



The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately.

This is only a summary. For more information, see the Benefit Booklet for this coverage option or call 1-888-772-1076. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms see the Glossary. You can view the Glossary at <http://www.healthcare.gov/sbc-glossary> or call 1-866-444-3272 to request a copy.

Important Questions	Answers	Why This Matters:
<u>What is the overall deductible?</u>	For <u>network providers</u> and <u>out-of-network providers</u> \$1,000/individual or \$2,000/family	Generally, you must pay all of the costs from <u>providers</u> up to the <u>deductible</u> amount before this <u>plan</u> begins to pay. If you have other family members on the <u>plan</u> each family member must meet their own individual <u>deductible</u> until the total amount of <u>deductible</u> expenses paid by all family members meets the overall family <u>deductible</u> .
<u>Are there services covered before you meet your deductible?</u>	Yes. Some <u>preventive care</u> is covered before you meet your <u>deductible</u> .	This plan covers some preventive care without cost-sharing and before you meet your deductible. See the Benefit Booklet for more details. The full list of preventive care services is found at https://www.healthcare.gov/coverage/preventive-care-benefits/ , but not all of the listed preventive care services are covered by this plan.
<u>Are there other deductibles for specific services?</u>	No.	You don't have to meet <u>deductibles</u> for specific services.
<u>What is the out-of-pocket limit for this plan?</u>	For <u>network providers</u> \$5,000/individual or \$10,000/family; for <u>out-of-network providers</u> \$10,000/individual or \$20,000/family	The <u>out-of-pocket limit</u> is the most you could pay in a year for covered services. If you have other family members in this <u>plan</u> , they have to meet their own <u>out-of-pocket limits</u> until the overall family <u>out-of-pocket limit</u> has been met.
<u>What is not included in the out-of-pocket limit?</u>	<u>Copayments</u> on certain services, <u>premiums</u> , <u>balance-billing</u> charges, 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> .
<u>Will you pay less if you use a network provider?</u>	Yes. See blueshieldca.com/fad or call 1-888-772-1076 for a list of <u>network providers</u> .	This <u>plan</u> uses a <u>provider network</u> . You will pay less if you use a <u>provider</u> in the <u>plan's</u> network. You will pay the most if you use an <u>out-of-network provider</u> , and you might receive a bill from a <u>provider</u> for the difference between the <u>provider's</u> charge and what your <u>plan</u> pays (<u>balance billing</u>). Be aware, your <u>network provider</u> might use an <u>out-of-network provider</u> for some services (such as lab work). Check with your <u>provider</u> before you get services.
<u>Do you need a referral to see a specialist?</u>	No.	You can see the <u>specialist</u> you choose without a <u>referral</u> .



All copayment and coinsurance costs shown in this chart are after your deductible has been met, if a deductible applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	\$25/visit; <u>deductible</u> does not apply	40% <u>coinsurance</u>	None
	<u>Specialist</u> visit	\$40/visit; <u>deductible</u> does not apply	40% <u>coinsurance</u>	
	<u>Preventive care/screening</u> /immunization	No Charge; <u>deductible</u> does not apply	40% <u>coinsurance</u>	You may have to pay for services that are not preventive care. Ask your provider if the services needed are preventive care. Then check what the plan will pay for because not all preventive care services are paid for by this plan.
If you have a test	<u>Diagnostic test</u> (x-ray, blood work)	<u>Lab & Pathology</u> : 20% <u>coinsurance</u> <u>X-Ray & Imaging</u> : 20% <u>coinsurance</u> <u>Other Diagnostic Examination</u> : 20% <u>coinsurance</u>	<u>Lab & Pathology</u> : 40% <u>coinsurance</u> <u>X-Ray & Imaging</u> : 40% <u>coinsurance</u> <u>Other Diagnostic Examination</u> : 40% <u>coinsurance</u>	
	Imaging (CT/PET scans, MRIs)	<u>Outpatient Radiology Center</u> : No Charge <u>Outpatient Hospital</u> : 20% <u>coinsurance</u>	<u>Outpatient Radiology Center</u> : 40% <u>coinsurance</u> <u>Outpatient Hospital</u> : 40% <u>coinsurance</u>	<u>Preadmission</u> is required. Failure to obtain <u>preadmission</u> may result in non-payment of benefits.
If you need drugs to treat your illness or condition. More information about prescription drug coverage is available at www.caremark.com	Generic drugs	\$10 <u>copay</u> /prescription 30-day supply (retail) \$20 <u>copay</u> /prescription 60-day supply (retail) \$30 <u>copay</u> /prescription 61-90 day supply (retail) \$20 <u>copay</u> /prescription (mail order)	Not covered	You can use Caremark mail order to fill your prescription for 90 days at the cost of only 2 times the copay that would apply to a 30-day retail supply. 30-day, 60-day, 90-day supply limit for retail. 90-day supply limit for mail order. Specialty Medications must be filled at

