




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](http://blueshieldca.com/policies) or call 1-855-599-2650. 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](http://healthcare.gov/sbc-glossary) or call 1-866-444-3272 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	\$250 per individual / \$750 per family.	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.
Are there services covered before you meet your deductible?	Yes. Preventive care and other services listed in your complete terms of coverage.	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost-sharing and before you meet your deductible. See a list of covered preventive services at <a href="http://healthcare.gov/coverage/preventive-care-benefits/">healthcare.gov/coverage/preventive-care-benefits/</a> .
Are there other deductibles for specific services?	No.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	\$250 per individual / \$750 per family for participating providers. \$1,250 per individual / \$3,750 per family for non-participating providers.	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.
What is not included in the out-of-pocket limit?	Copayments for certain services, premiums, balance-billing charges, and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out-of-pocket limit.
Will you pay less if you use a network provider?	Yes. See <a href="http://blueshieldca.com/fap">blueshieldca.com/fap</a> or call 1-855-599-2650 for a list of participating providers.	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance

		<u>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.
<b>Do you need a <u>referral</u> to see a <u>specialist</u>?</b>	No.	You can see the <u>specialist</u> you choose without a <u>referral</u> .

 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
		<u>Participating Provider</u> (You will pay the least)	<u>Non-Participating Provider</u> (You will pay the most)	
<b>If you visit a health care <u>provider's</u> office or clinic</b>	<u>Primary care</u> visit to treat an injury or illness	\$10/visit; calendar year <u>deductible</u> does not apply	20% <u>coinsurance</u>	Calendar year medical <u>deductible</u> does not apply when you access <u>participating providers</u> .
	<u>Specialist</u> visit	\$10/visit; calendar year <u>deductible</u> does not apply	20% <u>coinsurance</u>	
	<u>Preventive care/ screening/ immunization</u>	No charge	20% <u>coinsurance</u>	You may have to pay for services that aren't preventive. Ask your <u>provider</u> if the services needed are preventive. Then check what your <u>plan</u> will pay for. Calendar year medical <u>deductible</u> does not apply when you access <u>participating providers</u> .
<b>If you have a test</b>	<u>Diagnostic test</u> (x-ray, blood work)	No charge	20% <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)	No charge	20% <u>coinsurance</u> up to \$350/day plus 100% of additional charges	<u>Preauthorization</u> is required. Failure to obtain <u>preauthorization</u> may result in reduction or non-payment of benefits.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		<u>Participating Provider</u> (You will pay the least)	<u>Non-Participating Provider</u> (You will pay the most)	
<b>If you need drugs to treat your illness or condition</b> More information about <b>prescription drug coverage</b> is available at <a href="http://blueshieldca.com/formulary">blueshieldca.com/formulary</a>	Tier 1	Not covered	Not covered	-----None-----
	Tier 2	Not covered	Not covered	
	Tier 3	Not covered	Not covered	
	Tier 4 (excluding Specialty drugs)	Not covered	Not covered	-----None-----
<b>If you have outpatient surgery</b>	Facility fee (e.g., ambulatory surgery center)	No charge	20% <u>coinsurance</u> up to \$350/day plus 100% of additional charges	-----None-----
	Physician/surgeon fees	No charge	20% <u>coinsurance</u>	
<b>If you need immediate medical attention</b>	<u>Emergency room care</u>	<i>Facility Fee:</i> \$50/visit calendar year <u>deductible</u> does not apply <i>Physician Fees:</i> No charge	<i>Facility Fee:</i> \$50/visit calendar year <u>deductible</u> does not apply <i>Physician Fees:</i> No charge	Calendar year medical <u>deductible</u> does not apply.
	<u>Emergency medical transportation</u>	No charge	No charge	-----None-----
	<u>Urgent care</u>	\$10/visit; calendar year <u>deductible</u> does not apply	20% <u>coinsurance</u>	
<b>If you have a hospital stay</b>	Facility fee (e.g., hospital room)	\$150/visit; calendar year <u>deductible</u> does not apply	20% <u>coinsurance</u> up to \$600 per day plus 100% of additional charges	<u>Preauthorization</u> is required. Failure to obtain <u>preauthorization</u> may result in reduction or non-payment of benefits.
	Physician/surgeon fees	No charge	20% <u>coinsurance</u>	-----None-----

