**Summary of Benefits and Coverage:** What this Plan Covers & What You Pay For Covered Services

**Custom Access+ HMO® Per Admit 20-250**

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 about your coverage, or to get a copy of the complete terms of coverage, visit [bsca.com/policies/W0067301-M0021761EOC_COI202001.pdf](http://www.bscabook.com/W0067301-M0021761EOC_COI202001.pdf) or call 1-855-599-2650. 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 healthcare.gov/sbc-glossary or call 1-866-444-3272 to request a copy.

### Important Questions | Answers | Why This Matters:
--- | --- | ---
What is the overall deductible? | $0. | See the Common Medical Events chart below for your costs for services this plan covers.

Are there services covered before you meet your deductible? | Yes. Preventive care and services listed in your complete terms of coverage. | This plan covers some items and services even if you haven’t yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost-sharing and before you meet your deductible. See a list of covered preventive services at healthcare.gov/coverage/preventive-care-benefits.

Are there other deductibles for specific services? | No. | You don’t have to meet deductibles for specific services.

What is the out-of-pocket limit for this plan? | $2,000 per individual / $4,000 per family for participating providers. | The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.

What is not included in the out-of-pocket limit? | Copayments for certain services, premiums, and health care this plan doesn’t cover. | Even though you pay these expenses, they don’t count toward the out-of-pocket limit.

Will you pay less if you use a network provider? | Yes. See blueshieldca.com/fad or call 1-855-599-2650 for a list of network providers. | This plan uses a provider network. You will pay less if you use a provider in the plan’s network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider’s charge and what your plan pays (balance billing). Be aware, your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.

Do you need a referral to see a specialist? | Yes. | This plan will pay some or all of the costs to see a specialist for covered services but only if you have a referral before you see the specialist.
All **copayment** and **coinsurance** costs shown in this chart are after your **deductible** has been met, if a **deductible** applies.

<table>
<thead>
<tr>
<th>Common Medical Event</th>
<th>Services You May Need</th>
<th>Participating Provider (You will pay the least)</th>
<th>Non-Participating Provider (You will pay the most)</th>
<th>Limitations, Exceptions, &amp; Other Important Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>If you visit a health care provider’s office or clinic</td>
<td>Primary care visit to treat an injury or illness</td>
<td>$20/visit</td>
<td>Not Covered</td>
<td>----------------------None------------------------</td>
</tr>
<tr>
<td></td>
<td>Specialist visit</td>
<td>Access+ Specialist: $40/visit Other Specialist: $20/visit</td>
<td>Not Covered</td>
<td>Self-referral is available for Access+ Specialist visits.</td>
</tr>
<tr>
<td></td>
<td>Preventive care/screening/immunization</td>
<td>No Charge</td>
<td>Not Covered</td>
<td>You may have to pay for services that aren’t preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for.</td>
</tr>
<tr>
<td>If you have a test</td>
<td>Diagnostic test (x-ray, blood work)</td>
<td>Lab &amp; Path: No Charge X-Ray &amp; Imaging: No Charge Other Diagnostic Examination: No Charge</td>
<td>Lab &amp; Path: Not Covered X-Ray &amp; Imaging: Not Covered Other Diagnostic Examination: Not Covered</td>
<td>Preauthorization is required. Failure to obtain preauthorization may result in non-payment of benefits. The services listed are at a freestanding location.</td>
</tr>
<tr>
<td></td>
<td>Imaging (CT/PET scans, MRIs)</td>
<td>Outpatient Radiology Center: $100/test Outpatient Hospital: $100/test</td>
<td>Outpatient Radiology Center: Not Covered Outpatient Hospital: Not Covered</td>
<td>Preauthorization is required. Failure to obtain preauthorization may result in non-payment of benefits.</td>
</tr>
<tr>
<td>If you need drugs to treat your illness or condition</td>
<td>Tier 1</td>
<td>Retail: $10/prescription Mail Service: $20/prescription</td>
<td>Retail: Not Covered Mail Service: Not Covered</td>
<td>Preauthorization is required for select drugs. Failure to obtain preauthorization may result in non-payment of benefits. Retail: Covers up to a 30-day supply; Mail Service: Covers up to a 90-day supply.</td>
</tr>
<tr>
<td></td>
<td>Tier 2</td>
<td>Retail: $25/prescription Mail Service: $50/prescription</td>
<td>Retail: Not Covered Mail Service: Not Covered</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Tier 3</td>
<td>Retail: $50/prescription Mail Service: $100/prescription</td>
<td>Retail: Not Covered Mail Service: Not Covered</td>
<td></td>
</tr>
<tr>
<td>Common Medical Event</td>
<td>Services You May Need</td>
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<td>Non-Participating Provider (You will pay the most)</td>
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<td>-----------------------------------------------------</td>
</tr>
</tbody>
</table>
| formulary            | Tier 4                | Retail and Network Specialty Pharmacies: 20% coinsurance up to $200/prescription  
Mail Service: 20% coinsurance up to $400/prescription | Retail: Not Covered  
Mail Service: Not Covered | Preauthorization is required. Failure to obtain preauthorization may result in non-payment of benefits.  
Retail and Network Specialty Pharmacies: Covers up to a 30-day supply; Specialty drugs must be obtained at a Network Specialty Pharmacy.  
Mail Service: Covers up to a 90-day supply. |
| If you have outpatient surgery | Facility fee (e.g., ambulatory surgery center) | Ambulatory Surgery Center: $125/surgery  
Outpatient Hospital: $125/surgery | Ambulatory Surgery Center: Not Covered  
Outpatient Hospital: Not Covered | -----------None----------- |
|                      | Physician/surgeon fees | No Charge | Not Covered | -----------None----------- |
| If you need immediate medical attention | Emergency room care | Facility Fee: $100/visit  
Physician Fee: No Charge | Facility Fee: $100/visit  
Physician Fee: No Charge | -----------None----------- |
|                      | Emergency medical transportation | $100/transport | $100/transport | This payment is for emergency or authorized transport. |
|                      | Urgent care | $20/visit | Within Plan Service Area: Not Covered  
Outside Plan Service Area: $20/visit | -----------None----------- |
| If you have a hospital stay | Facility fee (e.g., hospital room) | $250/admission | Not Covered | Preauthorization is required. Failure to obtain preauthorization may result in non-payment of benefits. |
|                      | Physician/surgeon fees | No Charge | Not Covered | -----------None----------- |
| If you need mental health, behavioral health, or substance abuse services | Outpatient services | Office Visit: $20/visit  
Other Outpatient Services: No Charge  
Partial Hospitalization: No Charge  
Psychological Testing: No Charge | Office Visit: Not Covered  
Other Outpatient Services: Not Covered  
Partial Hospitalization: Not Covered  
Psychological Testing: Not Covered | Preauthorization is required except for office visits. Failure to obtain preauthorization may result in non-payment of benefits. |

