



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 <u>deductible</u> ? | \$100 individual / \$300 family Preventive Health Services are not subject to Calendar-Year <u>Deductible</u> . | You must pay all the costs up to the <u>deductible</u> amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the <u>deductible</u> 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 <u>deductible</u> . |
| 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 costs for services this plan covers. |
| Is there an <u>out-of-pocket limit</u> on my expenses? | \$300 / individual \$900 / 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> ? | Some <u>copayments</u> , 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 <u>network of providers</u> ? | Yes. For a list of <u>preferred providers</u> , see www.blueshieldca.com/sisc . | If you use an in-network doctor or other health care <u>provider</u> , this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an <u>out-of-network</u> provider for some services. Plans use the term in-network, <u>preferred</u> , or participating for <u>providers</u> in their network. See the chart starting on page 2 for how this plan 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 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 <u>excluded services</u> . |

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- **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 | \$10 / visit | 50% coinsurance | -----None----- |
| | Specialist visit | \$10 / visit | 50% coinsurance | -----None----- |
| | Other practitioner office visit | 10% 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) | 10% coinsurance at freestanding lab/x-ray center | 50% coinsurance at freestanding lab/x-ray center | -----None----- |
| | Imaging (CT/PET scans, MRIs) | 10% 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) | 10% coinsurance | No Charge | Non-Preferred facilities are subject to a maximum benefit payment up to \$350per day. |

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Blue Shield: 90-A \$10; 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

| 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 | 10% <u>coinsurance</u> | 50% <u>coinsurance</u> | -----None----- |
| If you need immediate medical attention | Emergency room services | \$100 / visit + 10% <u>coinsurance</u> | \$100 / visit + 10% <u>coinsurance</u> | -----None----- |
| | Emergency medical transportation | 10% <u>coinsurance</u> | 10% <u>coinsurance</u> | -----None----- |
| | Urgent care | \$10 / visit at freestanding urgent care center | 50% <u>coinsurance</u> | -----None----- |
| If you have a hospital stay | Facility fee (e.g., hospital room) | 10% <u>coinsurance</u> | 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 | 10% <u>coinsurance</u> | 50% <u>coinsurance</u> | -----None----- |
| If you have mental health, behavioral health, or substance abuse needs | Mental/Behavioral health outpatient services | \$10 / visit | 50% <u>coinsurance</u> | -----None----- |
| | Mental/Behavioral health inpatient services | 10% <u>coinsurance</u> | 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 | \$10 / visit | 50% <u>coinsurance</u> | -----None----- |
| | Substance use disorder inpatient services | 10% <u>coinsurance</u> | 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 | \$10 / visit | 50% <u>coinsurance</u> | -----None----- |
| | Delivery and all inpatient services | 10% <u>coinsurance</u> | No Charge | -----None----- |

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

Coverage for: Family | Plan Type: PPO

| 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 | 10% <u>coinsurance</u> | 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 | 10% <u>coinsurance</u> | 50% <u>coinsurance</u> | -----None----- |
| | Habilitation services | 10% <u>coinsurance</u> | 50% <u>coinsurance</u> | -----None----- |
| | Skilled nursing care | 10% <u>coinsurance</u> at freestanding SNF | 10% <u>coinsurance</u> at freestanding SNF | Up to 100 prior authorized days per calendar year; semi-private accommodations. |
| | Durable medical equipment | 10% <u>coinsurance</u> | 50% <u>coinsurance</u> | Prior authorization is required. Failure to prior authorize may result in reduced or nonpayment of benefits. |
| | Hospice service | 10% <u>coinsurance</u> | Not Covered | Prior authorization is required. Failure to prior authorize may result in reduced or nonpayment of benefits. <u>Co-insurance</u> 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 | | | |

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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>.

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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.*—————

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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 \$6740
- Patient pays \$800

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 |
| Total | \$7,540 |

Patient pays:

| | |
|----------------------|--------------|
| Deductibles | \$100 |
| Copays | \$200 |
| Coinsurance | \$300 |
| Limits or exclusions | \$200 |
| Total | \$800 |

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

- Amount owed to providers: \$5,400
- Plan pays \$4390
- Patient pays \$1010

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 | \$100 |
| Copays | \$800 |
| Coinsurance | \$10 |
| Limits or exclusions | \$100 |
| Total | \$1010 |

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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.

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