



**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 1-855-836-9705.

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. For <u>participating</u> : <b>\$4,000</b> per individual / <b>\$8,000</b> per family For <u>non-participating</u> : <b>\$7,000</b> per individual / <b>\$14,000</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> , <u>balance-billed</u> charges, 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 plan 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 plan 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 1-855-836-9705	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</u> , <u>preferred</u> , or <u>participating</u> 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> ?	No.	You can see the <u>specialist</u> you choose without permission from this <u>plan</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 7. See your policy or <u>plan</u> document for additional information about <u>excluded services</u> .

**Questions:** Call 1-855-836-9705 or visit us at [www.blueshieldca.com](http://www.blueshieldca.com).

If you aren't clear about any of the underlined terms used in this form, see the Glossary.

You can view the Glossary at [www.cciio.cms.gov](http://www.cciio.cms.gov) or call 1-866-444-3272 to request a copy.

Blue Shield of California is an independent member of the Blue Shield Association. Covered California is a registered trademark of the State of California.



- **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 a **non-participating provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if a **non-participating** 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 **participating providers** by charging you lower **deductibles**, **copayments** and **coinsurance** amounts.

Common Medical Event	Services You May Need	Your Cost If You Use a Participating Provider	Your Cost If You Use a Non-Participating Provider	Limitations & Exceptions
If you visit a health care <u>provider's</u> office or clinic	Primary care visit to treat an injury or illness	\$20 / visit	50% <b>coinsurance</b>	-----None-----
	<b>Specialist</b> visit	\$40 / visit	50% <b>coinsurance</b>	-----None-----
	Other practitioner office visit	\$20 / visit for acupuncture	\$20 / visit for acupuncture	-----None-----
	Preventive care/screening /immunization	No Charge	Not Covered	-----None-----
If you have a test	Diagnostic test (x-ray, blood work)	\$20 / visit for blood work at freestanding lab center \$40 / visit for x-rays at freestanding x-ray center	50% <b>coinsurance</b> at freestanding lab/x-ray center	-----None-----
	Imaging (CT/PET scans, MRIs)	10% <b>coinsurance</b> at freestanding diagnostic center	50% <b>coinsurance</b> at freestanding diagnostic center	-----None-----

**Questions:** Call 1-855-836-9705 or visit us at [www.blueshieldca.com](http://www.blueshieldca.com).

If you aren't clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary at [www.cciio.cms.gov](http://www.cciio.cms.gov) or call 1-866-444-3272 to request a copy.

Common Medical Event	Services You May Need	Your Cost If You Use a <u>Participating Provider</u>	Your Cost If You Use a <u>Non-Participating Provider</u>	Limitations & Exceptions
<p><b>If you need drugs to treat your illness or condition</b></p> <p>More information about <u>prescription drug coverage</u> is available at <a href="http://www.blueshieldca.com">www.blueshieldca.com</a></p>	Generic drugs	\$5 / prescription (retail) \$15 / prescription (mail)	Not Covered	<p>Covers up to a 30-day supply (retail); 31-90 day supply (mail).</p> <p>Select formulary and non-formulary drugs require prior authorization.</p>
	<b><u>Preferred</u></b> brand drugs	\$15 / prescription (retail) \$45 / prescription (mail)	Not Covered	
	<b><u>Non-preferred</u></b> brand drugs	\$25 / prescription (retail) \$75 / prescription (mail)	Not Covered	
	Specialty drugs	10% <u>coinsurance</u>	Not Covered	<p>Covers up to a 30-day supply.</p> <p>Prior authorization is required.</p>
<p><b>If you have outpatient surgery</b></p>	Facility fee (e.g., ambulatory surgery center)	10% <u>coinsurance</u>	50% <u>coinsurance</u>	<p>If service provided by a <b><u>non-participating provider</u></b>, Blue Shield payment is limited to \$300 per day. You pay for all charges in excess of \$300.</p> <p>Prior authorization is required. Failure to prior authorize may result in reduced or nonpayment of benefits.</p>
	Physician/surgeon fees	10% <u>coinsurance</u>	50% <u>coinsurance</u>	-----None-----

**Questions:** Call 1-855-836-9705 or visit us at [www.blueshieldca.com](http://www.blueshieldca.com).

If you aren't clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary at [www.cciio.cms.gov](http://www.cciio.cms.gov) or call 1-866-444-3272 to request a copy.

