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?	**$0** per individual/ **$0** per family Does not apply to preventative care and prescription drugs.	See the chart starting on page 2 for your costs for services this plan covers.
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 other costs for services this plan covers.
Is there an out–of–pocket limit on my expenses?	Yes. **$1,500** per individual / **$3,000** per family for medical only.	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?	Premiums, some copayments, cost sharing for certain services listed in formal contract of coverage, 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.	The chart starting on page 2 describes any limits on what the plan will pay for *specific* covered services, such as office Visits.
Does this plan use a network of providers?	Yes. For a list of **providers**, see www.blueshieldca.com/sisc **or call 1-800-642-6155** for a list of plan providers.	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?	Yes. However members may self-refer using the Access+ Self-Referral feature.	This plan will pay some or all of the costs to see a **specialist** for covered services but only if you have the plan's permission before you see the **specialist**.
Are there services this plan doesn't cover?	Yes.	Some of the services this plan doesn't cover are listed on page 9. See your policy or plan document for additional information about **excluded services**.

Questions: Call **1-800-642-6155** or visit us at www.blueshieldca.com/sisc**.** 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.dol.gov/ebsa/healthreform or call **1-866-444-3272** to request a copy.

- **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 **in-network providers** by charging you lower **deductibles**, **copayments** and **coinsurance** amounts.

Common Medical Event	Services You May Need	Your Cost If You Use an In-Network Provider	Your Cost If You Use an Out-of-Network 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	Not Covered	--------none--------
	Specialist Visit	$20 / visit	Not Covered	$30 / visit for Access+ Specialist Self-Referral.
	Other practitioner office Visit	$10/visit for chiropractic and acupuncture	Not Covered	Up to 30 combined visits per calendar year.
	Preventive care/screening/immunization	No Cost Share	Not Covered	Pre-authorization from primary care physician and medical plan is required. Failure to obtain pre-authorization for non-emergency procedures may result in reduction or non-payment of benefits.
If you have a test	Diagnostic test (x-ray, blood work)	No Cost Share	Not Covered	
	Imaging (CT/PET scans, MRIs)	No Cost Share	Not Covered	

Common Medical Event	Services You May Need	Your Cost If You Use an In-Network Provider	Your Cost If You Use an Out-of-Network Provider	Limitations & Exceptions
If you need drugs to treat your illness or condition **More information about prescription drug coverage is available at www.navitus.com**	Generic drugs	Retail 30-Days: Costco: $0/Rx Other: $9/Rx Mail 90-Days: $0/Rx	Member must pay the entire cost up front and apply for reimbursement. Net cost may be greater than if member uses an In-network provider.	Some narcotic pain medications and cough medications require the regular retail copay at Costco and 3 times the regular copay at Mail.
	Brand drugs	Brand: Retail 30-Days: Costco: $35/Rx Other: $35/Rx Mail 90-Days: $90/Rx Specialty: 30-Days: $35/Rx		If a brand drug is dispensed when a generic equivalent is available, then the member will be responsible for the generic copayment plus the cost difference between the generic and brand.
	Specialty drugs		Not Covered	Member must use Navitus Specialty Rx. Supplies of more than 30 days are not allowed
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	$100 / surgery	Not Covered	--------none--------
	Physician/surgeon fees	No Cost Share	Not Covered	--------none--------

Common Medical Event	Services You May Need	Your Cost If You Use an In-Network Provider	Your Cost If You Use an Out-of-Network Provider	Limitations & Exceptions
If you need immediate medical attention	Emergency room services	$100 / visit	$100 / visit	This is for the hospital/facility charge only; copay waived if admitted. Failure to prior authorize **out-of-network provider** services may result in reduced or nonpayment of benefits. The ER physician charge may be separate.
	Emergency medical transportation	$100 Copay/Trip	$100 Copay/Trip	--------none--------
	Urgent care (outside of service area)	$20 / visit	Not Covered	If you are within the service area, contact your PCP or medical group. Costs may vary by site of service.
If you have a hospital stay	Facility fee (e.g., hospital room)	$250 / admit	Not Covered	--------none--------
	Physician/surgeon fee	No Cost Share	Not Covered	--------none--------
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	Office Visit: $20 / visit	Not Covered	Pre-authorization from Mental Health Service Administrator (MHSA) is required. Failure to obtain pre-authorization may result in reduction or non-payment of benefits.
	Mental/Behavioral health inpatient services	$250 / admit	Not Covered	
	Substance use disorder outpatient services	Office Visit: $20 / visit	Not Covered	
	Substance use disorder inpatient services	$250 / admit	Not Covered	
If you are pregnant	Prenatal and postnatal care	$20 / visit	Not Covered	--------none--------
	Delivery and all inpatient services	$250 / admit	Not Covered	--------none--------

Common Medical Event	Services You May Need	Your Cost If You Use an In-Network Provider	Your Cost If You Use an Out-of-Network Provider	Limitations & Exceptions
If you need help recovering or have other special health needs	Home health care	$20 / visit	Not Covered	Coverage limited to 100 visits per member per calendar year. Failure to obtain pre-authorization for non-emergency procedures may result in reduction or non-payment of benefits.
	Rehabilitation services	$20 / visit	Not Covered	Coverage for physical, occupational and respiratory therapy services. Failure to obtain pre-authorization may result in reduction or non-payment of benefits.
	Habilitation services	$20 / visit	Not Covered	
	Skilled nursing care	$100 / day	Not Covered	Coverage limited to 100 days per member per benefit period combined with hospital/free-standing SNF. Failure to obtain pre-authorization may result in reduction or non-payment of benefits.
	Durable medical equipment	20%	Not Covered	Failure to obtain pre-authorization may result in reduction or non-payment of benefits.
	Hospice service	No Cost Share	Not Covered	Copayment may apply for other hospice services. Failure to obtain pre-authorization may result in reduction or non-payment of benefits.
If your child needs dental or eye care	Eye exam	Not Covered	Not Covered	Coverage for services consistent with Blue Shield of California's Preventive Health Guidelines. Please refer to you plan contract for details.
	Glasses	Not Covered	Not Covered	--------none--------
	Dental check-up	Not Covered	Not Covered	--------none--------

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
- Dental care (Adult)
- Long-term care
- Private-duty nursing
- Routine eye care (Adult)
- Routine foot care (unless you have been diagnosed with diabetes. Consult your formal contract of coverage)
- Weight loss programs

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.)

- Bariatric surgery (For morbid obesity. Consult your formal contract of coverage)
- Hearing Aid Rider (**50%** Coinsurance)
- Acupuncture or Chiropractic Care Through Self-Referral
- Infertility treatment (coverage limited to diagnosis and treatment of cause of infertility)

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 1-855-333-5730. 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 x61565 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 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.**

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** $7,040
- **Patient pays** $500

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	$0
Copays	$300
Coinsurance	$0
Limits or exclusions	$200
Total	**$500**

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

- **Amount owed to providers:** $5,400
- **Plan pays** $4,180
- **Patient pays** $1,220

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	$0
Copays	$1,100
Coinsurance	$20
Limits or exclusions	$100
Total	**$1,220**

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.

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.