* For more information about limitations and exceptions, see the Benefit Booklet

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Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need drugs to treat your illness or condition Sign up at www.caremark.com to check your specific drug coverage and costs or call 1-800-844-0719	Brand formulary drugs	\$30 <u>copay</u> /prescription 30-day supply (retail) \$60 <u>copay</u> /prescription 60-day supply (retail) \$90 <u>copay</u> /prescription 61-90 day supply (retail) \$60 <u>copay</u> /prescription (mail order)	Not covered	CVS Specialty Pharmacy. Visit CVSSpecialty.com or call Specialty Customer Care at 1-800-237-2767. 30-day supply limit for Specialty.
	Brand non-formulary drugs	\$50 <u>copay</u> /prescription 30-day supply (retail) \$100 <u>copay</u> /prescription 60-day supply (retail) \$150 <u>copay</u> /prescription 61-90 day supply (retail) \$100 <u>copay</u> /prescription (mail order)	Not covered	
	Specialty drugs	\$50/prescription	Not Covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	<i>Ambulatory Surgery Center:</i> No Charge <i>Outpatient Hospital:</i> 20% <u>coinsurance</u>	<i>Ambulatory Surgery Center:</i> 40% <u>coinsurance</u> <i>Outpatient Hospital:</i> 40% <u>coinsurance</u>	None
	Physician/surgeon fees	20% <u>coinsurance</u>	40% <u>coinsurance</u>	
If you need immediate medical attention	<u>Emergency room care</u>	<i>Facility Fee:</i> \$200/visit + 20% <u>coinsurance</u> ; <u>deductible</u> does not apply <i>Physician Fee:</i> 20% <u>coinsurance</u> ; <u>deductible</u> does not apply	<i>Facility Fee:</i> \$200/visit + 20% <u>coinsurance</u> ; <u>deductible</u> does not apply <i>Physician Fee:</i> 20% <u>coinsurance</u> ; <u>deductible</u> does not apply	None
	<u>Emergency medical transportation</u>	20% <u>coinsurance</u>	20% <u>coinsurance</u>	This payment is for emergency or authorized transport.
	<u>Urgent care</u>	\$75/visit; <u>deductible</u> does not apply	\$75/visit; <u>deductible</u> does not apply	None
If you have a hospital stay	Facility fee (e.g., hospital room)	20% <u>coinsurance</u>	40% <u>coinsurance</u>	<u>Preauthorization</u> is required. Failure to obtain <u>preauthorization</u> may result in non-payment of benefits.

