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 blueshieldca.com/policies or call **1-800-257-6213**. 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	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?	Yes. Preventive care and other services listed in your complete terms of coverage.	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/.
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?	**$1,500** per individual /**$4,500** per 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?	Copayments for certain services, premiums, and health care this plan doesn't cover.	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 blueshieldca.com/fap or call **1-800-257-6213** 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.
Do you need a referral to see a specialist?	Yes.	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.

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/visit	Not covered	-------------------None-------------------
	Specialist visit	*Access+ specialist:* $30/visit *Other specialist:* $10/visit	Not covered	
	Preventive care/ screening/ immunization	No charge	Not covered	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)	*Lab & Path:* No Charge *X-Ray & Imaging:* No Charge *Other Diagnostic Examination:* No Charge	*Lab & Path:* Not Covered *X-Ray & Imaging:* Not Covered *Other Diagnostic Examination:* Not Covered	The services listed are at a free standing location. Preauthorization is required. Failure to obtain preauthorization may result in reduction or non-payment of benefits.
	Imaging (CT/PET scans, MRIs)	*Outpatient Radiology Center:* No Charge *Outpatient Hospital:* No Charge	*Outpatient Radiology Center:* Not Covered *Outpatient Hospital:* Not Covered	Preauthorization is required. Failure to obtain preauthorization may result in reduction or non-payment of benefits.

Common Medical Event	Services You May Need	What You Will Pay Plan Provider (You will pay the least)	 Non-Plan Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at blueshieldca.com/ formulary	Tier 1	*Retail*: $5/prescription *Mail Service*: $10/prescription	*Retail*: Not Covered *Mail Service*: Not Covered	Preauthorization is required for select drugs. Failure to obtain preauthorization may result in reduction or non-payment of benefits. *Retail*: Covers up to a 30-day supply; *Mail Service*: Covers up to a 90-day supply.
	Tier 2	*Retail*: $20/prescription *Mail Service:* $40/prescription	*Retail*: Not Covered *Mail Service*: Not Covered	
	Tier 3	*Retail:* $35/prescription *Mail Service:* $70/prescription	*Retail*: Not Covered *Mail Service*: Not Covered	
	Tier 4 (excluding Specialty drugs)	*Retail:* $50/prescription *Mail Service:* $100/prescription	Not covered	Preauthorization is required. Failure to obtain preauthorization may result in reduction or non-payment of benefits.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	*Ambulatory Surgery Center*: No Charge *Outpatient Hospital*: No Charge	*Ambulatory Surgery Center*: Not Covered *Outpatient Hospital*: Not Covered	-------------------None--------------------
	Physician/surgeon fees	No charge	Not covered	
If you need immediate medical attention	Emergency room care	*Facility Fee*: No charge *Physician Fee*: No charge	*Facility Fee*: No charge *Physician Fee*: No charge	-------------------None--------------------
	Emergency medical transportation	No Charge	No Charge	
	Urgent care	*Within Plan Service Area*: $10/visit *Outside Plan Service Area*: No charge	*Within Plan Service Area*: Not covered *Outside of Plan Service Area*: No charge	-------------------None--------------------

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Plan Provider (You will pay the least)	Non-Plan Provider (You will pay the most)	
If you have a hospital stay	Facility fee (e.g., hospital room)	$100/admission	Not covered	Preauthorization is required. Failure to obtain preauthorization may result in reduction or non-payment of benefits.
	Physician/ surgeon fees	No charge	Not covered	------------------None--------------------
If you need mental health, behavioral health, or substance abuse services	Outpatient services	*Office Visit*: $10/visit *Outpatient Services*: No Charge *Partial Hospitalization*: No Charge *Psychological Testing*: No Charge	*Office Visit*: Not Covered *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 reduction or non-payment of benefits.
	Inpatient services	*Physician Inpatient Services*: No Charge *Hospital Services*: $100/admission *Residential Care*: $100/admission	*Physician Inpatient Services*: Not Covered *Hospital Services*: Not Covered *Residential Care*: Not Covered	Preauthorization is required. Failure to obtain preauthorization may result in reduction or non-payment of benefits.
If you are pregnant	Office visits	No charge	Not covered	------------------None--------------------
	Childbirth/delivery professional services	No charge	Not covered	
	Childbirth/delivery facility services	$100/admission	Not covered	
If you need help recovering or have other special health needs	Home health care	$15/visit	Not covered	Coverage is limited to 100 visits per member per calendar year. Preauthorization is required. Failure to obtain preauthorization may result in reduction or non-payment of benefits.
	Rehabilitation services	*Office Visit*: No charge *Outpatient Hospital*: No charge	*Office Visit*: Not Covered *Outpatient Hospital*: Not Covered	------------------None--------------------

