

 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.blueshieldca.com/NetworkPPO](http://www.blueshieldca.com/NetworkPPO) or call 1-888-877-8363. 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 <https://www.HealthCare.gov/sbc-glossary/> or call 1-888-877-8363 to request a copy.

Important Questions	Answers	Why this Matters:
What is the overall <u>deductible</u> ?	\$0	See the Common Medical Events chart below for your costs for services this <u>plan</u> covers.
Are there services covered before you meet your <u>deductible</u> ?	No.	The <u>Plan</u> does not have <u>deductibles</u> . A <u>copayment</u> or <u>coinsurance</u> may apply for the covered services.
Are there other <u>deductibles</u> for specific services?	Yes. \$200 per admission to or use of Non-Plan contracted facility; \$50 per emergency room visit. There are no other specific <u>deductibles</u> .	You must pay all of the costs for these services up to the specific <u>deductible</u> amount before this <u>plan</u> begins to pay for these services.
What is the <u>out-of-pocket limit</u> for this <u>plan</u> ?	For <u>Plan Providers</u> \$1,000 person. For Non-Plan Providers \$5,000 person.	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.
What is not included in the <u>out-of-pocket limit</u> ?	Premiums, <u>balance-billing</u> charges, health care this <u>plan</u> doesn't cover, Non-Plan contracted facility <u>deductibles</u> , emergency room visit <u>deductibles</u> , and room/board charges for non approved hospital confinement.	Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u> .
Will you pay less if you use a <u>network provider</u> ?	Yes. See <a href="http://www.blueshieldca.com/NetworkPPO">www.blueshieldca.com/NetworkPPO</a> or call 1-888-877-8363 for a list of <u>plan 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 network</u> . 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. Please note, if you are treated by an out-of-network provider at an in-network facility, then your cost sharing amounts are limited to the in-network rate.
Do you need a <u>referral</u> to see a <u>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 Plan Provider (You will pay the least)	What You Will Pay Non-Plan Provider (You will pay the most)	Limitations, Exceptions & Other Important Information
<b>If you visit a health care <u>provider's</u> office or clinic</b>	Primary care visit to treat an injury or illness	10% <u>coinsurance</u>	30% <u>coinsurance</u>	Non-emergency services provided by a non-PPO provider at a PPO facility is limited to 10% <u>coinsurance</u> , unless you consent to the non-PPO billing rates. Non-Plan <u>Provider</u> coverage limited to <u>UCR</u>
	<u>Specialist</u> visit	10% <u>coinsurance</u>	30% <u>coinsurance</u>	Non-emergency services provided by a non-PPO provider at a PPO facility is limited to 10% <u>coinsurance</u> , unless you consent to the non-PPO billing rates. Non-Plan <u>Provider</u> coverage limited to <u>UCR</u>
	<u>Preventive care/ screening/ immunization</u>	No Charge	No Charge	Non-Plan <u>Provider</u> coverage limited to <u>UCR</u>
	Telehealth Services	10% <u>coinsurance</u>	30% <u>coinsurance</u>	Non-Plan <u>Provider</u> coverage limited to <u>UCR</u>
<b>If you have a test</b>	<u>Diagnostic test</u> (x-ray, blood work)	10% <u>coinsurance</u>	30% <u>coinsurance</u>	Non-Plan <u>Provider</u> coverage limited to <u>UCR</u>
	Imaging (CT/PET scans, MRI's)	10% <u>coinsurance</u>	30% <u>coinsurance</u>	Non-Plan <u>Provider</u> coverage limited to <u>UCR</u>
	COVID-19 Test	10% <u>coinsurance</u>	30% <u>coinsurance</u>	Non-Plan <u>Provider</u> coverage limited to <u>UCR</u>
<b>If you need drugs to treat your illness or condition</b>	Generic drugs	20% <u>coinsurance</u> retail; \$5 <u>copay</u> mail order	Not Covered	Covers up to a 30-day supply (retail prescription); 31-90 day supply (mail order prescription). If a generic is available, you may elect brand and pay the difference in cost plus the <u>copay</u> or <u>coinsurance</u>
<b>More information about <u>prescription drug coverage</u></b>	Brand drugs (preferred and non-preferred)	20% <u>coinsurance</u> retail; \$20 <u>copay</u> mail order	Not Covered	Covers up to a 30-day supply (retail prescription); 31-90 day supply (mail order prescription). If a generic is available, you may elect brand and pay the difference in cost plus the <u>copay</u> or <u>coinsurance</u>