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Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you have a hospital stay	Physician/surgeon fees	20% <u>coinsurance</u>	40% <u>coinsurance</u>	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	<u>Office Visit: \$25/visit; deductible does not apply</u> <u>Other Outpatient Services: 20% coinsurance</u> <u>Partial Hospitalization: 20% coinsurance</u> <u>Psychological Testing: 20% coinsurance</u>	<u>Office Visit: 40% coinsurance</u> <u>Other Outpatient Services: 40% coinsurance</u> <u>Partial Hospitalization: 40% coinsurance</u> <u>Psychological Testing: 40% coinsurance</u>	<u>Preauthorization</u> is required except for office visits and office-based opioid treatment. Failure to obtain <u>preauthorization</u> may result in non-payment of benefits.
	Inpatient services	<u>Physician Inpatient Services: 20% coinsurance</u> <u>Hospital Services: 20% coinsurance</u> <u>Residential Care: 20% coinsurance</u>	<u>Physician Inpatient Services: 40% coinsurance</u> <u>Hospital Services: 40% coinsurance</u> <u>Residential Care: 40% coinsurance</u>	<u>Preauthorization</u> is required. Failure to obtain <u>preauthorization</u> may result in non-payment of benefits.
	Office visits	No Charge	40% <u>coinsurance</u>	Maternity care may include tests and services described elsewhere in this document (e.g. ultrasound).
If you are pregnant	Childbirth/delivery professional services	20% <u>coinsurance</u>	40% <u>coinsurance</u>	
	Childbirth/delivery facility services	20% <u>coinsurance</u>	40% <u>coinsurance</u>	
	Home health care	20% <u>coinsurance</u>	40% <u>coinsurance</u>	
If you need help recovering or have other special health needs	Rehabilitation services	<u>Office Visit: \$40/visit; deductible does not apply</u> <u>Outpatient Hospital: 20% coinsurance</u>	<u>Office Visit: 40% coinsurance</u> <u>Outpatient Hospital: 40% coinsurance</u>	None

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Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need help recovering or have other special health needs	<u>Habilitation services</u>	<i>Office Visit: \$40/visit; deductible does not apply</i> <i>Outpatient Hospital: 20% coinsurance</i>	<i>Office Visit: 40% coinsurance</i> <i>Outpatient Hospital: 40% coinsurance</i>	None
	<u>Skilled nursing care</u>	<i>Freestanding Skilled Nursing Facility: 20% coinsurance</i> <i>Hospital-based Skilled Nursing Facility: 20% coinsurance</i>	<i>Freestanding Skilled Nursing Facility: 40% coinsurance</i> <i>Hospital-based Skilled Nursing Facility: 40% coinsurance</i>	<u>Preauthorization</u> is required. Failure to obtain <u>preauthorization</u> may result in non-payment of benefits. Coverage limited to 120 days per member per Plan Year.
	<u>Durable medical equipment</u>	20% <u>coinsurance</u>	40% <u>coinsurance</u>	<u>Preauthorization</u> is required. Failure to obtain <u>preauthorization</u> may result in non-payment of benefits.
	<u>Hospice services</u>	20% <u>coinsurance</u>	40% <u>coinsurance</u>	<u>Preauthorization</u> is required except for pre-hospice consultation. Failure to obtain <u>preauthorization</u> may result in non-payment of benefits.
If your child needs dental or eye care	Children's eye exam	Not Covered	Not Covered	None
	Children's glasses	Not Covered	Not Covered	
	Children's dental check-up	Not Covered	Not Covered	

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Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your Benefit Booklet for more information and a list of any other excluded services.)

• Alteration or reshaping body structures or tissues (other than reconstructive surgery)	• Eye surgery	• Religious, personal growth counseling or marriage counseling
• Abortion procedures	• Gender reassignment services	• Routine eye care (Adult and child)
• Artificial insemination	• Genetic testing	• Routine foot care
• Assisted conception services	• Hearing Aids	• Sex reassignment services
• Assisted suicide and euthanasia	• Infertility treatment	• Sterilization
• Contraceptives	• Long-term care	• Third generation dependents
• Cosmetic surgery	• Non-emergency care when traveling outside the U.S.	• Treatments using tissue from aborted fetuses or embryonic cells
• Dental care (Adult and child)	• Non-medically necessary services	• Weight loss drugs used or prescribed for weight loss or weight control
• Experimental or investigational services	• Private-duty nursing	• Weight loss programs

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

• Acupuncture	• Bariatric surgery	• Chiropractic Care
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Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is shown in the chart below. Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318-2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice or assistance, contact: the agencies in the chart below.

