Understanding healthcare coverage

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blue california

Q: What is it?

A: Private healthcare coverage helps you pay for medical care and gives you access to a **network** of doctors and hospitals.

See the last page for helpful definitions of bolded words.

Q: How does it work?

A: First, you buy a health plan. A health plan determines how much you will pay when you get care and what types of medical services **(benefits)** are covered.

When you need medical care you visit a doctor or hospital in your plan's provider network. A network is a group of doctors, hospitals, and healthcare providers that agree with the health insurance company to accept certain amounts for each service as payment in full. Your costs for care are usually lower when using in-network providers compared to using out-of-network providers.

Healthcare coverage isn't just for when you're sick. Preventive care services can help keep you and your family healthy with annual health exams and immunizations such as flu shots – available at no additional cost.

Q: What do I pay monthly?

A: You'll pay a fixed monthly rate for your health plan. The amount depends on the plan you choose, where you live, and the age of each person on the policy. The lower your plan's monthly rate, the more you typically pay when you see the doctor, and vice versa. Identifying how often you see a doctor can help you choose the right plan for you.

Depending on your household size and income, you may be eligible for financial assistance through Covered California – our state's health exchange – to lower your plan's monthly rate or even your costs for medical care.

Q: What do I pay when I see a doctor?

A: It depends on the service and your plan's benefits. Some services have a **copayment**, which is a fixed dollar amount. Other services have a **coinsurance**, which is a fixed percentage amount. When you get care from an in-network* doctor, you pay the copayment or coinsurance, and the health plan pays the rest up to the **allowed charges**.

Some health plans have an annual **deductible**, which is the amount of money you pay for services before the health plan begins paying for them.

To protect you from unexpected costs, most plans have an annual out-of-pocket maximum. Once you reach the out-of-pocket maximum, your health plan covers 100% up to the allowed charges for most covered medical services.

Q: How can I get covered?

A: Just apply! If you are eligible, you can't be turned down for past or present medical conditions. The best time to apply is during open enrollment, November 1, 2021, through January 31, 2022. You can apply outside of this window if you have a qualifying event such as loss of employer coverage, moving to a new area, getting married, etc.

If you don't have a qualified health plan in 2022, you may have to pay a California tax penalty in 2023.

* Although some plans let you get care from hospitals and doctors that aren't in the plan's network, you'll pay more to see those out-of-network providers. The plan may also have other costs – such as a separate, higher deductible – for seeing those providers. These extra costs can be very high, so it's more cost-effective to get care from in-network providers.

Call your broker or visit us at blueshieldcaplans.com for more information or to get help applying for coverage.

How can Blue Shield of California help me?

We know you're committed to good health and wellness. That's why we're committed to providing you with access to affordable health care and a quality network of doctors.

Plans

We have a range of **HMO** and **PPO** plans for individuals and families that fit most budgets. You may even qualify for financial assistance.

Providers

With our Trio HMO plans, you can choose from a quality network of local doctors and hospitals such as Dignity Health, Hoag Memorial, John Muir, Providence, St. Joseph, St. Jude, Scripps, UC San Francisco, and more. With our PPO plans, you can choose from more than 58,000 doctors and 325 hospitals statewide in our Exclusive PPO Network.

We offer convenient and cost-effective ways to connect with doctors. You can use Teladoc to talk to a doctor by web, phone, or mobile app – day or night – inside or outside of California for a minimal or no copay.

Experience

We have the experience you can trust. As a nonprofit company, it's been our mission to provide access to affordable care to all Californians for over 80 years. That's why we pledged to limit our annual net income to 2% of revenue,‡ and if we earn more than 2%, we'll return the difference to our customers and the community.

Helpful resources

Your Blue Shield coverage gives you access to popular programs and services you can use throughout the year. Get answers to health-related questions with NurseHelp 24/7℠ or participate in our Wellvolution® program to help you get more active, quit smoking, lower stress, and much more. These resources are yours at no extra cost.

Dental and vision coverage

Healthy teeth and eyes are important, too. That's why we also offer dental and vision† plans – for your overall health.

To learn more or start getting covered, visit **blueshieldcaplans.com** or call your broker today.

† Underwritten by Blue Shield of California Life & Health Insurance Company and administered by the MESVision network.

‡ Subject to the board of directors' approval.

Helpful definitions

Allowed charges – The dollar amount Blue Shield uses to determine payment for covered services.

Benefits (covered services) – The medically necessary services and supplies covered by the member's health plan.

Coinsurance – The percentage of the allowed charges a member pays for benefits after meeting any calendar-year deductible.

Copayment – The fixed dollar amount a member pays for benefits after meeting any calendar-year deductible.

Deductible – The amount a member pays each calendar year for most benefits before the health plan begins to pay. Some benefits, such as preventive care, are covered before the member meets the calendar-year deductible.

HMO – A health plan in which members choose a primary care physician to administer their care, including referrals to specialist doctors. Covered benefits need to be received from providers in the primary doctor's medical group. There is no coverage for services received from doctors who are not in the member's medical group.

Network – A group of providers – including hospitals, doctors, specialists, and other healthcare providers – that have agreed with the health plan to provide benefits to plan members for a specified amount.

Out-of-pocket maximum – The combined maximum of the deductible, copayment and coinsurance amounts for all covered services an individual or family is required to pay each year.

PPO – A health plan in which members can choose to see any provider in the PPO provider network without a referral. Members also have the freedom to use non-network providers for most services if they are willing to pay a higher share of the cost.