



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, you can get the complete terms in the policy or plan document at www.blueshieldca.com/sisc or by calling 1-855-256-9404. 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 1-855-256-9404 to request a copy.

Important Questions	Answers	Why this Matters:
What is the overall <u>deductible</u> ?	\$300 per individual / \$600 per family Does not apply to preventive care and prescription drugs.	Generally, you must pay all of the costs from providers up to the <u>deductible</u> amount before this <u>plan</u> begins to pay. If you have other family members on the <u>plan</u> , each family member must meet their own individual <u>deductible</u> until the total amount of <u>deductible</u> expenses paid by all family members meets the overall family <u>deductible</u> .
Are there services covered before you meet your <u>deductible</u> ?	Yes. <u>Preventive care</u> and primary care services are covered before you meet your <u>deductible</u> .	This <u>plan</u> covers some items and services even if you haven't yet met the <u>deductible</u> amount. But a <u>copayment</u> or <u>coinsurance</u> may apply. For example, this <u>plan</u> covers certain <u>preventive services</u> without <u>cost-sharing</u> and before you meet your <u>deductible</u> . See a list of covered <u>preventive services</u> at https://www.healthcare.gov/coverage/preventive-care-benefits/ .
Are there other <u>deductibles</u> for specific services?	No.	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>network providers</u> : \$1,000 individual / \$3,000 family for medical, and \$1,500 individual/ \$2,500 family for prescription drugs.	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> ?	<u>Copayments</u> for certain services, <u>premiums</u> , <u>balance-billing</u> charges, and health care this <u>plan</u> doesn't cover.	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. For a list of PPO <u>providers</u> , see www.blueshieldca.com/sisc or call 1-855-256-9404.	This <u>plan</u> uses a provider <u>network</u> . You will pay less if you use a <u>provider</u> in the plan's <u>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 provider's 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.
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		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	\$20 / visit	50% <u>coinsurance</u>	None
	Specialist visit	\$20 / visit	50% <u>coinsurance</u>	None
	Preventive care/screening/immunization	No Charge	Not Covered	None
If you have a test	Diagnostic test (x-ray, blood work)	10% <u>coinsurance</u>	Not Covered	None
	Imaging (CT/PET scans, MRIs)	10% <u>coinsurance</u>	50% <u>coinsurance</u>	Prior authorization is required.
If you need drugs to treat your illness or condition More information about <u>prescription drug coverage</u> is available at www.navitus.com	Generic drugs	Retail 30-Days: Costco: \$0/Rx Other: \$7/Rx Mail 90-Days: \$0/Rx	Member must pay the entire cost up front and apply for reimbursement. Net cost may be greater than if member uses an In-network provider.	Some narcotic pain medications and cough medications require the regular retail copay at Costco and 3 times the regular copay at Mail.
	Brand drugs	Brand: Retail 30-Days: Costco: \$25/Rx Other: \$25/Rx Mail 90-Days: \$60/Rx		If a brand drug is dispensed when a generic equivalent is available, then the member will be responsible for the generic copayment plus the cost difference between the generic and brand.
	Specialty drugs	Specialty: 30-Days: \$25/Rx	Not Covered	Member must use Navitus Specialty Rx. Supplies of more than 30 days are not allowed
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	10% <u>coinsurance</u>	0% coinsurance with \$350/day max	Coverage is limited to \$350 /Admit for Non-Network Ambulatory Surgery Center. Certain surgeries are subject to utilization review.
	Physician/surgeon fees	10% <u>coinsurance</u>	50% <u>coinsurance</u>	None

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need immediate medical attention	<u>Emergency room care</u>	\$100 / visit +10% coinsurance	\$100 / visit +10% coinsurance	\$100 Copayment waived if admitted. You are responsible for billed charges exceeding maximum allowed amount for <u>out-of-network</u> providers.
	<u>Emergency medical transportation</u>	\$100 / visit +10% coinsurance	\$100 / visit +10% coinsurance	None
	<u>Urgent care</u>	\$20 / visit	50% coinsurance	None
If you have a hospital stay	Facility fee (e.g., hospital room)	10% coinsurance	0% coinsurance with \$600/day max	The maximum <u>plan</u> payment for non-emergency hospital services received from a <u>non-preferred</u> hospital is \$600 per day. Members are responsible for all charges in excess of \$600. Failure to prior authorize may result in reduced or nonpayment of benefits.
	Physician/surgeon fee	10% coinsurance	50% coinsurance	None
If you have mental health, behavioral health, or substance abuse needs	Outpatient services	Office Visit: \$20 / visit Facility: 10% coinsurance	50% coinsurance	None
	Inpatient services	10% coinsurance	50% coinsurance	This is for facility professional services only. Please refer to your hospital stay for facility fee.
If you are pregnant	Office Visits	\$20 / visit	50% coinsurance	<u>Cost sharing</u> does not apply for <u>preventative services</u> . Depending on the type of services, a <u>copayment</u> , <u>coinsurance</u> , or <u>deductible</u> may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound.)
	Childbirth/delivery professional services	10% coinsurance	50% coinsurance	None

