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 see **www.bac3tilebenefits.org** or by calling **1-888-208-0250**. 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 www.HealthCare.gov/sbc-glossary or call 1-888-208-0250 to request a copy.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	For **PPO providers**: **$250** person/**$750** family (up to three individuals) For **non-PPO providers**: **$500** person/**$1,500** family (up to three individuals)	Generally, you must pay all of the costs from **providers** up to the **deductible** amount before this **plan** begins to pay. If you have other family members on the **plan**, each family member must meet their own individual **deductible** until the total amount of **deductible** expenses paid by all family members meets the overall family **deductible.**
Are there services covered before you meet your deductible?	Yes. **Preventive care**.	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 https://www.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?	For **PPO providers**, **$1,250** person/**$3,750** family. For **non-PPO providers**, **$8,500** person/ **$25,500** family.	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?	**Premiums**, **balance-billed** charges, health care this **plan** doesn't cover, and drug **copays** for a brand name drug when a generic is available	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 www.blueshieldca.com/NetworkPPO **or** 1-888-208-0250 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.

Important Questions	Answers	Why this Matters:
Do you need a referral to see a specialist?	No.	You can see the **specialist** you choose without a **referral**.

- 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 Plan Provider (You will pay the least)	What You Will Pay Non-Plan Provider (You will pay the most)	Limitations & Exceptions
If you visit a health care provider's office or clinic or telehealth office visit	Primary care visit to treat an injury or illness	$10 **copayment** / visit	$20 **copayment** / visit	Non-PPO coverage limited to **UCR**. Non-emergency services provided by a non-PPO provider at a PPO facility is limited to $10 **copayment**/visit, unless you consent to the non-PPO billing rates.
	Specialist visit	$20 **copayment** / visit	$40 **copayment** / visit	Non-PPO coverage limited to **UCR**. Non-emergency services provided by a non-PPO provider at a PPO facility is limited to $20 **copayment**/visit, unless you consent to the non-PPO billing rates.
	Preventive care/screening/immunization	No charge for routine physicals or **Preventive Services** as defined in the **Plan;** no coverage for immunizations for adults that are not **Preventive Services**	40% **co-insurance**, except routine physicals will be covered at 100% of the PPO contracted rate; no coverage for immunizations for adults that are not **Preventive Services**	See SPD for definition of **Preventive Services.** Coverage for a Well Child service provided by a non-PPO **provider** or that is not a **Preventive Service** is limited to $75/exam, $75/inoculation and $50/lab service. Non-PPO coverage limited to **UCR**. 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.
If you have a test	**Diagnostic test** (x-ray, blood work)	20% **co-insurance;** no charge for **Preventive Services**	40% **co-insurance**	Non-PPO coverage limited to **UCR**.

Common Medical Event	Services You May Need	What You Will Pay Plan Provider (You will pay the least)	What You Will Pay Non-Plan Provider (You will pay the most)	Limitations & Exceptions
	COVID-19 Test (including over the counter tests)	20% **co-insurance**	40% **co-insurance**	No **Preauthorization** required.
	Imaging (CT/PET scans, MRIs)	20% **co-insurance**; no charge for **Preventive Services**	40% **co-insurance**	Non-PPO coverage limited to **UCR**.
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.savrx.com.	Generic drugs	No charge	Not covered	Covers up to a 30-day supply (retail); 31-90 day supply (mail order). When available, generic drugs will be substituted for formulary brand drugs, unless a treating physician specifically authorizes the use of a formulary brand drug. **Preauthorization** is required for **Specialty drugs**. Certain brand drugs are subject to step therapy which requires you to first try a more cost effective therapeutically equivalent drug.
	Preferred Brand Drugs	$10 **copay** retail; $20 **copay** mail order	Not covered	
	Non-preferred brand drugs	$40 **copay** retail; $80 **copay** mail order	Not covered	
	Specialty drugs	$40 **copay** retail; $80 **copay** mail order	Not covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% **co-insurance**	40% **co-insurance**	Prior authorization required or benefits may not be paid. Non-PPO coverage limited to **UCR**. Non-emergency services provided by a non-PPO provider at a PPO facility is limited to 20% **co-insurance**, unless you consent to the non-PPO billing rates.
	Physician/surgeon fees	20% **co-insurance**	40% **co-insurance**	