available at <a href="http://www.blueshieldca.com/NetworkPPO">www.blueshieldca.com/NetworkPPO</a>	<a href="#">Specialty drugs</a>	20% <u>coinsurance</u> retail; \$20 <u>copay</u> mail order	Not Covered	Prior authorization required or not covered. Covers up to a 30 day supply (retail prescription); 31-90 day supply (mail order prescription).
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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 & Other Important Information
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	10% <u>coinsurance</u>	30% <u>coinsurance</u>	Prior authorization required or not covered. Non-Plan <u>Provider</u> coverage limited to <u>UCR</u> . Non-emergency services provided by a non-PPO provider at a PPO facility is limited to 10% <u>co-insurance</u> , unless you consent to the non-PPO billing rates.
	Physician/surgeon fees	10% <u>coinsurance</u>	30% <u>coinsurance</u>	Prior authorization required or not covered. Non-Plan <u>Provider</u> coverage limited to <u>UCR</u> . Non-emergency services provided by a non-PPO provider at a PPO facility is limited to 10% <u>co-insurance</u> , unless you consent to the non-PPO billing rates.
If you need immediate medical attention	<a href="#">Emergency room care</a>	10% <u>coinsurance</u>	10% <u>coinsurance</u>	You will have to pay 30% <u>co-insurance</u> 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.
	<a href="#">Emergency medical transportation</a>	10% <u>coinsurance</u>	30% <u>coinsurance</u> 10% <u>coinsurance</u> for Air Ambulance	None
	<a href="#">Urgent care</a>	10% <u>coinsurance</u>	30% <u>coinsurance</u>	None
If you have a hospital stay	Facility fee (e.g., hospital room)	10% <u>coinsurance</u>	30% <u>coinsurance</u>	Prior utilization review required or your cost will be higher. Non-Plan <u>Provider</u> coverage limited to <u>UCR</u> .

	Physician/surgeon fees	10% <u>coinsurance</u>	30% <u>coinsurance</u>	Prior authorization required for surgery or services are not covered. Non-Plan <u>Provider</u> coverage limited to <u>UCR</u> . Non-emergency services provided by a non-PPO provider at a PPO facility is limited to 10% <u>co-insurance</u> , unless you consent to the non-PPO billing rates.
<b>If you need mental health, behavioral health, or substance abuse services</b>	Outpatient services	Mental / Behavioral Health: 10% <u>coinsurance</u> ; Substance Abuse: No charge	30% <u>coinsurance</u>	Non-Plan <u>Provider</u> coverage limited to <u>UCR</u> . Non-emergency services provided by a non-PPO provider at a PPO facility is limited to 10% <u>coinsurance</u> , unless you consent to the non-PPO billing rates.
	Inpatient services	Mental / Behavioral Health: 10% <u>coinsurance</u> ; Substance Abuse: No charge for first confinement; 10% <u>coinsurance</u> thereafter.	Mental / Behavioral Health: 30% <u>coinsurance</u> ; Substance Abuse: 30% <u>coinsurance</u>	Non-Plan <u>Provider</u> coverage limited to <u>UCR</u> . Non-emergency services provided by a non-PPO provider at a PPO facility is limited to 10% <u>coinsurance</u> , 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 & Other Important Information
If you are pregnant	Office visits	Prenatal and postnatal care: 10% <u>coinsurance</u>	30% <u>coinsurance</u>	Non-Plan <u>Provider</u> coverage limited to <u>UCR</u> .
	Childbirth/delivery professional services	10% <u>coinsurance</u>	30% <u>coinsurance</u>	Non-Plan <u>Provider</u> coverage limited to <u>UCR</u> .
	Childbirth/delivery facility services	10% <u>coinsurance</u>	30% <u>coinsurance</u>	Birthing center services and supplies are not covered. Non-Plan <u>Provider</u> coverage limited to <u>UCR</u> .
If you need help recovering or have other special health needs	<u>Home health care</u>	10% <u>coinsurance</u>	30% <u>coinsurance</u>	Prior utilization required or services are not covered. Limited to 100 visits per year. Non-Plan <u>Provider</u> coverage limited to <u>UCR</u> .
	<u>Rehabilitation services</u>	10% <u>coinsurance</u>	30% <u>coinsurance</u>	Non-Plan <u>Provider</u> coverage limited to <u>UCR</u> .
	<u>Habilitation services</u>	10% <u>coinsurance</u>	30% <u>coinsurance</u>	Non-Plan <u>Provider</u> coverage limited to <u>UCR</u> .
	<u>Skilled nursing care</u>	10% <u>coinsurance</u>	30% <u>coinsurance</u>	Prior utilization review required or your cost will be higher. <u>Skilled nursing care</u> coverage is limited to 75% of local <u>UCR</u> . Inpatient hospice coverage is limited to 60 days per period of confinement and \$330 / day max. Non-Plan <u>Provider</u> coverage limited to <u>UCR</u> .
	<u>Durable medical equipment</u>	10% <u>coinsurance</u>	30% <u>coinsurance</u>	<u>Plan</u> may approve purchase in lieu of rental. Rental cost in excess of purchase price is not covered. Non-Plan <u>Provider</u> coverage limited to <u>UCR</u> .
	<u>Hospice service</u>	10% <u>coinsurance</u>	30% <u>coinsurance</u>	Prior utilization review required or services are not covered. Limited to 100 visits per year for outpatient. Maximum daily allowance for inpatient is \$330 per day. Maximum number of inpatient covered days is 60 per confinement. Non-Plan <u>Provider</u> coverage limited to <u>UCR</u> .

