




**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](http://www.blueshieldca.com) or by calling 1-800-424-6521.

Important Questions	Answers	Why this Matters:
What is the overall <u>deductible</u> ?	<b>\$0</b>	See the chart starting on page 2 for your costs for services this <u>plan</u> covers.
Are there other <u>deductibles</u> 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 <u>plan</u> covers.
Is there an <u>out-of-pocket limit</u> on my expenses?	Yes. <b>\$1,000</b> per individual / <b>\$2,000</b> per two persons / <b>\$3,000</b> 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> ?	<u>Premiums</u> , some <u>copayments</u> , 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> .
Is there an overall annual limit on what the <u>plan</u> pays?	No.	The chart starting on page 2 describes any limits on what the <u>plan</u> will pay for <i>specific</i> covered services, such as office visits.
Does this <u>plan</u> use a <u>network of providers</u> ?	Yes. For a list of <u>preferred providers</u> , see <a href="http://www.blueshieldca.com">www.blueshieldca.com</a> or call 1-800-424-6521	If you use an <u>in-network</u> doctor or other health care <u>provider</u> , this <u>plan</u> will pay some or all of the costs of covered services. Be aware, your <u>in-network</u> doctor or hospital may use an <u>out-of-network provider</u> for some services. <u>Plans</u> use the term <u>in-network, preferred</u> , or participating for <u>providers</u> in their <u>network</u> . See the chart starting on page 2 for how this <u>plan</u> pays different kinds of <u>providers</u> .
Do I need a referral to see a <u>specialist</u> ?	Yes. However members may self refer using the Access+ Self Referral feature.	The <u>plan</u> will pay some or all of the costs to see a <u>specialist</u> for covered services but only if you have the <u>plan's</u> permission before you see the <u>specialist</u> .
Are there services this <u>plan</u> doesn't cover?	Yes.	Some of the services this <u>plan</u> doesn't cover are listed on page 5. See your policy or <u>plan</u> document for additional information about <u>excluded services</u> .

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- **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 **preferred providers** by charging you lower **deductibles**, **copayments** and **coinsurance** amounts.

Common Medical Event	Services You May Need	Your Cost If You Use a <u>Preferred Provider</u>	Your Cost If You Use a <u>Non-Preferred Provider</u>	Limitations & Exceptions
<b>If you visit a health care <u>provider's</u> office or clinic</b>	Primary care visit to treat an injury or illness	\$25 / visit	Not Covered	-----None-----
	<b>Specialist</b> visit	\$25 / visit	Not Covered	\$30 <b>copayment</b> per visit for Access+ <b>Specialist</b> Self Referral.
	Other practitioner office visit	Not Covered	Not Covered	-----None-----
	Preventive care/screening /immunization	\$25 / visit	Not Covered	Some exclusions may apply. Please refer to your Evidence of Coverage and <b>Plan</b> Contract for more details.
<b>If you have a test</b>	Diagnostic test (x-ray, blood work)	No Charge	Not Covered	-----None-----
	Imaging (CT/PET scans, MRIs)	No Charge	Not Covered	-----None-----

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Common Medical Event	Services You May Need	Your Cost If You Use a <u>Preferred Provider</u>	Your Cost If You Use a <u>Non-Preferred Provider</u>	Limitations & Exceptions
<b>If you need drugs to treat your illness or condition</b>  More information about <b><u>prescription drug coverage</u></b> is available at <a href="http://www.blueshieldca.com">www.blueshieldca.com</a> .	Generic drugs	\$10 / prescription (retail) \$10 / prescription (mail)	Not Covered	Covers up to a 30-day supply (retail); 31-90 day supply (mail).
	<b><u>Preferred</u></b> brand drugs	\$30 / prescription (retail) \$30 / prescription (mail)	Not Covered	Select formulary and non-formulary drugs require prior authorization.
	<b><u>Non-preferred</u></b> brand drugs	\$30 / prescription (retail) \$30 / prescription (mail)	Not Covered	
	Specialty drugs	\$30 / prescription	Not Covered	Covers up to a 30-day supply. Prior authorization is required.
<b>If you have outpatient surgery</b>	Facility fee (e.g., ambulatory surgery center)	\$50 / surgery	Not Covered	-----None-----
	Physician/surgeon fees	No Charge	Not Covered	-----None-----
<b>If you need immediate medical attention</b>	Emergency room services	\$100 / visit	\$100 / visit	-----None-----
	Emergency medical transportation	No Charge	No Charge	-----None-----
	<b><u>Urgent care</u></b>	\$25/ visit	Not Covered	\$25 <b><u>copayment</u></b> for services outside of member service area.
<b>If you have a hospital stay</b>	Facility fee (e.g., hospital room)	\$100 / admission	Not Covered	-----None-----
	Physician/surgeon fee	No Charge	Not Covered	-----None-----