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<table>
<thead>
<tr>
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<tr>
<td></td>
<td><strong>Inpatient services</strong></td>
<td><strong>Physician Inpatient Services:</strong> No Charge</td>
<td><strong>Physician Inpatient Services:</strong> Not Covered</td>
<td>Preauthorization is required. Failure to obtain preauthorization may result in non-payment of benefits.</td>
</tr>
<tr>
<td></td>
<td></td>
<td><strong>Hospital Services:</strong> $250/admission</td>
<td><strong>Hospital Services:</strong> Not Covered</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td><strong>Residential Care:</strong> $250/admission</td>
<td><strong>Residential Care:</strong> Not Covered</td>
<td></td>
</tr>
<tr>
<td></td>
<td><strong>Office visits</strong></td>
<td><strong>No Charge</strong></td>
<td><strong>Not Covered</strong></td>
<td></td>
</tr>
<tr>
<td></td>
<td><strong>Childbirth/delivery professional services</strong></td>
<td><strong>No Charge</strong></td>
<td><strong>Not Covered</strong></td>
<td></td>
</tr>
<tr>
<td></td>
<td><strong>Childbirth/delivery facility services</strong></td>
<td><strong>$250/admission</strong></td>
<td><strong>Not Covered</strong></td>
<td></td>
</tr>
<tr>
<td>If you are pregnant</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td><strong>Home health care</strong></td>
<td><strong>$20/visit</strong></td>
<td><strong>Not Covered</strong></td>
<td></td>
</tr>
<tr>
<td></td>
<td><strong>Rehabilitation services</strong></td>
<td><strong>Office Visit:</strong> $20/visit</td>
<td><strong>Office Visit:</strong> Not Covered</td>
<td>Preauthorization is required. Failure to obtain preauthorization may result in non-payment of benefits. Coverage limited to 100 visits per member per calendar year.</td>
</tr>
<tr>
<td></td>
<td></td>
<td><strong>Outpatient Hospital:</strong> $20/visit</td>
<td><strong>Outpatient Hospital:</strong> Not Covered</td>
<td></td>
</tr>
<tr>
<td></td>
<td><strong>Habilitation services</strong></td>
<td><strong>Office Visit:</strong> $20/visit</td>
<td><strong>Office Visit:</strong> Not Covered</td>
<td>Preauthorization is required. Failure to obtain preauthorization may result in non-payment of benefits.</td>
</tr>
<tr>
<td></td>
<td></td>
<td><strong>Outpatient Hospital:</strong> $20/visit</td>
<td><strong>Outpatient Hospital:</strong> Not Covered</td>
<td></td>
</tr>
<tr>
<td></td>
<td><strong>Skilled nursing care</strong></td>
<td><strong>Freestanding SNF:</strong> No Charge</td>
<td><strong>Freestanding SNF:</strong> Not Covered</td>
<td>Preauthorization is required. Failure to obtain preauthorization may result in non-payment of benefits. Coverage limited to 100 days per member per benefit period.</td>
</tr>
<tr>
<td></td>
<td></td>
<td><strong>Hospital-based SNF:</strong> No Charge</td>
<td><strong>Hospital-based SNF:</strong> Not Covered</td>
<td></td>
</tr>
<tr>
<td></td>
<td><strong>Durable medical equipment</strong></td>
<td><strong>20% coinsurance</strong></td>
<td><strong>Not Covered</strong></td>
<td>Preauthorization is required. Failure to obtain preauthorization may result in non-payment of benefits.</td>
</tr>
</tbody>
</table>

