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 http://www.bscabook.com/W0067301M0021760EOC_COI202001.pdf or call 1-855-829-3566. 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

<table>
<thead>
<tr>
<th>Question</th>
<th>Answer</th>
<th>Why This Matters:</th>
</tr>
</thead>
<tbody>
<tr>
<td>What is the overall deductible?</td>
<td>$0.</td>
<td>See the Common Medical Events chart below for your costs for services this plan covers.</td>
</tr>
<tr>
<td>Are there services covered before you meet your deductible?</td>
<td>Yes. Preventive care and services listed in your complete terms of coverage.</td>
<td>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.</td>
</tr>
<tr>
<td>Are there other deductibles for specific services?</td>
<td>No.</td>
<td>You don’t have to meet deductibles for specific services.</td>
</tr>
<tr>
<td>What is the out-of-pocket limit for this plan?</td>
<td>$2,000 per individual / $4,000 per family for participating providers.</td>
<td>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.</td>
</tr>
<tr>
<td>What is not included in the out-of-pocket limit?</td>
<td>Copayments for certain services, premiums, and health care this plan doesn’t cover.</td>
<td>Even though you pay these expenses, they don’t count toward the out-of-pocket limit.</td>
</tr>
<tr>
<td>Will you pay less if you use a network provider?</td>
<td>Yes. See blueshieldca.com/fad or call 1-855-829-3566 for a list of network providers.</td>
<td>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.</td>
</tr>
<tr>
<td>Do you need a referral to see a specialist?</td>
<td>Yes.</td>
<td>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.</td>
</tr>
</tbody>
</table>

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<table>
<thead>
<tr>
<th>Common Medical Event</th>
<th>Services You May Need</th>
<th>What You Will Pay</th>
<th>Limitations, Exceptions, &amp; Other Important Information</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Participating Provider</td>
<td>Non-Participating Provider</td>
</tr>
<tr>
<td></td>
<td></td>
<td>(You will pay the least)</td>
<td>(You will pay the most)</td>
</tr>
<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>
</tr>
<tr>
<td></td>
<td>Specialist visit</td>
<td>Trio+ Specialist: $20/visit Other Specialist: $20/visit</td>
<td>Not Covered</td>
</tr>
<tr>
<td></td>
<td>Preventive care/screening /immunization</td>
<td>No Charge</td>
<td>Not Covered</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>
</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>
</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>
</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>
</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>
</tr>
</tbody>
</table>

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**
---|---|---|---
**formulary** | Tier 4 | Participating Provider (You will pay the least): *Retail and Network Specialty Pharmacies: 20% coinsurance up to $200/prescription*  Mail Service: 20% coinsurance up to $400/prescription | Non-Participating Provider (You will pay the most): *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 |  
Physician/surgeon fees | No Charge | Not Covered |  

**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 |  
Emergency medical transportation | 100/transport | 100/transport | This payment is for emergency or authorized transport.  
Urgent care | 20/visit |  

**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 |  

**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>
<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></td>
<td>Inpatient services</td>
<td>Physician Inpatient Services: No Charge</td>
<td>Physician Inpatient Services: 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>Hospital Services: $250/admission</td>
<td>Hospital Services: Not Covered</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Residential Care: $250/admission</td>
<td>Residential Care: Not Covered</td>
<td></td>
</tr>
<tr>
<td>If you are pregnant</td>
<td>Office visits</td>
<td>No Charge</td>
<td>Not Covered</td>
<td>Preauthorization is required. Failure to obtain preauthorization may result in non-payment of benefits.</td>
</tr>
<tr>
<td></td>
<td>Childbirth/delivery professional services</td>
<td>No Charge</td>
<td>Not Covered</td>
<td>None</td>
</tr>
<tr>
<td></td>
<td>Childbirth/delivery facility services</td>
<td>$250/admission</td>
<td>Not Covered</td>
<td>None</td>
</tr>
<tr>
<td>If you need help recovering or have other special health needs</td>
<td>Home health care</td>
<td>$20/visit</td>
<td>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>Rehabilitation services</td>
<td>Office Visit: $20/visit Outpatient Hospital: $20/visit</td>
<td>Office Visit: Not Covered Outpatient Hospital: Not Covered</td>
<td>None</td>
</tr>
<tr>
<td></td>
<td>Habilitation services</td>
<td>Office Visit: $20/visit Outpatient Hospital: $20/visit</td>
<td>Office Visit: Not Covered Outpatient Hospital: Not Covered</td>
<td>None</td>
</tr>
<tr>
<td></td>
<td>Skilled nursing care</td>
<td>Freestanding SNF: No Charge</td>
<td>Freestanding SNF: 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>Hospital-based SNF: No Charge</td>
<td>Hospital-based SNF: Not Covered</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Durable medical equipment</td>
<td>20% coinsurance</td>
<td>Not Covered</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 Services You May Need

