failure to obtain <u>preauthorization</u> may result in reduction or non-payment of benefits.
	Inpatient services	<i>Physician Inpatient Services:</i> No charge <i>Hospital Services:</i> \$100/admission + 20% <u>coinsurance</u> <i>Residential Care:</i> \$100/admission + 20% <u>coinsurance</u>	40% <u>coinsurance</u> up to \$600/day plus 100% of additional charges	Preauthorization is required. Failure to obtain preauthorization may result in reduction or non-payment of benefits.

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Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Participating Provider (You will pay the least)	Non-Participating Provider (You will pay the most)	
If you are pregnant	Office visits	20% <u>coinsurance</u>	40% <u>coinsurance</u>	-----None-----
	Childbirth/delivery professional services	20% <u>coinsurance</u>	40% <u>coinsurance</u>	
	Childbirth/delivery facility services	\$100/admission + 20% <u>coinsurance</u>	40% <u>coinsurance</u> up to \$600/day plus 100% of additional charges	
If you need help recovering or have other special health needs	<u>Home health care</u>	20% <u>coinsurance</u>	Not covered	Coverage is limited to 100 visits per member per calendar year. <u>Preauthorization</u> is required. Failure to obtain <u>preauthorization</u> may result in reduction or non-payment of benefits.
	Rehabilitation services	\$25/visit	40% <u>coinsurance</u> up to \$350/day plus 100% of additional charges	-----None-----
	<u>Habilitation services</u>	\$25/visit	40% <u>coinsurance</u> up to \$350/day plus 100% of additional charges	-----None-----
	Skilled nursing care	20% <u>coinsurance</u>	<i>Freestanding SNF:</i> 20% <u>coinsurance</u> <i>Hospital-based SNF:</i> 40% <u>coinsurance</u> up to \$600/day plus 100% of additional charges	Coverage limited to 100 days per member per benefit period. <u>Preauthorization</u> is required. Failure to obtain <u>preauthorization</u> may result in reduction or non-payment of benefits.
	<u>Durable medical equipment</u>	20% <u>coinsurance</u>	40% <u>coinsurance</u>	<u>Preauthorization</u> is required. Failure to obtain <u>preauthorization</u> may result in reduction or non-payment of benefits.
	Hospice services	No charge	Not covered	

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Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Participating Provider (You will pay the least)	Non-Participating Provider (You will pay the most)	
If your child needs dental or eye care	Children's eye exam	VSP: \$5 copay/exam. Deductible does not apply.	VSP: \$5 <u>copayment</u> /exam, up to \$45, plus any balance billing charges. Deductible does not apply.	If elected, vision coverage is available under separate vision plan through VSP. Some types of lenses may be eligible for a higher allowance. Retirees are not eligible for vision coverage.
	Children's glasses	VSP: No charge, up to a \$150 allowance for frames (\$170 allowance for featured brand frames), then 100% <u>coinsurance</u> . Deductible does not apply.	VSP: No charge, up to \$70 for frames and a \$30 for lenses, then 100% <u>coinsurance</u> plus any balance billing charges. Deductible does not apply.	
	Children's dental check-up	Premier Access: No charge. Deductible does not apply.	Premier Access: Coverage may be available depending on the plan you elect.	If elected, additional coverage is available under separate dental plan. Retirees are not eligible for dental coverage.

**Excluded Services & Other Covered Services:**

<b>Services Your <u>Plan</u> Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other <u>excluded services</u>.)</b>			
<ul style="list-style-type: none"> <li>• Cosmetic surgery</li> <li>• Infertility treatment</li> </ul>	<ul style="list-style-type: none"> <li>• Long-term care</li> <li>• Non-emergency care when traveling outside the U.S.</li> </ul>	<ul style="list-style-type: none"> <li>• Private-duty nursing</li> <li>• Routine foot care</li> </ul>	<ul style="list-style-type: none"> <li>• Weight loss programs</li> </ul>

<b>Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your <u>plan</u> document.)</b>			
<ul style="list-style-type: none"> <li>• Acupuncture</li> <li>• Bariatric surgery</li> </ul>	<ul style="list-style-type: none"> <li>• Chiropractic care</li> <li>• Dental Care (Adult and Child) under separate plan (Actives only).</li> </ul>	<ul style="list-style-type: none"> <li>• Hearing aids</li> <li>• Routine eye care (Adult and Child) under separate plan (Actives only).</li> </ul>	

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**Your Rights to Continue Coverage:** There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, at 1-877-267-2323 x61565 or [cciio.cms.gov](http://cciio.cms.gov). Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit [HealthCare.gov](http://HealthCare.gov) or call 1-800-318-2596.

**Your Grievance and Appeals Rights:** There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact: 1-855-256-9404 or the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or [dol.gov/ebsa/healthreform](http://dol.gov/ebsa/healthreform).

**Does this plan provide Minimum Essential Coverage? Yes**

If you don't have Minimum Essential Coverage for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

**Does this plan meet the Minimum Value Standards? Yes**

If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

## Language Access Services:

English: For assistance in English at no cost, call 1-866-346-7198.

