Blue Shield: 80-E $20; Rx 7-25

Summary of Benefits and Coverage: What this Plan Covers & What it Costs

Coverage Period: 10/1/2013-9/30/2014

Coverage for: Family | Plan Type: PPO

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/sisc or by calling 1-800-642-6155.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	**$300** individual / **$600** family Preventive Health Services are not subject to Calendar-Year **Deductible**.	You must pay all the costs up to the **deductible** amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the **deductible** starts over (usually, but not always, January 1st). See the chart starting on page 2 for how much you pay for covered services after you meet the **deductible**.
Are there other deductibles for specific services?	No.	You don't have to meet **deductibles** for specific services, but see the chart starting on page 2 for costs for services this plan covers.
Is there an out–of–pocket limit on my expenses?	**$1,000 /** individual **$3,000 /** family	The **out-of-pocket limit** 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 out–of–pocket limit?	Some **copayments**, premiums, balance-billed 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.
Is there an overall annual limit on what the plan pays?	No.	There's no limit on how much you could pay during a coverage period for your share of the cost of covered services.
Does this plan use a network of providers?	Yes. For a list of **preferred providers**, see www.blueshieldca.com/sisc .	If you use an in-network doctor or other health care **provider**, this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an **out-of-network** provider for some services. Plans use the term in-network, **preferred**, or participating for **providers** in their network. See the chart starting on page 2 for how this plan pays different kinds of **providers**.
Do I need a referral to see a specialist?	No.	You can see the **specialist** you choose without permission from this plan.
Are there services this plan doesn't cover?	Yes.	Some of the services this plan doesn't cover are listed on page 6. See your policy or plan document for additional information about **excluded services**.

- **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 an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network 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 **preferred providers** by charging you lower **deductibles**, **copayments** and **coinsurance** amounts.

Common Medical Event	Services You May Need	Your Cost If You Use a Preferred Provider	Your Cost If You Use a Non-Preferred Provider	Limitations & Exceptions
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$20 / visit	50% **coinsurance**	--------------------None--------------------
	Specialist visit	$20 / visit	50% **coinsurance**	--------------------None--------------------
	Other practitioner office visit	20% **coinsurance** for chiropractic	50% **coinsurance** for chiropractic	Up to 20 visits per calendar year.
	Preventive care/screening/immunization	No Charge	Not Covered	--------------------None--------------------
If you have a test	Diagnostic test (x-ray, blood work)	20% **coinsurance** at freestanding lab/x-ray center	50% **coinsurance** at freestanding lab/x-ray center	--------------------None--------------------
	Imaging (CT/PET scans, MRIs)	20% **coinsurance** at freestanding diagnostic center	50% **coinsurance** at freestanding diagnostic center	Prior authorization is required. Failure to prior authorize may result in reduced or nonpayment of benefits.
If you need drugs to treat your illness or condition	Generic drugs	$7 Retail $14 Mail	Member may have greater out of pocket expenses.	Member pays the difference if purchasing a brand name drug when a generic alternative is available. Brand diabetic supplies available at generic copay.
	Preferred brand drugs	$25 Retail $60 Mail		
	Non-preferred brand drugs			
	Specialty drugs			
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% **coinsurance**	No Charge	**Non-Preferred** facilities are subject to a maximum benefit payment up to $350 per day.