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### Common Medical Event

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</tr>
</thead>
<tbody>
<tr>
<td>Hospice services</td>
<td>No Charge</td>
<td>Not Covered</td>
<td>Preauthorization is required except for pre-hospice consultation. Failure to obtain preauthorization may result in non-payment of benefits.</td>
</tr>
</tbody>
</table>

If your child needs dental or eye care:

<table>
<thead>
<tr>
<th>Services</th>
<th>Participating Provider</th>
<th>Non-Participating Provider</th>
<th>Limitations, Exceptions, &amp; Other Important Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>Children's eye exam</td>
<td>Not Covered</td>
<td>Not Covered</td>
<td></td>
</tr>
<tr>
<td>Children's glasses</td>
<td>Not Covered</td>
<td>Not Covered</td>
<td></td>
</tr>
<tr>
<td>Children's dental check-up</td>
<td>Not Covered</td>
<td>Not Covered</td>
<td></td>
</tr>
</tbody>
</table>

### Excluded Services & Other Covered Services:

#### Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)

- Cosmetic surgery
- Long-term care
- Private-duty nursing
- Routine foot care
- Dental care (Adult)
- Non-emergency care when traveling outside the U.S.
- Routine eye care (Adult)
- Weight loss programs
- Infertility Treatment
- Routine care

#### 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
- Hearing Aids

### 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: Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, at 1-877-267-2323 x61565 or cciio.cms.gov. 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 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: Blue Shield Customer Service at 1-855-599-2650 or the Department of Labor’s Employee Benefits Security Administration at 1-866-444-EBSA (3272) or dol.gov/ebsa/healthreform. Additionally, you can contact the California Department of Managed Health Care Help at 1-888-466-2219 or visit helpline@dmhc.ca.gov or visit http://www.healthhelp.ca.gov.

### Does this plan provide Minimum Essential Coverage? Yes

If you don’t have Minimum Essential Coverage for a month, you’ll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

### 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:**

- **English**: For assistance in English at no cost, call 1-866-346-7198.
- **Spanish (Español)**: Para obtener asistencia en Español sin cargo, llame al 1-866-346-7198.
- **Tagalog (Tagalog)**: Kung kailanganninyo ang libreng tulongsa Tagalog tumawag sa 1-866-346-7198.
- **Chinese (中文)**: 如果需要中文的免费帮助，请拨打这个号码 1-866-346-7198.
- **Navajo (Dine)**: Diné k’ehjí doo bąghíí ilínígó shika’ at’oowol nínízingo, kwįį’ hodíílníh 1-866-346-7198.
- **Vietnamese (Tiếng Việt)**: Để được hỗ trợ miễn phí tiếng Việt, vui lòng gọi đến số 1-866-346-7198.
- **Korean (한국어)**: 한국어도움이 필요하시면, 1-866-346-7198 무료전화로 전화하십시오.
- **Armenian (Հայերեն)**: Հայերեն ծանոթականությունը կարողանանք զբաղվել են 1-866-346-7198.
- **Russian (Русский)**: если нужна бесплатная помощь на русском языке, то позвоните 1-866-346-7198.
- **Japanese (日本語)**: 日本語支援が必要な場合、1-866-346-7198 に電話をかけてください。
- **Persian**: برای دریافت کمک رایگان زبان فارسی لطفاً با شماره 2198-1-866-346-7198 تماس بگیرید. (فارسی)
- **Punjabi**: ਜਨਰਾਲ ਵਿਚ ਮਿਡ ਦੀ ਮੈਡਿਕਾਲ ਕੈਰ ਕੇ 2198-1-866-346-7198 (ਜਨਰਾਲ)
- **Khmer**: សម្រាប់សារអញ្ចាញ កំពុងសិក្សាអំពីភាសាខ្មែរ 1-866-346-7198.
- **Arabic**: لمساعدات على التكلفة في اللغة العربية مجاناً، تفضل بالاتصال على هذا الرقم: 1-866-346-7198. (العربية)
- **Hmong (Hnoob)**: Xav tau kev pab dawb lub Hmoob, thov hu rau 1-866-346-7198.
- **Hindi**: हिंदीमें खर्च कैसे कवर करें, 1-866-346-7198 पर कॉल करें।
- **Thai**: สำหรับความช่วยเหลือในภาษาไทยโปรดติดต่อที่ 1-866-346-7198.