<b>If your child needs dental or eye care</b>	Children's eye exam	\$10 <u>copay</u>	Covered up to \$45	Limited to one exam per year.
	Children's glasses	\$10 <u>copay</u> for lenses; \$150 frame allowance.	Lenses covered up to \$125 depending on lens type; \$47 frame allowance.	Limited to one pair of lenses per year and one set of frames every 2 years.
	Children's dental check-up	30% <u>coinsurance</u> of <u>allowed amount</u>	30% <u>coinsurance</u> of <u>allowed amount</u>	\$3,000 annual maximum. There is no <u>deductible</u> for preventative services.

#### Excluded Services & Other Covered Services:

Services Your <u>Plan</u> Generally Does NOT Cover (Check your policy or <u>plan</u> document for more information and a list of any other <u>excluded services</u> .)		
<ul style="list-style-type: none"> <li>• Acupuncture</li> <li>• Cosmetic surgery, except within 12 months after and as the result of an injury, for the correction of congenital defect of a dependent child, or for replacement of diseased tissue surgically removed.</li> </ul>	<ul style="list-style-type: none"> <li>• Hearing Aids</li> <li>• Infertility treatment</li> <li>• Long-term care</li> <li>• Non-emergency care when traveling outside the U.S.</li> </ul>	<ul style="list-style-type: none"> <li>• Routine foot care</li> <li>• Treatment and services not medically necessary</li> <li>• Weight loss programs</li> </ul>
Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your <u>plan</u> document.)		
<ul style="list-style-type: none"> <li>• Bariatric surgery within Medicare national coverage guidelines</li> </ul>	<ul style="list-style-type: none"> <li>• Chiropractic care</li> <li>• Dental care (Adult)</li> <li>• Gene Therapy</li> </ul>	<ul style="list-style-type: none"> <li>• Private duty nursing, with prior utilization review.</li> <li>• Routine eye care (Adult)</li> </ul>

**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: U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-EBSA (3272) or [www.dol.gov/ebsa/healthreform](http://www.dol.gov/ebsa/healthreform). 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](http://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 Blue Shield Member Services at 1-888-877-8363 or Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or [www.dol.gov/ebsa/healthreform](http://www.dol.gov/ebsa/healthreform).

#### 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 1-800-788-0616 (TTY: 711)

TAGALOG (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-278-3296 (TTY: 711)

CHINESE (中文): 如果需要中文的帮助, 请拨打这个号码 1-800-757-7585 (TTY: 711)

NAVAJO (Dine): Dinekehgo shika at'ohwol ninisingo, kwijigo holne' 1-800-278-3296 (TTY: 711)

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*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 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 <a href="#">plan's</a> overall <a href="#">deductible</a>	\$0
■ <a href="#">Specialist coinsurance</a>	10%
■ Hospital (facility) <a href="#">coinsurance</a>	10%
■ Other (blood work) <a href="#">coinsurance</a>	10%

**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*)

■ The <a href="#">plan's</a> overall <a href="#">deductible</a>	\$0
■ <a href="#">Specialist coinsurance</a>	10%
■ Hospital (facility) <a href="#">coinsurance</a>	10%
■ Other (blood work) <a href="#">coinsurance</a>	10%

**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*)

■ The <a href="#">plan's</a> overall <a href="#">deductible</a>	\$0
■ <a href="#">Specialist coinsurance</a>	10%
■ Hospital (facility) <a href="#">coinsurance</a>	10%
■ Other (x-ray) <a href="#">coinsurance</a>	10%

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

<b>Total Example Cost</b>	<b>\$12,700</b>	<b>Total Example Cost</b>	<b>\$5,600</b>	<b>Total Example Cost</b>	<b>\$2,800</b>
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In this example, Peg would pay:

In this example, Joe would pay:

In this example, Mia would pay:

Cost Sharing		Cost Sharing		Cost Sharing	
<a href="#">Deductibles</a>	\$0	<a href="#">Deductibles</a>	\$0	<a href="#">Deductibles</a>	\$50
<a href="#">Copayments</a>	\$0	<a href="#">Copayments</a>	\$0	<a href="#">Copayments</a>	\$0
<a href="#">Coinsurance</a>	\$1,000	<a href="#">Coinsurance</a>	\$900	<a href="#">Coinsurance</a>	\$300
What isn't covered		What isn't covered		What isn't covered	
Limits or exclusions	\$60	Limits or exclusions	\$20	Limits or exclusions	\$0
<b>The total Peg would pay is</b>	<b>\$1,060</b>	<b>The total Joe would pay is</b>	<b>\$920</b>	<b>The total Mia would pay is</b>	<b>\$350</b>

The [plan](#) would be responsible for the other costs of these EXAMPLE covered service