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 need mental health, behavioral health, or substance abuse services	Outpatient services	<b>Office Visit:</b> \$10/visit; calendar year <u>deductible</u> does not apply  <b>Outpatient Services:</b> No charge  <b>Partial Hospitalization:</b> No charge  <b>Psychological Testing:</b> No charge	<b>Office Visit:</b> 20% <u>coinsurance</u> <b>Outpatient Services:</b> 20% <u>coinsurance</u> <b>Partial Hospitalization:</b> 20% <u>coinsurance</u> up to \$350/day plus 100% of additional charges <b>Psychological Testing:</b> 20% <u>coinsurance</u> up to \$350/day plus 100% of additional charges	<u>Preauthorization</u> is required except for office visits. Failure to obtain <u>preauthorization</u> may result in reduction or non-payment of benefits.
	Inpatient services	<b>Physician Inpatient Services:</b> No Charge  <b>Hospital Services:</b> \$150/admission  <b>Residential Care:</b> \$150/admission	<b>Physician Inpatient Services:</b> 20% <u>coinsurance</u> <b>Hospital Services:</b> 20% <u>coinsurance</u> up to \$600/day plus 100% of additional charges <b>Residential Care:</b> 20% <u>coinsurance</u> up to \$600/day plus 100% of additional charges	
If you are pregnant	Office visits	\$10/visit	20% <u>coinsurance</u>	-----None-----
	Childbirth/delivery professional services	\$10/visit	20% <u>coinsurance</u>	
	Childbirth/delivery facility services	\$150/visit; calendar year <u>deductible</u> does not apply	20% <u>coinsurance</u> up to \$600/day plus 100% of additional charges	

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)	
<b>If you need help recovering or have other special health needs</b>	<u>Home health care</u>	No Charge	Not covered	Coverage 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.
	<u>Rehabilitation services</u>	\$10/visit	<i>Office Visit: 20% <u>coinsurance</u></i> <i>Outpatient Hospital: 20% <u>coinsurance</u> up to \$350/day plus 100% of additional charges</i>	-----None-----
	<u>Habilitation services</u>	\$10/visit	<i>Office Visit: 20% <u>coinsurance</u></i> <i>Outpatient Hospital: 20% <u>coinsurance</u> up to \$350/day plus 100% of additional charges</i>	
	<u>Skilled nursing care</u>	<i>Freestanding SNF: No Charge</i> <i>Hospital-based SNF: \$150/visit</i>	<i>Freestanding SNF: No Charge</i> <i>Hospital-based SNF: 20% <u>coinsurance</u> up to \$600/day plus 100% of additional charges</i>	Coverage is 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>	No Charge	20% <u>coinsurance</u>	<u>Preauthorization</u> is required. Failure to obtain <u>preauthorization</u> may result in reduction or non-payment of benefits.
	<u>Hospice services</u>	No charge	Not covered	<u>Preauthorization</u> is required. Failure to obtain <u>preauthorization</u> may result in reduction or non-payment of benefits. Calendar year medical <u>deductible</u> does not apply.
<b>If your child needs dental or eye care</b>	Children's eye exam	Not covered	Not covered	-----None-----
	Children's glasses	Not covered	Not covered	
	Children's dental check-up	Not covered	Not covered	

## Excluded Services & Other Covered Services:

### Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)

- Cosmetic surgery
- Dental care (Adult)
- Hearing aids
- Infertility treatment
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing
- Routine eye care (Adult)
- Routine foot care
- Weight loss programs

### Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

- Acupuncture
- Bariatric surgery
- Chiropractic care

**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: 1-855-599-2650 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 libreng 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 ɓąąh ílínígó shíka' at'oowól nínízingo, kwijí' 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): 한국어도움이 필요하시면, 1-866-346-7198 무료전화 로전화하십시오.