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

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Blue Shield of California is an independent member of the Blue Shield Association.
This is 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.

<table>
<thead>
<tr>
<th>Peg is Having a Baby</th>
<th>Managing Joe’s Type 2 Diabetes</th>
<th>Mia’s Simple Fracture</th>
</tr>
</thead>
<tbody>
<tr>
<td>(9 months of participating pre-natal care and a hospital delivery)</td>
<td>(a year of routine participating care of a well-controlled condition)</td>
<td>(participating emergency room visit and follow up care)</td>
</tr>
<tr>
<td>The plan’s overall deductible</td>
<td>$0</td>
<td>$0</td>
</tr>
<tr>
<td>Specialist copayment</td>
<td>$20</td>
<td>$20</td>
</tr>
<tr>
<td>Hospital (facility) copayment</td>
<td>$250</td>
<td>$250</td>
</tr>
<tr>
<td>Other copayment</td>
<td>$0</td>
<td>$0</td>
</tr>
</tbody>
</table>

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 | $12,800 | $7,400 | $1,900 |

In this example, Peg would pay:

| Cost Sharing | Deductibles | $0 |
| Copayments | $290 |
| Coinsurance | $0 |

What isn’t covered
Limits or exclusions | $60 |

The total Peg would pay is | $350 |

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)

In this example, Joe would pay:

| Cost Sharing | Deductibles | $0 |
| Copayments | $810 |
| Coinsurance | $350 |

What isn’t covered
Limits or exclusions | $60 |

The total Joe would pay is | $1,220 |

This EXAMPLE event includes services like:
Emergency room care (including medical supplies)
Diagnostic test (x-ray)
Durable medical equipment (crutches)
Rehabilitation services (physical therapy)

In this example, Mia would pay:

| Cost Sharing | Deductibles | $0 |
| Copayments | $300 |
| Coinsurance | $10 |

What isn’t covered
Limits or exclusions | $0 |

The total Mia would pay is | $310 |

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

Notice Informing Individuals about Nondiscrimination and Accessibility Requirements

Discrimination is against the law
Blue Shield of California complies with applicable state laws and federal civil rights laws, and does not discriminate on the basis of race, color, national origin, ancestry, religion, sex, marital status, gender, gender identity, sexual orientation, age or disability. Blue Shield of California does not exclude people or treat them differently because of race, color, national origin, ancestry, religion, sex, marital status, gender, gender identity, sexual orientation, age, or disability.

Blue Shield of California:

- Provides aids and services at no cost to people with disabilities to communicate effectively with us such as:
  - Qualified sign language interpreters
  - Written information in other formats (including large print, audio, accessible electronic formats, and other formats)
- Provides language services at no cost to people whose primary language is not English such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, contact the Blue Shield of California Civil Rights Coordinator.

If you believe that Blue Shield of California has failed to provide these services or discriminated in another way on the basis of race, color, national origin, ancestry, religion, sex, marital status, gender, gender identity, sexual orientation, age or disability, you can file a grievance with:

Blue Shield of California
Civil Rights Coordinator
P.O. Box 629007
El Dorado Hills, CA 95762-9007
Phone: (844) 831-4133 (TTY: 711)
Fax: (844) 696-6070
Email: BlueShieldCivilRightsCoordinator@blueshieldca.com

You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, our Civil Rights Coordinator is available to help you. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue SW.
Room 509F, HHH Building
Washington, DC 20201
(800) 368-1019; TTY: (800) 537-7697

Complaint forms are available at www.hhs.gov/ocr/office/file/index.html.