Common Medical Event	Services You May Need	Your Cost If You Use a <u>Participating Provider</u>	Your Cost If You Use a <u>Non-Participating Provider</u>	Limitations & Exceptions
If you need immediate medical attention	Emergency room services	\$150 / visit	\$150 / visit	-----None-----
	Emergency medical transportation	\$150 / transport	\$150 / transport	-----None-----
	<u>Urgent care</u>	\$40 / visit at freestanding <u>urgent care</u> center	50% <u>coinsurance</u> at freestanding <u>urgent care</u> center	-----None-----
If you have a hospital stay	Facility fee (e.g., hospital room)	10% <u>coinsurance</u>	50% <u>coinsurance</u>	If service provided by a <u>non-participating provider</u> , Blue Shield payment is limited to \$500 per day. You pay for all charges in excess of \$500.  Prior authorization is required. Failure to prior authorize may result in reduced or nonpayment of benefits.
	Physician/surgeon fee	10% <u>coinsurance</u>	50% <u>coinsurance</u>	-----None-----

**Questions:** Call 1-855-836-9705 or visit us at [www.blueshieldca.com](http://www.blueshieldca.com).

If you aren't clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary at [www.cciio.cms.gov](http://www.cciio.cms.gov) or call 1-866-444-3272 to request a copy.

Common Medical Event	Services You May Need	Your Cost If You Use a Participating Provider	Your Cost If You Use a Non-Participating Provider	Limitations & Exceptions
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	\$20 / visit	50% <u>coinsurance</u>	-----None-----
	Mental/Behavioral health inpatient services	10% <u>coinsurance</u>	50% <u>coinsurance</u>	If service provided by a <b>non-participating provider</b> , Blue Shield payment is limited to \$500 per day. You pay for all charges in excess of \$500.  Prior authorization is required. Failure to prior authorize may result in reduced or nonpayment of benefits.
	Substance use disorder outpatient services	\$20 / visit	50% <u>coinsurance</u>	-----None-----
	Substance use disorder inpatient services	10% <u>coinsurance</u>	50% <u>coinsurance</u>	If service provided by a <b>non-participating provider</b> , Blue Shield payment is limited to \$500 per day. You pay for all charges in excess of \$500.  Prior authorization is required. Failure to prior authorize may result in reduced or nonpayment of benefits.
If you are pregnant	Prenatal and postnatal care	No Charge / prenatal visit \$20 / postnatal visit	50% <u>coinsurance</u>	-----None-----
	Delivery and all inpatient services	10% <u>coinsurance</u>	50% <u>coinsurance</u>	If service provided by a <b>non-participating provider</b> , Blue Shield payment is limited to \$500 per day. You pay for all charges in excess of \$500.

**Questions:** Call 1-855-836-9705 or visit us at [www.blueshieldca.com](http://www.blueshieldca.com).

If you aren't clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary at [www.cciio.cms.gov](http://www.cciio.cms.gov) or call 1-866-444-3272 to request a copy.

Common Medical Event	Services You May Need	Your Cost If You Use a Participating Provider	Your Cost If You Use a Non-Participating Provider	Limitations & Exceptions
If you need help recovering or have other special health needs	<u>Home health care</u>	10% <u>coinsurance</u>	Not Covered	Covers up to 100 visits per calendar year. <u>Non-participating home health care</u> and home infusion are not covered unless pre-authorized. When these services are pre-authorized, you pay the <u>participating provider copayment</u> .  Prior authorization is required. Failure to prior authorize may result in reduced or nonpayment of benefits.
	<u>Rehabilitation services</u>	\$20 / visit	50% <u>coinsurance</u>	-----None-----
	<u>Habilitation services</u>	\$20 / visit	50% <u>coinsurance</u>	-----None-----
	<u>Skilled nursing care</u>	10% <u>coinsurance</u> at freestanding SNF	10% <u>coinsurance</u> at freestanding SNF	Covers up to 100 days per benefit period combined with Hospital Skilled Nursing Facility Unit.  Prior authorization is required. Failure to prior authorize may result in reduced or nonpayment of benefits.
	<u>Durable medical equipment</u>	10% <u>coinsurance</u>	50% <u>coinsurance</u>	-----None-----

**Questions:** Call 1-855-836-9705 or visit us at [www.blueshieldca.com](http://www.blueshieldca.com).

If you aren't clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary at [www.cciio.cms.gov](http://www.cciio.cms.gov) or call 1-866-444-3272 to request a copy.