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Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Plan Provider (You will pay the least)	Non-Plan Provider (You will pay the most)	
	Habilitation services	*Office Visit*: No charge *Outpatient Hospital*: No charge	*Office Visit*: Not Covered *Outpatient Hospital*: Not Covered	
	Skilled nursing care	*Freestanding SNF*: No charge *Hospital-based SNF*: No charge	*Freestanding SNF*: Not Covered *Hospital-based SNF*: Not Covered	Coverage limited to 100 days per member calendar year. Preauthorization is required. Failure to obtain preauthorization may result in reduction or non-payment of benefits.
	Durable medical equipment	No charge	Not covered	Preauthorization is required. Failure to obtain preauthorization may result in reduction or non-payment of benefits.
	Hospice services	No charge	Not covered	
If your child needs dental or eye care	Children's eye exam	Not covered	Not covered	-----------------None------------------
	Children's glasses	Not covered	Not covered	
	Children's dental check-up	Not covered	Not covered	

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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	• Dental care (Adult) • Long-term care	• Non-emergency care when traveling outside the U.S. • Private-duty nursing	• Routine foot 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 • Chiropractic care	• Hearing aids • Infertility treatment	• 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: 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: 1-800-257-6213 or the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or dol.gov/ebsa/healthreform.

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

Spanish (Español): Para obtener asistencia en Español sin cargo, llame al 1-866-346-7198.

Tagalog (Tagalog): Kung kailanganninyo ang libreng tulongsa Tagalog tumawag sa 1-866-346-7198.

Chinese (中文): 如果需要中文的免费帮助，请拨打这个号码 1-866-346-7198.

Navajo (Dine): Diné k'ehjí doo bąąh ílínígó shíka' at'oowoł nínízingo, kwiji' hodíílnih 1-866-346-7198.

Vietnamese (Tiếng Việt): Đểđược hỗ trợ miễn phí tiếng Việt, vui lòng gọi đến số 1-866-346-7198.

Korean (한국어): 한국어도움이필요하시면, 1-866-346-7198 무료전화 로전화하십시오.

Armenian (Հայերեն): Հայերենկեզվովանվճարօգնությունստանալուհամարխնդրում ենքզանգահարել 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،لطفاً با شماره تلفن 1-866-346-7198 تماس بگیرید.

Punjabi(پنجابی):- پنجابی وچ مدد لئی مہربانی کر کے 1-866-346-7198 تے مفت کال کرو

Khmer (ភាសាខ្មែរ): [illegible] 1-866-346-7198.

Arabic(العربية): لحصول على المساعدة في اللغة العربية مجانا ، تفضل باتصال على هذا الرقم: 1-866-346-7198.

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

Hindi (हिन्दी): हिन्दीमेंबिना खर्च केसहायताकेलिए, 1-866-346-7198 परकॉलकरें।

Thai (ไทย): สำหรับความช่วยเหลือเป็นภาษาไทยโดยไม่มีค่าใช้จ่ายโปรดโทร 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 Plan pre-natal care and a hospital delivery)

The plan's overall deductible	$0
Specialist copayment	$10
Hospital (facility) copayment	$0
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:

Cost Sharing	
Deductibles	$0
Copayments	$60
Coinsurance	$0
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$120**

Managing Joe's Type 2 Diabetes
(a year of routine Plan care of a well-controlled condition)

The plan's overall deductible	$0
Specialist copayment	$10
Hospital (facility) copayment	$0
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:

Cost Sharing	
Deductibles	$0
Copayments	$735
Coinsurance	$0
What isn't covered	
Limits or exclusions	$1,783
The total Joe would pay is	**$2,518**

Mia's Simple Fracture
(Plan emergency room visit and follow up care)

The plan's overall deductible	$0
Specialist copayment	$10
Hospital (facility) copayment	$0
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	**$2,500**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$0
Copayments	$370
Coinsurance	$18
What isn't covered	
Limits or exclusions	$37
The total Mia would pay is	**$425**

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

blue of california

Notice Informing Individuals about Nondiscrimination and Accessibility Requirements

Discrimination is against the law

Blue Shield of California complies with applicable federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability or sex. Blue Shield of California does not exclude people or treat them differently because of race, color, national origin, age, disability or sex.

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, age, disability or sex, 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: (916) 350-7405
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.**