Armenian (Հայերեն): Հայերենի հարկումը անվճարով և առանց ցանցի օգտագործման համարժեքների 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 ਓਹ ਮਦਦ ਲੈਂਦੀ ਮਹਿਰਾਬੀ ਕਰ ਕੇ 1-866-346-7198 ਨੇ ਮੁਫਤ ਕਾਲ ਕਰੋ.

Khmer (ភាសាខ្មែរ): សូមទូរស័ព្ទមកទាក់ទងសេវាសម្រាប់អ្នកខ្មែរ 1-866-346-7198.

Arabic (العربية): للحصول على المساعدة في اللغة العربية مجاناً، نفضل 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): हिन्दीमेंबिना खर्च केसहायताकेलिए, 1-866-346-7198 परकॉलकरें।

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

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*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>	\$250
■ <u>Specialist copayment</u>	\$10
■ Hospital (facility) <u>coinsurance</u>	10%
■ Other <u>coinsurance</u>	10%

**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	\$250
Copayments	\$310
Coinsurance	\$830
<i>What isn't covered</i>	
Limits or exclusions	\$60
<b>The total Peg would pay is</b>	<b>\$1,490</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>	\$250
■ <u>Specialist copayment</u>	\$10
■ Hospital (facility) <u>coinsurance</u>	10%
■ Other <u>coinsurance</u>	10%

**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	\$250
Copayments	\$895
Coinsurance	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$1,783
<b>The total Joe would pay is</b>	<b>\$2,928</b>

### Mia's Simple Fracture

(participating emergency room visit and follow up care)

■ The <u>plan's</u> overall <u>deductible</u>	\$250
■ <u>Specialist copayment</u>	\$10
■ Hospital (facility) <u>coinsurance</u>	10%
■ Other <u>coinsurance</u>	10%

**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	\$250
Copayments	\$70
Coinsurance	\$138
<i>What isn't covered</i>	
Limits or exclusions	\$37
<b>The total Mia would pay is</b>	<b>\$595</b>

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

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





## Notice Informing Individuals about Nondiscrimination and Accessibility Requirements

### Discrimination is against the law

Blue Shield of California complies with applicable federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability or sex. Blue Shield of California does not exclude people or treat them differently because of race, color, national origin, age, disability or sex.

Blue Shield of California:

- Provides aids and services at no cost to people with disabilities to communicate effectively with us such as:
  - Qualified sign language interpreters
  - Written information in other formats (including large print, audio, accessible electronic formats and other formats)
- Provides language services at no cost to people whose primary language is not English such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, contact the Blue Shield of California Civil Rights Coordinator.

If you believe that Blue Shield of California has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability or sex, you can file a grievance with:

Blue Shield of California  
Civil Rights Coordinator  
P.O. Box 629007  
El Dorado Hills, CA 95762-9007

**Phone: (844) 831-4133 (TTY: 711)**

**Fax: (916) 350-7405**

**Email: [BlueShieldCivilRightsCoordinator@blueshieldca.com](mailto:BlueShieldCivilRightsCoordinator@blueshieldca.com)**

You can file a grievance in person or by mail, fax or email. If you need help filing a grievance, our Civil Rights Coordinator is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf> or by mail or phone at:

U.S. Department of Health and Human Services  
200 Independence Avenue SW.  
Room 509F, HHH Building  
Washington, DC 20201  
(800) 368-1019; TTY: (800) 537-7697

Complaint forms are available at  
[www.hhs.gov/ocr/office/file/index.html](http://www.hhs.gov/ocr/office/file/index.html).