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
		Participating Provider (You will pay the least)	Non-Participating Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$20/visit; deductible does not apply	30% coinsurance	----------None----------
	Specialist visit	$20/visit; deductible does not apply	30% coinsurance	
	Preventive care/screening /immunization	No Charge; deductible does not apply	Not Covered	You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	*Lab & Path*: 10% coinsurance *X-Ray & Imaging*: 10% coinsurance *Other Diagnostic Examination*: 10% coinsurance	*Lab & Path*: 30% coinsurance *X-Ray & Imaging*: 30% coinsurance *Other Diagnostic Examination*: 30% coinsurance	The services listed are at a freestanding location.
	Imaging (CT/PET scans, MRIs)	*Outpatient Radiology Center*: 10% coinsurance *Outpatient Hospital*: 10% coinsurance	*Outpatient Radiology Center*: 30% coinsurance *Outpatient Hospital*: 30% coinsurance subject to a benefit maximum of $350/day	Preauthorization is required. Failure to obtain preauthorization may result in non-payment of benefits.
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at blueshieldca.com/formulary	Tier 1	*Retail*: Level A: No Charge Level B: $5/prescription *Mail Service*: $10/prescription	*Retail*: 25% coinsurance + $5/prescription *Mail Service*: Not Covered	Preauthorization is required for select drugs. Failure to obtain preauthorization may result in non-payment of benefits. *Retail*: Covers up to a 30-day supply; 90-days may be covered with a copayment for each 30-day supply; *Mail Service*: Covers up to a 90-day supply.
	Tier 2	*Retail*: Level A: $15/prescription Level B: $25/prescription *Mail Service*: $50/prescription	*Retail*: 25% coinsurance + $25/prescription *Mail Service*: Not Covered	
	Tier 3	*Retail*: Level A: $40/prescription Level B: $40/prescription *Mail Service*: $80/prescription	*Retail*: 25% coinsurance + $40/prescription *Mail Service*: Not Covered	

* For more information about limitations and exceptions, see the plan or policy document at blueshieldca.com/cseba.

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)	
	Tier 4	*Retail and Network Specialty Pharmacies*: Level A: $40/prescription Level B: $40/prescription *Mail Service*: $80/prescription	*Retail*: 25% coinsurance + $40/prescription *Mail Service*: Not Covered	Preauthorization is required. Failure to obtain preauthorization may result in non-payment of benefits. *Retail and Network Specialty Pharmacies*: Covers up to a 30-day supply; Specialty drugs must be obtained at a Network Specialty Pharmacy. *Mail Service*: Covers up to a 90-day supply.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	*Ambulatory Surgery Center*: 10% coinsurance *Outpatient Hospital*: 10% coinsurance	*Ambulatory Surgery Center*: 30% coinsurance subject to a benefit maximum of $350/day *Outpatient Hospital*: 30% coinsurance subject to a benefit maximum of $350/day	----------None----------
	Physician/surgeon fees	10% coinsurance	30% coinsurance	
If you need immediate medical attention	Emergency room care	*Facility Fee*: $150/visit + 10% coinsurance; deductible does not apply *Physician Fee*: 10% coinsurance	*Facility Fee*: $150/visit + 10% coinsurance; deductible does not apply *Physician Fee*: 10% coinsurance	----------None----------
	Emergency medical transportation	10% coinsurance	10% coinsurance	This payment is for emergency or authorized transport.
	Urgent care	$20/visit; deductible does not apply	30% coinsurance	----------None----------
If you have a hospital stay	Facility fee (e.g., hospital room)	10% coinsurance	30% coinsurance subject to a benefit maximum of $600/day	Preauthorization is required. Failure to obtain preauthorization may result in non-payment of benefits.
	Physician/surgeon fees	10% coinsurance	30% coinsurance	----------None----------

* For more information about limitations and exceptions, see the plan or policy document at blueshieldca.com/cseba.

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	*Office Visit*: $20/visit; deductible does not apply *Other Outpatient Services*: 10% coinsurance *Partial Hospitalization*: 10% coinsurance *Psychological Testing*: 10% coinsurance	*Office Visit*: 30% coinsurance *Other Outpatient Services*: 30% coinsurance *Partial Hospitalization*: 30% coinsurance subject to a benefit maximum of $350/day *Psychological Testing*: 30% coinsurance	Preauthorization is required except for office visits. Failure to obtain preauthorization may result in non-payment of benefits.
	Inpatient services	*Physician Inpatient Services*: 10% coinsurance *Hospital Services*: 10% coinsurance *Residential Care*: 10% coinsurance	*Physician Inpatient Services:* 30% coinsurance *Hospital Services:* 30% coinsurance subject to a benefit maximum of $600/day *Residential Care:* 30% coinsurance subject to a benefit maximum of $600/day	Preauthorization is required. Failure to obtain preauthorization may result in non-payment of benefits.
If you are pregnant	Office visits	10% coinsurance	30% coinsurance	----------None----------
	Childbirth/delivery professional services	10% coinsurance	30% coinsurance	
	Childbirth/delivery facility services	10% coinsurance	30% coinsurance subject to a benefit maximum of $600/day	
If you need help recovering or have other special health needs	Home health care	10% coinsurance	Not Covered	Preauthorization is required. Failure to obtain preauthorization may result in non-payment of benefits. Coverage limited to 100 visits per member per Calendar Year.
	Rehabilitation services	*Office Visit*: 10% coinsurance *Outpatient Hospital*: 10% coinsurance	*Office Visit*: 30% coinsurance *Outpatient Hospital*: 30% coinsurance subject to a benefit maximum of $350/day	----------None----------