Common Medical Event	Services You May Need	What You Will Pay Plan Provider (You will pay the least)	What You Will Pay Non-Plan Provider (You will pay the most)	Limitations & Exceptions
If you need immediate medical attention	**Emergency room care**	20% **co-insurance**	20% **co-insurance**	You will have to pay 40% **co-insurance** after $200 deductible for emergency services at a non-PPO facility if (1) you did not have an emergency medical condition; or (2) you receive emergency services for treatment of an emergency medical condition from a non-PPO provider or non-PPO emergency facility and consent to the non-PPO billing rate for certain post-stabilization services. Non-PPO coverage limited to **UCR**.
	Emergency medical transportation	20% **co-insurance**	20% **co-insurance**;	Non-PPO coverage limited to **UCR**.
	Urgent care	20% **co-insurance**	40% **co-insurance**	Non-PPO coverage limited to **UCR**.
If you have a hospital stay	Facility fee (e.g., hospital room)	20% **co-insurance**	40% **co-insurance**	Prior authorization required or benefits may not be paid. Non-PPO coverage limited to **UCR**.
	Physician/surgeon fee	20% **co-insurance**	40% **co-insurance**	Non-PPO coverage limited to **UCR**. Non-emergency services provided by a non-PPO provider at a PPO facility is limited to 20% **co-insurance**, unless you consent to the non-PPO billing rates.

Common Medical Event	Services You May Need	What You Will Pay Plan Provider (You will pay the least)	What You Will Pay Non-Plan Provider (You will pay the most)	Limitations & Exceptions
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$10 **copay** (office visits); 20% **co-insurance** (other than office visits)	$20 **copay** (office visits); 40% **co-insurance** (other than office visits)	Non-PPO coverage limited to **UCR**. Non-emergency services provided by a non-PPO provider at a PPO facility is limited to $10 **copay** for office visits; 20% **co-insurance** for services other than office visits, unless you consent to the non-PPO billing rates.
	Inpatient Services	20% **co-insurance**	40% **co-insurance**	For substance use disorder inpatient services, first confinement without prior outpatient treatment covered at 100% **in-network**. Non-PPO coverage limited to **UCR**. Non-emergency services provided by a non-PPO provider at a PPO facility is limited to 20% **co-insurance** unless you consent to the non-PPO billing rates.
If you are pregnant	Office visits	20% **co-insurance**	40% **co-insurance**	Non-PPO coverage limited to **UCR**.
	Childbirth/delivery professional services	20% **co-insurance**	40% **co-insurance**	Non-PPO coverage limited to **UCR**.
	Childbirth/delivery facility services	20% **co-insurance**	40% **co-insurance**	Non-PPO coverage limited to **UCR**.
If you need help recovering or have other special health needs	**Home health care**	20% **co-insurance**	40% **co-insurance**	Prior authorization required for non-PPO **providers** or benefits may not be paid. Non-PPO coverage limited to **UCR**.
	Rehabilitation services	20% **co-insurance**	40% **co-insurance**	Non-PPO coverage limited to **UCR**.
	Habilitation services	20% **co-insurance**	40% **co-insurance**	Non-PPO coverage limited to **UCR**.
	Skilled nursing care	20% **co-insurance**	40% **co-insurance**	Prior authorization required or benefits may not be paid. Coverage is limited to a maximum of 50% of local **UCR**.
	Durable medical equipment	20% **co-insurance**	40% **co-insurance**	Non-PPO coverage limited to **UCR**.
	Hospice services	20% **co-insurance**	40% **co-insurance**	Prior authorization required for non-PPO **providers** or benefits may not be paid. Non-PPO coverage limited to **UCR**.
If your child needs	Children's eye exam	$10 **co-pay**	Covered up to $45	Limited to one exam per year.