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
	Childbirth/delivery facility services	10% <u>coinsurance</u>	0% <u>coinsurance</u> with \$600/day max	<u>Non-Preferred</u> facility are subject to a maximum benefit payment up to \$600 per day.
If you need help recovering or have other special health needs	<u>Home health care</u>	10% <u>coinsurance</u>	Not Covered	Covers up to 100 visits per calendar year. <u>Non-preferred home health care</u> and home infusion are not covered unless pre-authorized. When these services are pre-authorized, you pay the <u>preferred provider copayment</u> . Prior authorization is required. Failure to prior authorize may result in reduced or nonpayment of benefits.
	<u>Rehabilitation services</u>	10% <u>coinsurance</u>	Not Covered	None
	<u>Habilitation services</u>	10% <u>coinsurance</u>	Not Covered	None
	<u>Skilled nursing care</u>	10% <u>coinsurance</u> at freestanding SNF	10% <u>coinsurance</u> at freestanding SNF	Covers up to 100 days per calendar year combined with Hospital Skilled Nursing Facility Unit. Prior authorization is required. Failure to prior authorize may result in reduced or nonpayment of benefits.
	<u>Durable medical equipment</u>	10% <u>coinsurance</u>	Not Covered	Prior authorization is required. Therapeutic shoes & inserts for members with diabetes (2 pairs each/calendar year).
	<u>Hospice service</u>	10% <u>coinsurance</u>	Not Covered	Prior authorization is required.
If your child needs dental or eye care	Children's eye exam	Not Covered	Not Covered	None
	Children's glasses	Not Covered	Not Covered	None
	Children's dental check-up	Not Covered	Not Covered	None

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
- Dental care (Adult/Child)
- Infertility treatment
- Long-term care
- Routine foot care
- Private -duty nursing
- Routine eye care (Adult/Child)
- Services not deemed **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.)

- Acupuncture
- Hearing aids
- Bariatric surgery
- Chiropractic care

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: [insert State, HHS, DOL, and/or other applicable agency contact information]. 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 of California
ATTN: Initial Appeals
P.O. Box 5588
El Dorado Hills, CA 95762-0011

Or Contact: 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.

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 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 1-866-346-7198.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-866-346-7198.

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

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijigo holne' 1-866-346-7198.

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 <u>plan's</u> overall <u>deductible</u>	\$300
■ <u>Specialist copayment</u>	\$20
■ Hospital (facility) <u>coinsurance</u>	10%
■ Other <u>coinsurance</u>	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	\$12,800
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In this example, Peg would pay:

<i>Cost Sharing</i>	
Deductibles	\$300
Copayments	\$300
Coinsurance	\$400
<i>What isn't covered</i>	
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 <u>plan's</u> overall <u>deductible</u>	\$300
■ <u>Specialist copayment</u>	\$20
■ Hospital (facility) <u>coinsurance</u>	10%
■ Other <u>coinsurance</u>	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	\$7,400
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In this example, Joe would pay:

<i>Cost Sharing</i>	
Deductibles	\$200
Copayments	\$900
Coinsurance	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$70
The total Joe would pay is	\$1,170

Mia's Simple Fracture

(in-network emergency room visit and follow up care)

■ The <u>plan's</u> overall <u>deductible</u>	\$300
■ <u>Specialist copayment</u>	\$20
■ Hospital (facility) <u>coinsurance</u>	10%
■ Other <u>coinsurance</u>	10%

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	\$1,900
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In this example, Mia would pay:

<i>Cost Sharing</i>	
Deductibles	\$300
Copayments	\$200
Coinsurance	\$100
<i>What isn't covered</i>	
Limits or exclusions	\$0
The total Mia would pay is	\$600

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