Common Medical Event	Services You May Need	Your Cost If You Use a Participating Provider	Your Cost If You Use a Non-Participating Provider	Limitations & Exceptions
	<u>Hospice service</u>	No Charge	Not Covered	Prior authorization is required. Failure to prior authorize may result in reduced or nonpayment of benefits.
If your child needs dental or eye care	Eye exam	No Charge	Covered up to a maximum allowance of \$30	-----None-----
	Glasses	No Charge	Covered up to a maximum allowance of: \$25 single vision \$35 lined bifocal \$45 lined trifocal \$45 lenticular	-----None-----
	Dental check-up	Not Covered	Not Covered	-----None-----

**Excluded Services & Other Covered Services:**

Services Your <u>Plan</u> Does NOT Cover (This isn't a complete list. Check your policy or <u>plan</u> document for other <u>excluded services</u> .)		
• Chiropractic care	• Infertility treatment	• Routine eye care (Adult)
• Cosmetic surgery	• Long-term care	• Routine foot care
• Dental care (Adult/Child)	• Non-emergency care when traveling outside the U.S.	• Weight loss programs
• Hearing aids	• Private -duty nursing	

**Questions:** Call 1-855-836-9705 or visit us at [www.blueshieldca.com](http://www.blueshieldca.com).

If you aren't clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary at [www.cciio.cms.gov](http://www.cciio.cms.gov) or call 1-866-444-3272 to request a copy.

**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.)

- Acupuncture
- Bariatric surgery

## Your Rights to Continue Coverage:

Federal and State laws may provide protections that allow you to keep this health insurance coverage as long as you pay your premium. There are exceptions, however, such as if:

- You commit fraud
- The insurer stops offering services in the State
- You move outside the coverage area

For more information on your rights to continue coverage, contact the insurer at **1-855-836-9705**. You may also contact your state insurance department at 1-888-466-2219.

## 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: 1-855-836-9705 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>.

## 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.**

**Questions:** Call 1-855-836-9705 or visit us at [www.blueshieldca.com](http://www.blueshieldca.com).

If you aren't clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary at [www.cciio.cms.gov](http://www.cciio.cms.gov) or call **1-866-444-3272** to request a copy.



### 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.*—————

**Questions:** Call 1-855-836-9705 or visit us at [www.blueshieldca.com](http://www.blueshieldca.com).

If you aren't clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary at [www.cciio.cms.gov](http://www.cciio.cms.gov) or call **1-866-444-3272** to request a copy.

## 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** \$6,590
- **Patient pays** \$950

**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>	\$350
<u>Coinsurance</u>	\$450
Limits or exclusions	\$150
<b>Total</b>	<b>\$950</b>

### Managing type 2 diabetes (routine maintenance of a well-controlled condition)

- **Amount owed to providers:** \$5,400
- **Plan pays** \$4,650
- **Patient pays** \$750

**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>	\$540
<u>Coinsurance</u>	\$130
Limits or exclusions	\$80
<b>Total</b>	<b>\$750</b>

**Questions:** Call 1-855-836-9705 or visit us at [www.blueshieldca.com](http://www.blueshieldca.com).

If you aren't clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary at [www.cciio.cms.gov](http://www.cciio.cms.gov) or call 1-866-444-3272 to request a copy.

## 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.

**Questions:** Call 1-855-836-9705 or visit us at [www.blueshieldca.com](http://www.blueshieldca.com).

If you aren't clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary at [www.cciio.cms.gov](http://www.cciio.cms.gov) or call 1-866-444-3272 to request a copy.