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

Tagalog (Tagalog): Kung kailanganninyo ang libheng tulong sa Tagalog tumawag sa 1-866-346-7198.

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

Navajo (Dine): Diné k'ehjí doo bąąh ílínígó shíka' at'owool nínízingo, kwiji' hodíílnih 1-866-346-7198.

Vietnamese (Tiếng Việt): Để được hỗ trợ miễn phí tiếng Việt, vui lòng gọi đến số 1-866-346-7198.

Korean (한국어): 한국어 도움이 필요하시면, 1-866-346-7198 무료전화 로전화하십시오.

Armenian (Հայերեն): Հայերենը եզրվալով ճարտարաբանության ստանդարտի սահմանը հասնող հարցերով 1-866-346-7198.

Russian (Русский): если нужна бесплатная помощь на русском языке, то позвоните 1-866-346-7198.

Japanese (日本語): 日本語支援が必要な場合、1-866-346-7198 に電話をかけてください。無料で提供します。

Persian (فارسی): برای دریافت کمک رایگان زبان فارسی، لطفاً با شماره تلفن 1-866-346-7198 تماس بگیرید.

Punjabi (ਪੰਜਾਬੀ): ਪੰਜਾਬੀ ਵੱਲੋਂ ਮੁਫਤ ਕਾਲ ਕਰੋ: 1-866-346-7198

Khmer (ភាសាខ្មែរ): សូមជំនួយជាភាសាខ្មែរសេរីដោយឥតគិតថ្លៃ សូមទាក់ទងមកលេខ 1-866-346-7198.

Arabic (العربية): للحصول على المساعدة في اللغة العربية مجاناً، تفضل باتصال على هذا الرقم: 1-866-346-7198.

Hmong (Hmoob): Xav tau kev pab dawb lub Hmoob, thov hu rau 1-866-346-7198.

Hindi (हिन्दी): हिन्दी में बिना खर्च के सहायता के लिए, 1-866-346-7198 पर कॉल करें।

Thai (ไทย): สำหรับความช่วยเหลือเป็นภาษาไทยโดยไม่มีค่าใช้จ่ายโปรดโทร 1-866-346-7198.

-----*To see examples of how this [plan](#) might cover costs for a sample medical situation, see the next section.*-----

## About these Coverage Examples:



**This is not a cost estimator.** Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

### Peg Is Having A Baby

(9 months of participating pre-natal care and a hospital delivery)

■ The <u>plan's</u> overall <u>deductible</u>	\$750
■ <u>Specialist copayment</u>	\$25
■ Hospital (facility) <u>copay+coins</u>	\$100+20%
■ Other <u>copayment</u>	\$25

This EXAMPLE event includes services like:  
 Specialist office visits (*prenatal care*)  
 Childbirth/Delivery Professional Services  
 Childbirth/Delivery Facility Services  
 Diagnostic tests (*ultrasounds and blood work*)  
 Specialist visit (*anesthesia*)

<b>Total Example Cost</b>	<b>\$12,800</b>
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In this example, Peg would pay:

<i>Cost Sharing</i>	
Deductibles	\$750
Copayments	\$615
Coinsurance	\$2,304
<i>What isn't covered</i>	
Limits or exclusions	\$60
<b>The total Peg would pay is</b>	<b>\$3,729</b>

### Managing Joe's Type 2 Diabetes

(a year of routine participating care of a well-controlled condition)

■ The <u>plan's</u> overall <u>deductible</u>	\$750
■ <u>Specialist copayment</u>	\$25
■ Hospital (facility) <u>copay+coins</u>	\$100+20%
■ Other <u>copayment</u>	\$25

This EXAMPLE event includes services like:  
 Primary care physician office visits (*including disease education*)  
 Diagnostic tests (*blood work*)  
 Prescription drugs  
 Durable medical equipment (*glucose meter*)

<b>Total Example Cost</b>	<b>\$7,400</b>
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In this example, Joe would pay:

<i>Cost Sharing</i>	
Deductibles	\$750
Copayments	\$1,285
Coinsurance	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$1,783
<b>The total Joe would pay is</b>	<b>\$3,818</b>

### Mia's Simple Fracture

(participating emergency room visit and follow up care)

■ The <u>plan's</u> overall <u>deductible</u>	\$750
■ <u>Specialist copayment</u>	\$25
■ Hospital (facility) <u>copay+coins</u>	\$100+20%
■ Other <u>copayment</u>	\$25

This EXAMPLE event includes services like:  
 Emergency room care (*including medical supplies*)  
 Diagnostic test (*x-ray*)  
 Durable medical equipment (*crutches*)  
 Rehabilitation services (*physical therapy*)

<b>Total Example Cost</b>	<b>\$2,500</b>
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In this example, Mia would pay:

<i>Cost Sharing</i>	
Deductibles	\$750
Copayments	\$175
Coinsurance	\$276
<i>What isn't covered</i>	
Limits or exclusions	\$37
<b>The total Mia would pay is</b>	<b>\$1,238</b>

The plan would be responsible for the other costs of these EXAMPLE covered services.

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