
 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 www.blueshieldca.com/sites/calpersmember/plans-benefits/documents.sp or call 1-800-334-5847. 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 or call 1-866-444-3272 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	\$0.	See the Common Medical Events chart below for your costs for services this <u>plan</u> covers.
Are there services covered before you meet your deductible?	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 healthcare.gov/coverage/preventive-care-benefits/ .
Are there other deductibles for specific services?	No.	You don't have to meet <u>deductibles</u> for specific services.
What is the <u>out-of-pocket limit</u> for this <u>plan</u> ?	For participating providers: <u>Medical: \$1,500</u> per individual / <u>\$3,000</u> per family. <u>Pharmacy: \$5,850</u> per individual / <u>\$11,700</u> per family. Includes \$1,000 for mail-service formulary prescription drugs per member.	The <u>out-of-pocket limit</u> is the most you could pay in a year for covered services. If you have other family members in this <u>plan</u> , they have to meet their own <u>out-of-pocket limits</u> until the overall family <u>out-of-pocket limit</u> has been met.
What is not included in the <u>out-of-pocket limit</u> ?	<u>Copayments</u> for certain services, <u>premiums</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> .
Will you pay less if you use a <u>network provider</u> ?	Yes. See www.blueshieldca.com/calpers or call 1-800-334-5847 for a list of <u>network providers</u> .	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 <u>provider</u> for the difference between the <u>provider's</u> charge 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> ?	Yes.	This <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 a <u>referral</u> before you see the <u>specialist</u> .

Pending Regulatory Approval

 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
		Plan Provider (You will pay the least)	Non Plan Provider (You will pay the most)	
If you visit a health care <u>provider's</u> office or clinic	<u>Primary care</u> visit to treat an injury or illness	\$15/visit	Not covered	-----None-----
	<u>Specialist</u> visit	\$15/visit	Not covered	
	<u>Preventive care/ screening/ immunization</u>	No charge	Not covered	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.
If you have a test	<u>Diagnostic test</u> (x-ray, blood work)	<i>Lab & Path:</i> No charge <i>X-Ray & Imaging:</i> No charge <i>Other Diagnostic Examination:</i> No charge	Not covered	The services listed are at a free standing location. <u>Preauthorization</u> is required. Failure to obtain <u>preauthorization</u> may result in reduction or non-payment of benefits.
	Imaging (CT/PET scans, MRIs)	<i>Outpatient Radiology Center:</i> No charge <i>Outpatient Hospital:</i> No charge	Not covered	<u>Preauthorization</u> is required. Failure to obtain <u>preauthorization</u> may result in reduction or non-payment of benefits.

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

Pending Regulatory Approval

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		<u>Plan Provider</u> (You will pay the least)	<u>Non Plan Provider</u> (You will pay the most)	
<p>If you need drugs to treat your illness or condition More information about prescription drug coverage is available at blueshieldca.com/formulary</p>	Generic drugs	<i>Retail:</i> \$5/prescription <i>Extended Quantity of Maintenance Drugs at Select Retail Pharmacies:</i> \$10/prescription <i>Mail Order:</i> \$10/prescription	Not covered	<i>Retail:</i> Covers up to a 30-day supply; 50% coinsurance of Blue Shield contracted rate for drugs to treat erectile dysfunction.
	Brand Formulary Drugs	<i>Retail:</i> \$20/prescription <i>Extended Quantity of Maintenance Drugs at Select Retail Pharmacies:</i> \$40/prescription <i>Mail Order:</i> \$40/prescription	Not covered	<i>Extended Quantity of Maintenance Drugs at Select Retail Pharmacies:</i> Covers up to a 90-day supply. A list of select retail pharmacies can be obtained by going to the Pharmacy Resources page at www.blueshieldca.com/calpers . <i>Mail Order:</i> Covers up to a 90-day supply. Failure to obtain pre- authorization may result in denial of coverage.
	Brand Non-Formulary Drugs	<i>Retail:</i> \$50/prescription <i>Extended Quantity of Maintenance Drugs at Select Retail Pharmacies:</i> \$100/prescription <i>Mail Order:</i> \$100/prescription	Not covered	Select formulary and non-formulary drugs require pre-authorization.
	Specialty drugs	\$30/prescription	Not covered	Covers up to a 30-day supply. Coverage limited to drugs dispensed by Network Specialty Pharmacies unless medically necessary for a covered emergency. Pre-authorization is required. Failure to obtain pre-authorization may result in denial of coverage.

