**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/ 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.

<table>
<thead>
<tr>
<th>Important Questions</th>
<th>Answers</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 1-855-599-2650 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>

Blue Shield of California is an independent member of the Blue Shield Association.
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>What You Will Pay</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>Participating Provider (You will pay the least): $20/visit</td>
<td>Non-Participating Provider (You will pay the most): Not Covered</td>
</tr>
<tr>
<td></td>
<td>Specialist visit</td>
<td>Access+ Specialist: $40/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>

* For more information about limitations and exceptions, see the plan or policy document at [bsca.com/policies/](http://bsca.com/policies/).
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<th>Common Medical Event</th>
<th>Services You May Need</th>
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<th>Non-Participating Provider (You will pay the most)</th>
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| 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---------------------- |
|                      | Physician Fee: No Charge | $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---------------------- |

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| 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. |
| | Inpatient services | Physician Inpatient Services: No Charge  
Hospital Services: $250/admission  
Residential Care: $250/admission | Physician Inpatient Services: Not Covered  
Hospital Services: Not Covered  
Residential Care: Not Covered | Preauthorization is required. Failure to obtain preauthorization may result in non-payment of benefits. |
| If you are pregnant | Office visits | No Charge | Not Covered |
| | Childbirth/delivery professional services | No Charge | Not Covered |
| | Childbirth/delivery facility services | $250/admission | Not Covered |
| If you need help recovering or have other special health needs | Home health care | $20/visit | Not Covered |
| | Rehabilitation services | Office Visit: $20/visit  
Outpatient Hospital: $20/visit | Office Visit: Not Covered  
Outpatient Hospital: Not Covered | Preauthorization is required. Failure to obtain preauthorization may result in non-payment of benefits. Coverage limited to 100 visits per member per calendar year. |
| | Habilitation services | Office Visit: $20/visit  
Outpatient Hospital: $20/visit | Office Visit: Not Covered  
Outpatient Hospital: Not Covered | Preauthorization is required. Failure to obtain preauthorization may result in non-payment of benefits. |
| | Skilled nursing care | Freestanding SNF: No Charge  
Hospital-based SNF: No Charge | Freestanding SNF: Not Covered  
Hospital-based SNF: Not Covered | Preauthorization is required. Failure to obtain preauthorization may result in non-payment of benefits. Coverage limited to 100 days per member per benefit period. |

* For more information about limitations and exceptions, see the plan or policy document at bscad.com/policies/.
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<th>Services You May Need</th>
<th>Participating Provider (You will pay the least)</th>
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<tbody>
<tr>
<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>
<td></td>
</tr>
<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>
<td></td>
</tr>
</tbody>
</table>

**If your child needs dental or eye care**

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

**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

* For more information about limitations and exceptions, see the plan or policy document at [bsca.com/policies/](http://bsca.com/policies/).
**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 ccio.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/ebsha/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
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.

* For more information about limitations and exceptions, see the plan or policy document at bsca.com/policies/.
Language Access Services:
English: For assistance in English at no cost, call 1-866-346-7198.


Navajo (Dine): Diné k'éhii dòo bąąh ilínígó shika' a't'oowóól ninízingó, kwįįį 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.


Armenian (հայերեն): Հայերեն ոլորտում օգտվենք երկնաքննության հետ, 08-09-13-25 (0-8-09-13-25), 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。無料で提供します。

Persian (فارسی): برای دریافت کمک رایگان زبان فارسی، تماس با شماره تلفن 1-866-346-7198 نام داگرید.

Punjabi (ਪੰਜਾਬੀ): ਪੰਜਾਬੀ ਵਿਚ ਸੰਗਰਹਿਣ ਵਾਲੀ ਟਿਕਾਣ ਦੇਖਾਓ 1-866-346-7198 ਦੇ ਕਲਾਸ ਵਹੇ।

Khmer (ភាសាខ្មែរ): ផ្លាស់ប្លង់ខ្មែរ សម្រាប់គ្រប់គ្រូ 1-866-346-7198 (1)


Hmong (Hmoob): Xav tau kev pab dowb lub Hmoob. thov hu rau 1-866-346-7198.

Hindi (हिंदी): हिंदी में बिना खर्च के सहायता के लिए, 1-866-346-7198 पर कॉल करें।

Thai (ไทย): สามารถ召唤พระเจ้าในภาษาไทยโดยไม่ต้องใช้โทรศัพท์ 1-866-346-7198.

Laotian (ລາວ): ແທນເຂກາຍໝາຍເຂກາຍ ບ້ານເຂກາຍໝາຍເຂກາຍ 1-866-346-7198.

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* For more information about limitations and exceptions, see the plan or policy document at b scam/policies/.

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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.

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### 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**: $12,700

**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>$300</td>
</tr>
<tr>
<td>Coinsurance</td>
<td>$0</td>
</tr>
</tbody>
</table>

**What isn’t covered**

<table>
<thead>
<tr>
<th>Limits or exclusions</th>
<th>$60</th>
</tr>
</thead>
</table>

The total Peg would pay is **$360**

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### 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**: $5,600

**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>$700</td>
</tr>
<tr>
<td>Coinsurance</td>
<td>$200</td>
</tr>
</tbody>
</table>

**What isn’t covered**

| Limits or exclusions | $20   |

The total Joe would pay is **$920**

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### 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**: $2,800

**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>
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<tr>
<td>Copayments</td>
<td>$300</td>
</tr>
<tr>
<td>Coinsurance</td>
<td>$20</td>
</tr>
</tbody>
</table>

**What isn’t covered**

| Limits or exclusions | $0    |

The total Mia would pay is **$320**

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