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Common Medical Event	Services You May Need	Your Cost If You Use a Preferred Provider	Your Cost If You Use a Non-Preferred Provider	Limitations & Exceptions
<b>If you have mental health, behavioral health, or substance abuse needs</b>	Mental/Behavioral health outpatient services	Not Covered	Not Covered	Covered by Managed Health Network (MHN). Please contact the provider for more details.
	Mental/Behavioral health inpatient services	Not Covered	Not Covered	
	Substance use disorder outpatient services	Not Covered	Not Covered	
	Substance use disorder inpatient services	Not Covered	Not Covered	
<b>If you are pregnant</b>	Prenatal and postnatal care	No Charge	Not Covered	-----None-----
	Delivery and all inpatient services	\$100 / admission	Not Covered	-----None-----
<b>If you need help recovering or have other special health needs</b>	<b><u>Home health care</u></b>	No Charge	Not Covered	Covers up to 100 visits per calendar year.
	<b><u>Rehabilitation services</u></b>	\$25 / visit	Not Covered	-----None-----
	<b><u>Habilitation services</u></b>	\$25 / visit	Not Covered	-----None-----
	<b><u>Skilled nursing care</u></b>	No Charge	Not Covered	Covers up to 100 pre-authorized days per calendar year.
	<b><u>Durable medical equipment</u></b>	No Charge	Not Covered	-----None-----
	<b><u>Hospice service</u></b>	No Charge	Not Covered	-----None-----
<b>If your child needs dental or eye care</b>	Eye exam	\$25 / visit	Not Covered	Some exclusions may apply. Please refer to your Evidence of Coverage and <b><u>Plan</u></b> Contract for more details.
	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.)**

- |                             |  |                        |
|-----------------------------|--|------------------------|
| • Acupuncture               | • Infertility treatment                              | • Routine foot care    |
| • Chiropractic care         | • Long-term care                                     | • Weight loss programs |
| • Cosmetic surgery          | • Non-emergency care when traveling outside the U.S. |                        |
| • Dental care (Adult/Child) | • Private -duty nursing                              |                        |

### **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.)**

- |                     |                |   |
|---------------------|----------------|---|
| • Bariatric surgery | • Hearing aids | • Routine eye care (Adult) (one 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 **1-800-424-6521**. 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](http://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](http://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: 1-800-424-6521 or the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or [www.dol.gov/ebsa/healthreform](http://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>.

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## 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 \$7,210
- Patient pays \$330

#### 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
<b>Total</b>	<b>\$7,540</b>

#### Patient pays:

<u>Deductibles</u>	\$0
<u>Copays</u>	\$180
<u>Coinsurance</u>	\$0
Limits or exclusions	\$150
<b>Total</b>	<b>\$330</b>

### Managing type 2 diabetes

(routine maintenance of a well-controlled condition)

- Amount owed to providers: \$5,400
- Plan pays \$4,600
- Patient pays \$800

#### 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
<b>Total</b>	<b>\$5,400</b>

#### Patient pays:

<u>Deductibles</u>	\$0
<u>Copays</u>	\$720
<u>Coinsurance</u>	\$0
Limits or exclusions	\$80
<b>Total</b>	<b>\$800</b>

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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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