Contact Information for Your Rights to Continue Coverage & Your Grievance and Appeals Rights:

Reta Customer Service	1-877-303-7382
Blue Shield Customer Service	1-888-772-1076
Department of Labor's Employee Benefits Security Administration	1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform

* For more information about limitations and exceptions, see the Benefit Booklet

Does this plan provide Minimum Essential Coverage? Yes

Minimum Essential Coverage generally includes plans, health insurance available through the Marketplace or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of Minimum Essential Coverage, you may not be eligible for the premium tax credit.

Does this plan meet the Minimum Value Standards? Yes

If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al 1-866-346-7198

Tagalog (Tagalog): Kung kailanganninyo ang tulongsa Tagalog tumawag sa 1-866-346-7198

Traditional 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, kwijjigo holne' 1-866-346-7198

Pennsylvania Dutch (Deitsch): Fer Hilf griege in Deitsch, ruf 1-866-346-7198

Samoan (Gagana Samoa): Mo se fesoasoani i le Gagana Samoa, vala'au mai i le numera telefoni 1-866-346-7198

Carolinian (Kapasal Falawasch): ngere aukke ghut alillis reel kapasal Falawasch au fafaingi tilifon ye t 1-866-346-7198

Chamorro (Chamoru): Para un ma ayuda gi finu Chamoru, å'gang 1-866-346-7198

Your health benefits will be self-insured by your Plan sponsor. Blue Shield of California will provide certain administrative services for the Plan and will not be an insurer of the Plan or financially liable for health care benefits under the Plan.

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

* For more information about limitations and exceptions, see the Benefit Booklet

About these Coverage Examples:



This is not a cost estimator. Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby

(9 months of participating pre-natal care and a hospital delivery)

■ The <u>plan's</u> overall <u>deductible</u>	\$1,000
■ <u>Specialist copayment</u>	\$40
■ <u>Hospital (facility) coinsurance</u>	20%
■ <u>Other coinsurance</u>	20%

This EXAMPLE event includes services like:

Specialist office visits (*prenatal care*)
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic tests (*ultrasounds and blood work*)
Specialist visit (*anesthesia*)

Total Example Cost	\$12,687
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In this example, Peg would pay:

Cost Sharing	
<u>Deductibles</u>	\$1,000
<u>Copayments</u>	\$10
<u>Coinsurance</u>	\$2,314

What isn't covered

Limits or exclusions	\$61
The total Peg would pay is	\$3,385

Managing Joe's Type 2 Diabetes

(a year of routine participating care of a well-controlled condition)

■ The <u>plan's</u> overall <u>deductible</u>	\$1,000
■ <u>Specialist copayment</u>	\$40
■ <u>Hospital (facility) coinsurance</u>	20%
■ <u>Other coinsurance</u>	20%

This EXAMPLE event includes services like:

Primary care physician office visits (*including disease education*)
Diagnostic tests (*blood work*)
Prescription drugs
Durable medical equipment (*glucose meter*)

Total Example Cost	\$5,600
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In this example, Joe would pay:

Cost Sharing	
<u>Deductibles</u>	\$912
<u>Copayments</u>	\$555
<u>Coinsurance</u>	\$0

What isn't covered

Limits or exclusions	\$22
The total Joe would pay is	\$1,489

Mia's Simple Fracture

(participating emergency room visit and follow up care)

■ The <u>plan's</u> overall <u>deductible</u>	\$1,000
■ <u>Specialist copayment</u>	\$40
■ <u>Hospital (facility) coinsurance</u>	20%
■ <u>Other coinsurance</u>	20%

This EXAMPLE event includes services like:

Emergency room care (*including medical supplies*)
Diagnostic test (*x-ray*)
Durable medical equipment (*crutches*)
Rehabilitation services (*physical therapy*)

Total Example Cost	\$2,800
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In this example, Mia would pay:

Cost Sharing	
<u>Deductibles</u>	\$1,000
<u>Copayments</u>	\$405
<u>Coinsurance</u>	\$178

What isn't covered

Limits or exclusions	\$00
The total Mia would pay is	\$1,583

The plan would be responsible for the other costs of these EXAMPLE covered services.

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