|  |
| --- |
| **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 [bsca.com/policies](https://www.blueshieldca.com/bsca/bsc/public/member/mp/welcome/!ut/p/z1/04_Sj9CPykssy0xPLMnMz0vMAfIjo8zivfy9zQydTQz9LFydnQ0Cvb38HE19jQ0MvMz0w8EKjCw8LTwMDAy93EOcjQ0c3V0djd0sQo0tTEz0o4jRb4ADOBoQpx-Pgij8xofrR4GV4PMBITMKckNDIwwyHQHjLe_F/dz/d5/L2dBISEvZ0FBIS9nQSEh/p0/IZ7_JOK61C41N0SG00QKFLJ7FP0000=CZ6_JOK61C41N8ECC0QKJNA5M300J6=MEformView!ML==/#Z7_JOK61C41N0SG00QKFLJ7FP0000) or call **1-888-870-5064**. 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://www.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?** | **$1,500** per individual / **$3,000** per family for participating providers; **$3,000** per individual / **$6,000** per family for non-participating providers. | 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 policy, the overall family deductible must be met before the plan begins to pay. |
| **Are there services covered before you meet your deductible?** | Yes. Preventive care and 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 [healthcare.gov/coverage/preventive-care-benefits](https://www.healthcare.gov/coverage/preventive-care-benefits/). |
| **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?** | **$3,000** per individual / **$6,000** per family for participating providers; **$6,000** per individual / **$12,000** 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, the overall family out-of-pocket limit must be 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 [blueshieldca.com/fad](http://blueshieldca.com/fad) or call **1-888-870-5064** for a list of network 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 billing). Be aware, your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services. |
| **Do you need a referral to see a specialist?** | No. | You can see the specialist you choose without a referral. |

| **Exclamation** | 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 | 10% coinsurance | 30% coinsurance | ----------------------None----------------------- |
| Specialist visit | 10% coinsurance | 30% coinsurance |
| Preventive care/screening /immunization | No Charge; deductible does not apply | 30% coinsurance | 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 | Preauthorization is required. Failure to obtain preauthorization may result in non-payment of benefits. |
| **If you need drugs to treat your illness or condition** | Tier 1 | *Retail*: Not Covered *Mail Service*: Not Covered | *Retail*: Not Covered *Mail Service*: Not Covered | Your Prescription Drug Coverage is covered by Express Scripts. For more information, please call 1-877-805-5601. |
| Tier 2 | *Retail*: Not Covered *Mail Service*: Not Covered | *Retail*: Not Covered *Mail Service*: Not Covered |
| Tier 3 | *Retail*: Not Covered *Mail Service*: Not Covered | *Retail*: Not Covered *Mail Service*: Not Covered |
| Tier 4 | *Retail and Network Specialty Pharmacies*: Not Covered *Mail Service*: Not Covered | *Retail*: Not Covered *Mail Service*: Not Covered |  |
| **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 *Outpatient Hospital*: 30% coinsurance | ----------------------None----------------------- |
| Physician/surgeon fees | 10% coinsurance | 30% coinsurance |
| **If you need immediate medical attention** | Emergency room care | *Facility Fee*: 10% coinsurance *Physician Fee*: 10% coinsurance | *Facility Fee*: 10% coinsurance *Physician Fee*: 10% coinsurance | ----------------------None----------------------- |
| Emergency medical transportation | 10% coinsurance | 10% coinsurance | This payment is for emergency or authorized transport. |
| Urgent care | 10% coinsurance | 30% coinsurance | ----------------------None----------------------- |
| **If you have a hospital stay** | Facility fee (e.g., hospital room) | 10% coinsurance | 30% coinsurance | Preauthorization is required. Failure to obtain preauthorization may result in non-payment of benefits. |
| Physician/surgeon fees | 10% coinsurance | 30% coinsurance | ----------------------None----------------------- |
| **If you need mental health, behavioral health, or substance abuse services** | Outpatient services | *Office Visit*: 10% coinsurance *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 *Psychological Testing*: 30% coinsurance | Preauthorization is required except for office visits and office-based opioid treatment. 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 *Residential Care:* 30% coinsurance | 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 |
| **If you need help recovering or have other special health needs** | Home health care | 10% coinsurance | 30% coinsurance | 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 | ----------------------None----------------------- |
| Habilitation services | *Office Visit*: 10% coinsurance *Outpatient Hospital*: 10% coinsurance | *Office Visit*: 30% coinsurance *Outpatient Hospital*: 30% coinsurance |
| Skilled nursing care | *Freestanding SNF*: 10% coinsurance *Hospital-based SNF*: 10% coinsurance | *Freestanding SNF*: 30% coinsurance *Hospital-based SNF*: 30% coinsurance | 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 | 10% coinsurance | 30% coinsurance | 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 | * Long-term care | * Private-duty nursing | * Routine foot care |
| * Dental care (Adult) | * Non-emergency care when traveling outside the U.S. | * Routine eye care (Adult) | * 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 (only thru Progyny) |

**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: Blue Shield Customer Service at 1-888-870-5064 or the Department of Labor's Employee Benefits Security Administration at **1-866-444-EBSA (3272)** or [dol.gov/ebsa/healthreform](https://www.dol.gov/agencies/ebsa/laws-and-regulations/laws/affordable-care-act/).

**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.

**Language Access Services:**



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

**PRA Disclosure Statement**

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Exclamation

**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.

**About these Coverage Examples:**

**Peg is Having a Baby**(9 months of participating pre-natal care and a hospital delivery)

◼ **The plan’s overall deductible** **$1,500**

◼ **Specialist coinsurance 10%**

◼ **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 | $1,500 |
| Copayments | $0 |
| Coinsurance | $1,100 |
| *What isn’t covered* | | |
| Limits or exclusions | $70 |
| **The total Peg would pay is** | **$2,670** |

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

◼ **The plan’s overall deductible** **$1,500**

◼ **Specialist coinsurance 10%**

◼ **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 | $1,500 |
| Copayments | $0 |
| Coinsurance | $40 |
| *What isn’t covered* | | |
| Limits or exclusions | $3,500 |
| **The total Joe would pay is** | **$5,040** |

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

◼ **The plan’s overall deductible** **$1,500**

◼ **Specialist** **coinsurance** **10%**

◼ **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 | $1,500 |
| Copayments | $0 |
| Coinsurance | $100 |
| *What isn’t covered* | |
| Limits or exclusions | $10 |
| **The total Mia would pay is** | **$1,610** |