Common Medical Event	Services You May Need	What You Will Pay Plan Provider (You will pay the least)	What You Will Pay Non-Plan Provider (You will pay the most)	Limitations & Exceptions
dental or eye care	Children's glasses	$10 **co-pay** for lenses, $150 frame allowance	Covered to $100 depending on lens type; $70 frame allowance	Limited to one pair of lenses per year and one set of frames every 2 years.
	Children's dental check-up	20% **co-insurance** after $50 **deductible**	20% **co-insurance** after $50 **deductible**	The maximum benefit for dental services per calendar year is $2,000.

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).

- Acupuncture
- Cosmetic surgery, except within 12 months after and as the result of an injury, for the
- Non-emergency care when traveling outside the U.S
- Routine foot care
- Correction of a congenital defect of a dependent child, or for replacement of diseased tissue surgically removed
- Treatment that is not medically necessary, except for covered **Preventive Services**
- Hearing aids
- Infertility treatment
- Long term care
- Weight loss programs

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

- Bariatric surgery within Medicare national coverage guidelines
- Chiropractic care
- Dental care (Adult)
- Private duty nursing, with prior utilization review.
- Routine eye care (Adult)

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 agency in the chart below. Additionally, a consumer assistance program can help you file your appeal. Contact the California Department of Managed Health Care and Department of Insurance at 980 9th St, Suite #500 Sacramento, CA 95814, 1-888-466-2219 or http://www.HealthHelp.ca.gov.

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

Administrative Office	1-888-208-0250 or www.bac3tilebenefits.org
Department of Labor's Employee Benefits Security Administration	1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform

Department of Health & Human Services, Center for Consumer Information & Insurance Oversight	1-877-267-2323 x61565 or www.cciio.cms.gov
California Department of Insurance	1-800-927-HELP (4357) or www.insurance.ca.gov
California Department of Managed Healthcare	1-888-466-2219 or 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.

Language Access Services:

Para obtener asistencia en Español, llame al **1-888-208-0250**.

Kung kailangan ninyo ang tulong sa Tagalog tumawag sa **1-888-208-0250**.

如果需要中文的帮助，请拨打这个号码 **1-888-208-0250**.

Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' **1-888-208-0250**.

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

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 in-network pre-natal care and a hospital delivery)		**Managing Joe's type 2 Diabetes** (a year of routine in-network care of a well-controlled condition)		**Mia's Simple Fracture** (in-network emergency room visit and follow up care)	
The plan's overall deductible	$250	The plan's overall deductible	$250	The plan's overall deductible	$250
Specialist coinsurance	20%	Specialist coinsurance	20%	Specialist coinsurance	20%
Hospital (facility)	20%	Hospital (facility)	20%	Hospital (facility)	20%
Other (blood work)	20%	Other (blood work)	20%	Other (x-ray)	20%
This EXAMPLE event includes services like:		**This EXAMPLE event includes services like:**		**This EXAMPLE event includes services like:**	
Specialist office visits (*prenatal care*)		**Primary care physician** office visits (*including disease education*)		**Emergency room care** (*including medical supplies*)	
Childbirth/Delivery Professional Services		**Diagnostic tests** (*blood work*)		**Durable medical equipment** (*crutches*)	
Childbirth/Delivery Facility Services		**Prescription drugs**		**Diagnostic test** (*x-ray*)	
Diagnostic tests (*ultrasounds and blood work*)		**Durable medical equipment** (*glucose meter*)		**Rehabilitation services** (*physical therapy*)	
Specialist visit (*anesthesia*)					
Total Example Cost	**$12,700**	**Total Example Cost**	**$5,600**	**Total Example Cost**	**$2,800**
In this example, Peg would pay:		**In this example, Joe would pay:**		**In this example, Mia would pay:**	
Cost Sharing		***Cost Sharing***		***Cost Sharing***	
Deductibles	$250	**Deductibles**	$250	**Deductibles**	$250
Copays	$0	**Copays**	$300	**Copays**	$60
Coinsurance	$1,000	**Coinsurance**	$100	**Coinsurance**	$400
What isn't covered		***What isn't covered***		***What isn't covered***	
Limits or exclusions	$60	Limits or exclusions	$20	Limits or exclusions	$0
The total Peg would pay is	**$1,310**	**The total Joe would pay is**	**$670**	**The total Mia would pay is**	**$710**