<table>
<thead>
<tr>
<th>Service</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>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>
<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>

### If your child needs dental or eye care

<table>
<thead>
<tr>
<th>Service</th>
<th>Participating Provider (You will pay the least)</th>
<th>Non-Participating Provider (You will pay the most)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Children's eye exam</td>
<td>Not Covered</td>
<td>Not Covered</td>
</tr>
<tr>
<td>Children's glasses</td>
<td>Not Covered</td>
<td>Not Covered</td>
</tr>
<tr>
<td>Children's dental check-up</td>
<td>Not Covered</td>
<td>Not Covered</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
- Dental care (Adult)
- Infertility Treatment
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing
- Routine foot care
- Routine eye care (Adult)
- 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
- 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 1-855-829-3566 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.
Navajo (Dine): Diné k’eñji doó báah ilíñígó shíka’ at’oowol ninízinggo, kwijí’ hodííñí. 1-866-346-7198.
Vietnamese (Tiếng Việt): Để được hỗ trợ miễn phí tiếng Việt, vui lòng gọi đến số 1-866-346-7198.
Armenian (Հայերեն): Հայերենով բարեփոխումներն էականացնելու համար, համաձայն հաղթանակ 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。
ペルシャフ：برای دریافت کمک رایگان رایگان زبان فارسی، لطفاً با شماره تلفن 1-866-346-7198 تماس بگیرید.
Persian: براي دریافت کمک رایگان زبان فارسی، لطفاً با شماره تلفن 1-866-346-7198 تماس بگیرید.
Hmong (Hnoob): Xav tau kev pab dawb lub Hmoob, thov huv rau 1-866-346-7198.
Hindi (हिंदी): हिंदी में मदद के लिए, 1-866-346-7198 पर कॉल करें।
Thai (ไทย): สำหรับความช่วยเหลือในภาษาไทยโดยไม่เสียค่าใช้จ่าย 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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### 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 plan’s overall deductible: $0
- Specialist copayment: $20
- Hospital (facility) copayment: $250
- Other copayment: $0

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

**In this example, Peg would pay:**

<table>
<thead>
<tr>
<th>Cost Sharing</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Deductibles</td>
<td>$0</td>
</tr>
<tr>
<td>Copayments</td>
<td>$290</td>
</tr>
<tr>
<td>Coinsurance</td>
<td>$0</td>
</tr>
</tbody>
</table>

**What isn’t covered**
- Limits or exclusions: $60

**The total Peg would pay is:** $350

### Managing Joe’s Type 2 Diabetes

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

- The plan’s overall deductible: $0
- Specialist copayment: $20
- Hospital (facility) copayment: $250
- Other copayment: $0

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:** $7,400

**In this example, Joe would pay:**

<table>
<thead>
<tr>
<th>Cost Sharing</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Deductibles</td>
<td>$0</td>
</tr>
<tr>
<td>Copayments</td>
<td>$810</td>
</tr>
<tr>
<td>Coinsurance</td>
<td>$350</td>
</tr>
</tbody>
</table>

**What isn’t covered**
- Limits or exclusions: $60

**The total Joe would pay is:** $1,220

### Mia’s Simple Fracture

(participating emergency room visit and follow up care)

- The plan’s overall deductible: $0
- Specialist copayment: $20
- Hospital (facility) copayment: $250
- Other copayment: $0

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:** $1,900

**In this example, Mia would pay:**

<table>
<thead>
<tr>
<th>Cost Sharing</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Deductibles</td>
<td>$0</td>
</tr>
<tr>
<td>Copayments</td>
<td>$300</td>
</tr>
<tr>
<td>Coinsurance</td>
<td>$10</td>
</tr>
</tbody>
</table>

**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.
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.