



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 1-888-319-5999.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	\$0.	See the chart starting on page 2 for your costs for services this plan covers.
Are there other deductibles for specific services?	No.	You don't have to meet <u>deductibles</u> for specific services, but see the chart starting on page 2 for other costs for services this plan covers.
Is there an <u>out-of-pocket limit</u> on my expenses?	Yes. For plan providers: \$2,500 per individual / \$5,000 per family.	The <u>out-of-pocket limit</u> 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> ?	Premiums, chiropractic benefits, cost sharing for certain services listed in formal contract of coverage, 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 2 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. See www.blueshieldca.com or call 1-888-319-5999 for a list of plan 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 in-network 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 2 for how this plan pays different kinds of <u>providers</u> .
Do I need a referral to see a <u>specialist</u> ?	Yes. Members need written approval to see a specialist except for OB/GYN or pediatrician serving as Primary Care Physician. <input type="checkbox"/> Members may self refer using the Access+ Self Referral feature or for OB/GYN	The plan will pay some or all of the costs to see a <u>specialist</u> for covered services but only if you have the plan's permission before you see the <u>specialist</u> .

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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:
	services. Please see the formal contract of coverage for details.	
Are there services this plan doesn't cover?	Yes.	Some of the services this plan doesn't cover are listed on page 10. 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 a non-participating **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 Plan Provider	Your Cost If You Use a Non-Plan Provider	Limitations & Exceptions
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	\$25 copayment / visit	Not Covered	For other services received during the office visit, additional member cost-share may apply.
	Specialist visit	\$25 copayment / visit	Not Covered	For other services received during the office visit, additional member cost-share may apply. \$50 copayment per visit for Access+ Specialist Self Referral.
	Other practitioner office visit	<u>Acupuncture</u> : \$15 copayment / visit <u>Chiropractic</u> : \$15 copayment / visit	Not Covered	Coverage for chiropractic services is limited to 15 visits per calendar year. Services provided by American Specialty Health (ASH) Network. □ Additional member cost-share applies for covered X-ray services received in conjunction with the office visit.

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	Preventive care/screening /immunization	No Charge	Not Covered	Preventive health services are only covered when provided by Plan 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> No Charge <u>X-ray & Imaging at Free Standing Radiology Center:</u> <u>Center:</u> No Charge <u>Other Diagnostic Examination at Free Standing Location:</u> No Charge <u>X-Ray, Lab & Other Examination at Outpatient Hospital:</u> No Charge	Not Covered	Benefits in this section are for diagnostic, non-preventive health services. Pre-authorization from primary care physician and medical plan is required. Failure to obtain pre-authorization may result in non-payment of benefits.
	Imaging (CT/PET scans, MRIs)	<u>Radiological & Nuclear Imaging at Outpatient Hospital:</u> \$250 Copayment / visit	Not Covered	Benefits in this section are for diagnostic, non-preventive health services. Pre-authorization from primary care physician and medical plan is required. Failure to obtain pre-authorization may result in non-payment of benefits.

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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</p>	Generic drugs	<u>Retail</u> : \$5 copayment / prescription <u>Mail Order</u> : \$10 copayment / prescription	Not Covered	<u>Retail</u> : Covers up to a 30-day supply;
	Brand Formulary Drugs	<u>Retail</u> : \$15 copayment / prescription) <u>Mail Order</u> : \$30 copayment / prescription	Not Covered	<u>Mail Order</u> : Covers up to a 90-day supply
	Brand Non-Formulary Drugs	<u>Retail</u> : \$25 copayment / prescription <u>Mail Order</u> : \$50 copayment / prescription	Not Covered	Select formulary and non-formulary drugs require prior authorization.
	Specialty drugs	20% / prescription	Not Covered	Covers up to a 30-day supply. Blue Shield's Short Cycle Specialty Drug Program allows initial prescriptions for select Specialty Drugs to be dispensed for a 15-day trial supply. In such circumstances the specialty drug cost share will be pro-rated. Pre-authorization is required.
<p>If you have outpatient surgery</p>	Facility fee (e.g., ambulatory surgery center)	\$100 copayment / surgery	Not Covered	-----None-----
	Physician/surgeon fees	No Charge	Not Covered	-----None-----

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If you need immediate medical attention	Emergency room services	\$200 copayment / visit	\$200 copayment / visit	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	\$100 copayment / transport	\$100 copayment / transport	-----None-----
	Urgent care	<u>Within Plan service area:</u> \$25 copayment / visit <u>Outside Plan service area:</u> \$25 copayment / visit	<u>Within Plan service area:</u> Not Covered <u>Outside Plan service area:</u> \$25 copayment / visit	Pre-authorization from primary care physician and medical plan is required. Failure to obtain pre-authorization may result in non-payment of benefits.
If you have a hospital stay	Facility fee (e.g., hospital room)	\$250 copayment / day for up to 3 days / admission	Not Covered	Pre-authorization from primary care physician and medical plan is required. Failure to obtain pre-authorization may result in non-payment of benefits.
	Physician/surgeon fee	No Charge	Not Covered	-----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> \$25 copayment / visit</p> <p><u>Mental Health Non-Routine Outpatient Services:</u> \$25 copayment / visit</p>	<p>Not Covered</p>	<p><u>Mental Health Routine Outpatient Services:</u> Services include professional/physician office visits.</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.</p> <p>Pre-authorization from Mental Health Service Administrator (MHSA) is required for non-routine outpatient mental health services. Failure to obtain pre-authorization may result in non-payment of benefits.</p>

