**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 or by calling 1-800-642-6155.

| Important Questions | Answers | Why this Matters: |
|---|---|---|
| **What is the overall deductible?** | **$5,000** per individual / **$10,000** per family<br>Does not apply to preventive care. | 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 other costs for services this **plan** covers. |
| **Is there an out–of–pocket limit on my expenses?** | Yes.<br>**$6,350** per individual / **$12,700** per 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?** | **Premiums**, **balance-billed** charges, some **copayments**, 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 **preferred providers**, see **www.blueshieldca.com/sisc** or call **1-800-642-6155** | 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 | $60 / visit (for the 1st 3 visits, thereafter 30%) **coinsurance** ($60 /visit – Not subject to the Calendar Year Deductible) | 50% **coinsurance** | ----------None---------- |
| | **Specialist** visit | $60 / visit (for the 1st 3 visits, thereafter 30%) **coinsurance** ($60 /visit – Not subject to the Calendar Year Deductible) | 50% **coinsurance** | ----------None---------- |
| | Other practitioner office visit | 30% **coinsurance** for chiropractic<br>30% **coinsurance** for acupuncture | 50% **coinsurance** for chiropractic<br>50% **coinsurance** for acupuncture | Chiropractic: Covers up to 20 visits per calendar year.<br>Acupuncture: Covers up to 12 visits per calendar year. |
| | Preventive care/screening /immunization | No Charge | Not Covered | ----------None---------- |
| **If you have a test** | Diagnostic test (x-ray, blood work) | 30% **coinsurance** at freestanding lab/x-ray center | 50% **coinsurance** at freestanding lab/x-ray center | ----------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 |
|---|---|---|---|---|
| | Imaging (CT/PET scans, MRIs) | 30% **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**<br><br>More information about **prescription drug coverage** is available at www.blueshieldca.com/sisc. | Generic drugs | $9 / prescription (Retail)<br>$18 / prescription (Mail Service) | $9 /prescription (Retail)<br>Not Covered (Mail Service) | Covers up to a 30-day supply (retail prescriptions).<br><br>Covers up to a 90-day supply (mail service prescriptions)<br><br>Selected formulary drugs require prior authorization. |
| | **Preferred** brand drugs | $35 / prescription (Retail)<br>$90/prescription (Mail Service) | $35 / prescription (Retail)<br>Not Covered (Mail Service) | |
| | **Non-preferred** brand drugs | $35 / prescription (Retail)<br>$90/prescription (Mail Service) | $35 / prescription (Retail)<br>Not Covered (Mail Service) | |
| | Specialty drugs | $35 / prescription | Not Covered | Covers up to a 30-day supply. Prior authorization may be required. |
| **If you have outpatient surgery** | Facility fee (e.g., ambulatory surgery center) | 30% **coinsurance** | 0% **coinsurance** with $350/day max | **Non-Preferred** ASC's are subject to a maximum **plan** payment up to $350 per day. |
| | Physician/surgeon fees | 30% **coinsurance** | 50% **coinsurance** | ----------None---------- |
| **If you need immediate medical attention** | Emergency room services | $100 / visit<br>+ 30% **coinsurance** | $100 / visit<br>+ 30% **coinsurance** | ----------None---------- |
| | Emergency medical transportation | 30% **coinsurance** | 30% **coinsurance** | ----------None---------- |
| | **Urgent care** | 30% **coinsurance** at freestanding **urgent care** center | 50% **coinsurance** | ----------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 have a hospital stay** | Facility fee (e.g., hospital room) | 30% **coinsurance** | 0% **coinsurance** with $600/day max | The maximum **plan** payment for non-emergency hospital services received from a **non-preferred** hospital is $600 per day. Members are responsible for all charges in excess of $600. Prior authorization is required. Failure to prior authorize may result in reduced or nonpayment of benefits. |
| | Physician/surgeon fee | 30% **coinsurance** | 50% **coinsurance** | ----------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 have mental health, behavioral health, or substance abuse needs** | Mental/Behavioral health outpatient services | $60 / visit (for the 1st 3 visits, thereafter 30%) **coinsurance** ($60 / visit – Not subject to the Calendar Year Deductible) | 50% **coinsurance** | ----------None---------- |
| | Mental/Behavioral health inpatient services | 30% **coinsurance** | 0% **coinsurance** with $600/day max | The maximum **plan** payment for non-emergency hospital services received from a **non-preferred** hospital is $600 per day. Members are responsible for all charges in excess of $600. Prior authorization is required. Failure to prior authorize may result in reduced or nonpayment of benefits. |
| | Substance use disorder outpatient services | $60 / visit (for the 1st 3 visits, thereafter 30%) **coinsurance** ($60 /visit – Not subject to the Calendar Year Deductible) | 50% **coinsurance** | ----------None---------- |
| | Substance use disorder inpatient services | 30% **coinsurance** | 0% **coinsurance** with $600/day max | The maximum **plan** payment for non-emergency hospital services received from a **non-preferred** hospital is $600 per day. Members are responsible for all charges in excess of $600. Prior authorization is required. Failure to prior authorize may result in reduced or nonpayment of benefits. |
| **If you are pregnant** | Prenatal and postnatal care | 30% **coinsurance** | 50% **coinsurance** | ----------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 |
|---|---|---|---|---|
| | Delivery and all inpatient services | 30% **coinsurance** | 0% **coinsurance** with $600/day max | **Non-Preferred** facility are subject to a maximum benefit payment up to $600 per day. |
| **If you need help recovering or have other special health needs** | **Home health care** | 30% **coinsurance** | Not Covered | Covers up to 100 visits per calendar year. **Non-preferred home health care** and home infusion are not covered unless pre-authorized. When these services are pre-authorized, you pay the **preferred provider copayment**. Prior authorization is required. Failure to prior authorize may result in reduced or nonpayment of benefits. |
| | **Rehabilitation services** | 30% **coinsurance** | 50% **coinsurance** | ----------None---------- |
| | **Habilitation services** | 30% **coinsurance** | 50% **coinsurance** | ----------None---------- |
| | **Skilled nursing care** | 30% **coinsurance** at freestanding SNF | 30% **coinsurance** at freestanding SNF | Covers up to 100 days per calendar year combined with Hospital Skilled Nursing Facility Unit. Prior authorization is required. Failure to prior authorize may result in reduced or nonpayment of benefits. |
| | **Durable medical equipment** | 30% **coinsurance** | 50% **coinsurance** | Prior authorization is required. Failure to prior authorize may result in reduced or nonpayment of benefits. |
| | **Hospice service** | 30% **coinsurance** | 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 | Not Covered | ----------None---------- |
| | Glasses | | | |

| 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 |
|---|---|---|---|---|
| | 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
- Dental care (Adult/Child)
- Infertility treatment
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Private -duty nursing
- Routine eye care (Adult/Child)
- Routine foot care
- Services not deemed **medically necessary**
- 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.)**

- Acupuncture
- Bariatric surgery
- Chiropractic care
- Hearing aids

## 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 **1-800-642-6155**. 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 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** $1,540
- **Patient pays** $6,000

**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** | $5,000 |
| **Copays** | $200 |
| **Coinsurance** | $600 |
| Limits or exclusions | $200 |
| **Total** | **$6,000** |

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

- **Amount owed to providers:** $5,400
- **Plan pays** $400
- **Patient pays** $5,000

**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** | $4,700 |
| **Copays** | $200 |
| **Coinsurance** | $0 |
| Limits or exclusions | $100 |
| **Total** | **$5,000** |

# 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 1-800-642-6155 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.cciio.cms.gov or call **1-866-444-3272** to request a copy.