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

Pending Regulatory Approval

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		<u>Plan Provider</u> (You will pay the least)	<u>Non Plan Provider</u> (You will pay the most)	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	<i>Ambulatory Surgery Center:</i> No charge <i>Outpatient Hospital:</i> No charge	Not covered	-----None-----
	Physician/surgeon fees	No charge	Not covered	
If you need immediate medical attention	<u>Emergency room care</u>	<i>Facility Fee:</i> \$50/visit <i>Physician Fee:</i> No charge	<i>Facility Fee:</i> \$50/visit <i>Physician Fee:</i> No charge	-----None-----
	<u>Emergency medical transportation</u>	No charge	No charge	
	<u>Urgent care</u>	<i>Within <u>Plan</u> Service Area:</i> \$15/visit <i>Outside <u>Plan</u> Service Area:</i> \$15/visit	<i>Within <u>Plan</u> Service Area:</i> Not covered <i>Outside <u>Plan</u> Service Area:</i> \$15/visit	
If you have a hospital stay	Facility fee (e.g., hospital room)	No charge	Not covered	<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	Not covered	-----None-----

Pending Regulatory Approval

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		<u>Plan Provider</u> (You will pay the least)	<u>Non Plan Provider</u> (You will pay the most)	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Office Visit: \$15/visit Outpatient Services: No charge Partial Hospitalization: No charge Psychological Testing: No charge	Not covered	<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	Physician Inpatient Services: No charge Hospital Services: No charge Residential Care: No charge	Not covered	
If you are pregnant	Office visits	No charge	Not covered	-----None-----
	Childbirth/delivery professional services	No charge	Not covered	
	Childbirth/delivery facility services	No charge	Not covered	

Pending Regulatory Approval

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Plan Provider (You will pay the least)	Non Plan Provider (You will pay the most)	
If you need help recovering or have other special health needs	<u>Home health care</u>	\$15/visit	Not covered	<u>Preauthorization</u> is required. Failure to obtain <u>preauthorization</u> may result in reduction or non-payment of benefits.
	<u>Rehabilitation services</u>	<i>Office Visit:</i> \$15/visit <i>Outpatient Hospital:</i> \$15/visit	Not covered	-----None-----
	<u>Habilitation services</u>	<i>Office Visit:</i> \$15/visit <i>Outpatient Hospital:</i> \$15/visit	Not covered	
	<u>Skilled nursing care</u>	<i>Freestanding SNF:</i> No charge <i>Hospital-based SNF:</i> No charge	Not covered	Coverage limited to 100 days per member calendar year. <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	Not covered	<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	
If your child needs dental or eye care	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)
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing
- 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
- Hearing aids
- Infertility treatment
- Routine eye care (Adult)

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. 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 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: 1-800-334-5847 or the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or 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 ɓąąh ílínígó shíka' at'oowól 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): Հայերեն կեղևի սեղանը և արտադրությունը նույնպես առկա է հայերենի և անգլերենի միջոցով 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 ਲੈ ਮਿਰਬਾਨੀ ਕਰ ਕੇ 1-866-346-7198 ਨੇ ਮੁਫਤ ਕਾਲ ਕਰੋ.

Khmer (ខ្មែរ): សូមទាក់ទងការងារជំនួយឥតគិតថ្លៃ សូមទាក់ទងលេខ 1-866-346-7198.

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

Hmong (Hnoob): 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): สำหรับความช่วยเหลือที่เป็นภาษาไทยโดยไม่เสียค่าใช้จ่ายโปรดโทร 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 Plan pre natal care and a hospital delivery)

■ The <u>plan's overall deductible</u>	\$0
■ <u>Specialist copayment</u>	\$15
■ Hospital (facility) <u>copayment</u>	\$0
■ Other <u>copayment</u>	\$0

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*)

Total Example Cost	\$12,800
---------------------------	-----------------

In this example, Peg would pay:

<i>Cost Sharing</i>	
Deductibles	\$0
Copayments	\$180
Coinsurance	\$1,792
<i>What isn't covered</i>	
Limits or exclusions	\$60
The total Peg would pay is	\$2,032

Managing Joe's Type 2 Diabetes

(a year of routine Plan care of a well controlled condition)

■ The <u>plan's overall deductible</u>	\$0
■ <u>Specialist copayment</u>	\$15
■ Hospital (facility) <u>copayment</u>	\$0
■ Other <u>copayment</u>	\$0

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*)

Total Example Cost	\$7,400
---------------------------	----------------

In this example, Joe would pay:

<i>Cost Sharing</i>	
Deductibles	\$0
Copayments	\$835
Coinsurance	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$1,783
The total Joe would pay is	\$2,618

Mia's Simple Fracture

(Plan emergency room visit and follow up care)

■ The <u>plan's overall deductible</u>	\$0
■ <u>Specialist copayment</u>	\$15
■ Hospital (facility) <u>copayment</u>	\$0
■ Other <u>copayment</u>	\$0

This EXAMPLE event includes services like:

Emergency room care (*including medical supplies*)
 Diagnostic test (*x-ray*)
 Durable medical equipment (*crutches*)
 Rehabilitation services (*physical therapy*)

Total Example Cost	\$2,500
---------------------------	----------------

In this example, Mia would pay:

<i>Cost Sharing</i>	
Deductibles	\$0
Copayments	\$140
Coinsurance	\$169
<i>What isn't covered</i>	
Limits or exclusions	\$37
The total Mia would pay is	\$346

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

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.