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	Mental/Behavioral health inpatient services	<u>Mental Health Inpatient Hospital Services:</u> \$250 copayment / day for up to 3 days / admission <u>Mental Health Residential Services:</u> \$250 copayment / day for up to 3 days / admission <u>Mental Health Inpatient Physician Services:</u> No Charge	Not Covered	Pre-authorization from Mental Health Service Administrator (MHSA) is required. Failure to obtain pre-authorization may result in non-payment of benefits.
	Substance use disorder outpatient services	<u>Substance Abuse Routine Outpatient Services:</u> \$25 copayment/visit <u>Substance Abuse Non-Routine Outpatient Services:</u> \$25 copayment/visit	Not Covered	<u>Substance Abuse Routine Outpatient Services:</u> Services include professional/physician office visits. <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. Failure to obtain pre-authorization may result in non-payment of benefits.

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	Substance use disorder inpatient services	<u>Substance Abuse Inpatient Hospital Services:</u> \$250 copayment / day for up to 3 days / admission <u>Substance Abuse Residential Services:</u> \$250 copayment / day for up to 3 days / admission <u>Substance Abuse Inpatient Physician Services:</u> No Charge	Not Covered	Pre-authorization from Mental Health Service Administrator (MHSA) is required. Failure to obtain pre-authorization may result in non-payment of benefits.
If you are pregnant	Prenatal and postnatal care	<u>Prenatal:</u> No Charge <u>Postnatal:</u> \$25 copayment/visit	Not Covered	-----None-----
	Delivery and all inpatient services	\$250 copayment / day for up to 3 days / admission	Not Covered	-----None-----

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If you need help recovering or have other special health needs	Home health care	\$25 copayment / visit	Not Covered	Coverage limited to 100 visits per member per calendar year. Pre-authorization from primary care physician and medical plan is required. Failure to obtain pre-authorization may result in non-payment of benefits.
	Rehabilitation services	<u>Office Visit:</u> \$25 copayment / visit <u>Outpatient Hospital:</u> \$25 copayment / visit	Not Covered	Coverage for physical, occupational and respiratory therapy services.
	Habilitation services	<u>Office Visit:</u> \$25 copayment / visit <u>Outpatient Hospital:</u> \$25 copayment / visit	Not Covered	
	Skilled nursing care	\$100 copayment / day	Not Covered	Coverage limited to 100 days per member per benefit period combined with hospital/free-standing skilled nursing facility. Pre-authorization from primary care physician and medical plan is required. Failure to obtain pre-authorization may result in non-payment of benefits.
	Durable medical equipment	50% coinsurance	Not Covered	Pre-authorization from primary care physician and medical plan is required. Failure to obtain pre-authorization may result in non-payment of benefits.
	Hospice service	No Charge	Not Covered	Pre-authorization from primary care physician and medical plan is required. Failure to obtain pre-authorization may result in non-payment of benefits.

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If your child needs dental or eye care	Eye exam	No Charge	Not Covered	Coverage limited to one comprehensive eye exam per calendar year. Services provided by Blue Shield's Vision Plan Administrator (VPA).
	Glasses	Single Vision: No Charge Lined bifocal: No Charge Lined trifocal: No Charge Lenticular: No Charge	Not Covered	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).
	Dental check-up	Not Covered	Not Covered	-----None-----

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 eye care (Adult)
• Dental care (Adult/Child)	• Non-emergency care when traveling outside the U.S.	• Routine foot care (unless for treatment of diabetes)
• Hearing aids	• Private -duty nursing (unless enrolled in a participating hospice program)	• 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	• Bariatric surgery (Pre-authorization from primary care physician and medical plan is required. Failure to obtain pre-authorization may result in non-payment of benefits.)	• Chiropractic care (coverage limited to 15 visits per calendar year)

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- Infertility treatment (coverage for diagnosis and treatment of cause of infertility only)
- Routine eye care (Child) (one comprehensive eye exam per calendar year)

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.cci.o.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 \$7,130
- Patient pays \$410

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	\$0
Copays	\$260
Coinsurance	\$0
Limits or exclusions	\$150
Total	\$410

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

- Amount owed to providers: \$5,400
- Plan pays \$4,320
- Patient pays \$1,170

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	\$0
Copays	\$450
Coinsurance	\$640
Limits or exclusions	\$80
Total	\$1,170

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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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