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 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 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?	**No.**	The Plan does not have deductibles. A copayment or coinsurance may apply for the covered services.
Are there other deductibles 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 deductibles.	You must pay all of the costs for these services up to the specific deductible amount before this plan begins to pay for these services.
What is the out-of-pocket limit for this plan?	For Plan Providers **$1,000** person. For Non-Plan Providers **$5,000** person.	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-billing charges, health care this plan doesn't cover, Non-Plan contracted facility deductibles, emergency room visit deductibles, and room/board charges for non approved hospital confinement.	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 call 1-888-877-8363 for a list of plan 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. 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 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 & Other Important Information
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	10% coinsurance	30% coinsurance	Non-emergency services provided by a non-PPO provider at a PPO facility is limited to 10% coinsurance, unless you consent to the non-PPO billing rates. Non-Plan Provider coverage limited to UCR
	Specialist visit	10% coinsurance	30% coinsurance	Non-emergency services provided by a non-PPO provider at a PPO facility is limited to 10% coinsurance, unless you consent to the non-PPO billing rates. Non-Plan Provider coverage limited to UCR
	Preventive care/ screening/ immunization	No Charge	No Charge	Non-Plan Provider coverage limited to UCR
	Telehealth Services	10% coinsurance	30% coinsurance	Non-Plan Provider coverage limited to UCR
If you have a test	Diagnostic test (x-ray, blood work)	10% coinsurance	30% coinsurance	Non-Plan Provider coverage limited to UCR
	Imaging (CT/PET scans, MRI's)	10% coinsurance	30% coinsurance	Non-Plan Provider coverage limited to UCR
	COVID-19 Test	10% coinsurance	30% coinsurance	Non-Plan Provider coverage limited to UCR
If you need drugs to treat your illness or condition **More information about prescription drug coverage**	Generic drugs	20% coinsurance retail; $5 copay 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 copay or coinsurance
	Brand drugs (preferred and non-preferred)	20% coinsurance retail; $20 copay 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 copay or coinsurance

available at www.blueshieldca.com/NetworkPPO	Specialty drugs	20% coinsurance retail; $20 copay 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).

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% coinsurance	30% coinsurance	Prior authorization required or not covered. Non-Plan Provider coverage limited to UCR. Non-emergency services provided by a non-PPO provider at a PPO facility is limited to 10% co-insurance, unless you consent to the non-PPO billing rates.
	Physician/surgeon fees	10% coinsurance	30% coinsurance	Prior authorization required or not covered. Non-Plan Provider coverage limited to UCR. Non-emergency services provided by a non-PPO provider at a PPO facility is limited to 10% co-insurance, unless you consent to the non-PPO billing rates.
If you need immediate medical attention	Emergency room care	10% coinsurance	10% coinsurance	You will have to pay 30% co-insurance 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.
	Emergency medical transportation	10% coinsurance	30% coinsurance 10% coinsurance for Air Ambulance	None
	Urgent care	10% coinsurance	30% coinsurance	None
If you have a hospital stay	Facility fee (e.g., hospital room)	10% coinsurance	30% coinsurance	Prior utilization review required or your cost will be higher. Non-Plan Provider coverage limited to UCR.

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

If your child needs dental or eye care	Children's eye exam	$10 copay	Covered up to $45	Limited to one exam per year.
	Children's glasses	$10 copay 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% coinsurance of allowed amount	30% coinsurance of allowed amount	$3,000 annual maximum. There is no deductible for preventative services.

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 correction of congenital defect of a dependent child, or for replacement of diseased tissue surgically removed.
- Hearing Aids
- Infertility treatment
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Routine foot care
- Treatment and services not medically necessary
- 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)
- Gene Therapy
- 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: U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-EBSA (3272) or 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 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.

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): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-800-278-3296 (TTY: 711)

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)

The plan's overall deductible	$0
Specialist coinsurance	10%
Hospital (facility) coinsurance	10%
Other (blood work) coinsurance	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*)

Total Example Cost	**$12,700**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$0
Copayments	$0
Coinsurance	$1,000
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$1,060**

Managing Joe's type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

The plan's overall deductible	$0
Specialist coinsurance	10%
Hospital (facility) coinsurance	10%
Other (blood work) coinsurance	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*)

Total Example Cost	**$5,600**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$0
Copayments	$0
Coinsurance	$900
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$920**

Mia's Simple Fracture
(in-network emergency room visit and follow up care)

The plan's overall deductible	$0
Specialist coinsurance	10%
Hospital (facility) coinsurance	10%
Other (x-ray) coinsurance	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*)

Total Example Cost	**$2,800**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$50
Copayments	$0
Coinsurance	$300
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$350**

The plan would be responsible for the other costs of these EXAMPLE covered service