* For more information about limitations and exceptions, see the plan or policy document at blueshieldca.com/cseba.

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)	
	Habilitation services	*Office Visit*: 10% coinsurance *Outpatient Hospital*: 10% coinsurance	*Office Visit*: 30% coinsurance *Outpatient Hospital*: 30% coinsurance subject to a benefit maximum of $350/day	
	Skilled nursing care	*Freestanding SNF*: 10% coinsurance *Hospital-based SNF*: 10% coinsurance	*Freestanding SNF*: 10% coinsurance *Hospital-based SNF*: 30% coinsurance subject to a benefit maximum of $600/day	Preauthorization is required. Failure to obtain preauthorization may result in non-payment of benefits. Coverage limited to 100 days per member per benefit period.
	Durable medical equipment	10% coinsurance	30% coinsurance	Preauthorization is required. Failure to obtain preauthorization may result in non-payment of benefits.
	Hospice services	No Charge; deductible does not apply	Not Covered	Preauthorization is required except for pre-hospice consultation. Failure to obtain preauthorization may result in non-payment of benefits.
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)
- 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. 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.

* For more information about limitations and exceptions, see the plan or policy document at blueshieldca.com/cseba.

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: Blue Shield Customer Service at 1-855-724-7698 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

Minimum Essential Coverage generally includes plans, health insurance available through the Marketplace or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of Minimum Essential Coverage, you may not be eligible for the premium tax credit.

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.

* For more information about limitations and exceptions, see the plan or policy document at blueshieldca.com/cseba.

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 tulongsa 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 bąąh ílínígó shíka' at'oowoł nínízingo, kwiijį' 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): 한국어도움이필요하시면, 1-866-346-7198 무료전화 로전화하십시오.

Armenian (Հայերեն): Հայերեն լեզվով անվճար օգնություն ստանալու համար խնդրում ենք զանգահարել 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 ਵਿਚ ਸਹਾਇਤਾ ਲਈ ਕਿਰਪਾ ਕਰਕੇ 1-866-346-7198 'ਤੇ ਕਾੱਲ ਕਰੋ।

Khmer (ភាសាខ្មែរ)៖ សូមជំនួយភាសាអង់គ្លេសដោយឥតគិតថ្លៃ សូមទាក់ទងមកលេខ 1-866-346-7198។

Arabic (العربية): لحصول على المساعدة في اللغة العربية مجانا، 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): สำหรับความช่วยเหลือเป็นภาษาไทยโดยไม่มีค่าใช้จ่ายโปรดโทร 1-866-346-7198

Laotian (ພາສາລາວ): ສໍາລັບການຊ່ວຍເຫຼືອເປັນພາສາລາວແບບບໍ່ເສຍຄ່າ, ກະລຸນາໂທ1-866-346-7198.

To see examples of how this plan might cover costs for a sample medical situation, see the next section.

PRA Disclosure Statement

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1146. The time required to complete this information collection is estimated to average 0.08 hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

* For more information about limitations and exceptions, see the plan or policy document at blueshieldca.com/cseba.

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 plan's overall deductible	$500
Specialist copayment	$20
Hospital (facility) coinsurance	10%
Other coinsurance	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)*

Total Example Cost	$12,700

In this example, Peg would pay:

Cost Sharing	
Deductibles	$500
Copayments	$0
Coinsurance	$1,200
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	$1,760

Managing Joe's Type 2 Diabetes
(a year of routine participating care of a well-controlled condition)

The plan's overall deductible	$500
Specialist copayment	$20
Hospital (facility) coinsurance	10%
Other coinsurance	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)*

Total Example Cost	$5,600

In this example, Joe would pay:

Cost Sharing	
Deductibles	$500
Copayments	$400
Coinsurance	$40
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	$960

Mia's Simple Fracture
(participating emergency room visit and follow up care)

The plan's overall deductible	$500
Specialist copayment	$20
Hospital (facility) coinsurance	10%
Other coinsurance	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)*

Total Example Cost	$2,800

In this example, Mia would pay:

Cost Sharing	
Deductibles	$500
Copayments	$20
Coinsurance	$200
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	$720

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