Common Medical Event	Services You May Need	Your Cost If You Use a Preferred Provider	Your Cost If You Use a Non-Preferred Provider	Limitations & Exceptions
	Physician/surgeon fees	20% **coinsurance**	50% **coinsurance**	--------------------None--------------------
If you need immediate medical attention	Emergency room services	$100 / visit + 20% **coinsurance**	$100 / visit + 20% **coinsurance**	--------------------None--------------------
	Emergency medical transportation	20% **coinsurance**	20% **coinsurance**	--------------------None--------------------
	Urgent care	$20 / visit at freestanding urgent care center	50% coinsurance	--------------------None--------------------
If you have a hospital stay	Facility fee (e.g., hospital room)	20% **coinsurance**	No Charge	**Non-Preferred** facilities are subject to a maximum benefit payment up to $600 per day. Prior authorization is required. Failure to prior authorize may result in reduced or nonpayment of benefits.
	Physician/surgeon fee	20% **coinsurance**	50% **coinsurance**	--------------------None--------------------
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	$20 / visit	50% **coinsurance**	--------------------None--------------------
	Mental/Behavioral health inpatient services	20% **coinsurance**	No Charge	**Non-Preferred** facilities are subject to a maximum benefit payment up to $600 per day. Prior authorization is required. Failure to prior authorize may result in reduced or nonpayment of benefits.
	Substance use disorder outpatient services	$20 / visit	50% **coinsurance**	--------------------None--------------------
	Substance use disorder inpatient services	20% **coinsurance**	No Charge	**Non-Preferred** facilities are subject to a maximum benefit payment up to $600 per day. Prior authorization is required. Failure to prior authorize may result in reduced or nonpayment of benefits.
If you are pregnant	Prenatal and postnatal care	$20 / visit	50% **coinsurance**	--------------------None--------------------
	Delivery and all inpatient services	20% **coinsurance**	No Charge	--------------------None--------------------

Common Medical Event	Services You May Need	Your Cost If You Use a Preferred Provider	Your Cost If You Use a Non-Preferred Provider	Limitations & Exceptions
If you need help recovering or have other special health needs	Home health care	20% **coinsurance**	Not Covered	Up to 100 prior authorized visits per calendar year. Prior authorization is required. Failure to prior authorize may result in reduced or nonpayment of benefits.
	Rehabilitation services	20% **coinsurance**	50% **coinsurance**	--------------------None---------------------
	Habilitation services	20% **coinsurance**	50% **coinsurance**	--------------------None---------------------
	Skilled nursing care	20% **coinsurance** at freestanding SNF	20% **coinsurance** at freestanding SNF	Up to 100 prior authorized days per calendar year; semi-private accommodations.
	Durable medical equipment	20% **coinsurance**	50% **coinsurance**	Prior authorization is required. Failure to prior authorize may result in reduced or nonpayment of benefits.
	Hospice service	20% **coinsurance**	Not Covered	Prior authorization is required. Failure to prior authorize may result in reduced or nonpayment of benefits. **Coinsurance** may apply for other hospice services.
If your child needs dental or eye care	Eye exam	No Charge	Not Covered	--------------------None---------------------
	Glasses			
	Dental check-up			

Excluded Services & Other Covered Services:

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

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	• Chiropractic care	• Hearing aids
• Bariatric surgery		

Your Rights to Continue Coverage:

If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a **premium**, which may be significantly higher than the premium you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply.

For more information on your rights to continue coverage, contact the plan at **1-800-894-5565**. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa, or the U.S. Department of Health and Human Services at 1-877-267-2323 X 61565 or www.cciio.cms.gov.

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: 1-800-642-6155 or the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or 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 helpline@dmhc.ca.gov or visit http://www.healthhelp.ca.gov.

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, kwiijigo holne' 1-866-346-7198.

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

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** $5740
- **Patient pays** $1800

Sample care costs:

Hospital charges (mother)	$2,700
Routine obstetric care	$2,100
Hospital charges (baby)	$900
Anesthesia	$900
Laboratory tests	$500
Prescriptions	$100
Radiology	$100
Vaccines, other preventive	$40
Total	**$7,540**

Patient pays:

Deductibles	$300
Copays	$300
Coinsurance	$1000
Limits or exclusions	$200
Total	**$1800**

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

- **Amount owed to providers:** $5,400
- **Plan pays** $4200
- **Patient pays** $1200

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
Total	**$5,400**

Patient pays:

Deductibles	$200
Copays	$900
Coinsurance	$0
Limits or exclusions	$100
Total	**$1200**

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-party.

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.