Gold Local Access+ HMO® 500/35 OffEx

Coverage Period: Beginning On or After 1/1/2017

Summary of Benefits and Coverage: What this Plan Covers & What it Costs **Coverage for:** Individual + Family | **Plan Type:** HMO

This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at www.blueshieldca.com/bsca/bsc/public/employer/DisplayDocument?fileName=201701A48541.pdf or by calling **1-888-319-5999**.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	For plan providers: **$500** per individual / **$1,000** per family calendar year deductible for facility services. The Calendar Year Medical Deductible does not apply to breast pump, chiropractic benefits, initial prenatal and preconception physician office visit, outpatient prescription drug benefits, physician and specialist office visits, preventive health benefits, pediatric vision benefits at participating providers, and other services listed in your plan documents. Includes medical care cost-shares; in a family, a member only needs to satisfy the individual deductible, not the entire family deductible, prior to receiving plan benefits.	You must pay all the costs up to the **deductible** amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the **deductible** starts over (usually, but not always, January 1st). See the chart starting on page 3 for how much you pay for covered services after you meet the **deductible**.
Are there other deductibles for specific services?	No.	You don't have to meet **deductibles** for specific services, but see the chart starting on page 3 for other costs for services this plan covers.

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Important Questions	Answers	Why this Matters:
Is there an out-of-pocket limit on my expenses?	Yes. For plan providers: **$5,600** per individual / **$11,200** per family. Annual Out-of-Pocket Maximums includes calendar year medical deductible, physician office dollar copay & prescription drug copays; for an individual on family coverage plan, a member can receive 100% benefits for covered services once the individual out-of-pocket maximum is met.	The **out-of-pocket limit** is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.
What is not included in the out-of-pocket limit?	Premiums, chiropractic, infertility treatment, some copayments, cost sharing for certain services listed in formal contract of coverage, and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the **out-of-pocket limit**.
Is there an overall annual limit on what the plan pays?	No.	The chart starting on page 3 describes any limits on what the plan will pay for *specific* covered services, such as office visits.
Does this plan use a network of providers?	Yes. This health plan uses the Local Access+ HMO Provider Network. See www.blueshieldca.com **or call 1-888-319-5999** for a list of plan providers.	If you use an in-network doctor or other health care **provider**, this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network **provider** for some services. Plans use the term in-network, **preferred**, or participating for **providers** in their **network**. See the chart starting on page 3 for how this plan pays different kinds of **providers**.
Do I need a referral to see a specialist?	Yes. Members need written approval to see a specialist except for OB/GYN or pediatrician serving as Primary Care Physician. Members may self refer using the Access+ Self Referral feature or for OB/GYN services. Please see the formal contract of coverage for details.	The plan will pay some or all of the costs to see a **specialist** for covered services but only if you have the plan's permission before you see the **specialist**.

Important Questions	Answers	Why this Matters:
Are there services this plan doesn't cover?	Yes.	Some of the services this plan doesn't cover are listed on page 12. See your policy or plan document for additional information about **excluded services**.

- **Copayments** are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.
- **Coinsurance** is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is $1,000, your **coinsurance** payment of 20% would be $200. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges $1,500 for an overnight stay and the **allowed amount** is $1,000, you may have to pay the $500 difference. (This is called **balance billing**.)
- This plan may encourage you to use plan **providers** by charging you lower **deductibles**, **copayments** and **coinsurance** amounts.

Common Medical Event	Services You May Need	Your Cost If You Use a Plan Provider	Your Cost If You Use a Non-Plan Provider	Limitations & Exceptions
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$35 copayment / visit	Not Covered	For other services received during the office visit, additional member cost-share may apply.
	Specialist visit	$55 copayment / visit	Not Covered	For other services received during the office visit, additional member cost-share may apply. $55 copayment per visit for Access+ Specialist Self Referral.
	Other practitioner office visit	Acupuncture: $15 copayment / visit Chiropractic: $15 copayment / visit	Not Covered	Coverage for chiropractic services is limited to 15 visits per calendar year. Services provided by American Specialty Health (ASH) Network. Additional member cost-share applies for covered X-ray services received in conjunction with the office visit.

Common Medical Event	Services You May Need	Your Cost If You Use a Plan Provider	Your Cost If You Use a Non-Plan Provider	Limitations & Exceptions
	Preventive care/screening /immunization	No Charge	Not Covered	Preventive health services are only covered when provided by plan providers. Coverage for services consistent with ACA requirements and California laws. Please refer to your plan contract for details.
If you have a test	Diagnostic test (x-ray, blood work)	Lab & Path at Free-Standing Location: $35 copayment / visit X-Ray & Imaging at Free-Standing Radiology Center: $50 copayment / visit Other Diagnostic Examination at Free-Standing Location: $50 copayment / visit Other Diagnostic Examination at Outpatient Hospital: $50 copayment / visit	Not Covered	Benefits in this section are for diagnostic, non-preventive health services. Pre-authorization from primary care physician and medical plan is required. Failure to obtain pre-authorization for non-emergency procedures may result in non-payment of benefits.

Common Medical Event	Services You May Need	Your Cost If You Use a Plan Provider	Your Cost If You Use a Non-Plan Provider	Limitations & Exceptions
	Imaging (CT/PET scans, MRIs)	Radiological & Nuclear Imaging at Free-Standing Radiology Center: $50 copayment / visit Radiological & Nuclear Imaging at Outpatient Hospital: $250 copayment / visit	Not Covered	Benefits in this section are for diagnostic, non-preventive health services. Pre-authorization from primary care physician and medical plan is required. Failure to obtain pre-authorization for non-emergency procedures may result in non-payment of benefits. Radiological & Nuclear Imaging at Outpatient Hospital: Subject to calendar year deductible for facility services.

Common Medical Event	Services You May Need	Your Cost If You Use a Plan Provider	Your Cost If You Use a Non-Plan Provider	Limitations & Exceptions
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.blueshieldca.com/bsca/pharmacy	Tier 1 Drugs	Retail Pharmacies: $15 copayment / prescription Mail Service Pharmacies: $30 copayment / prescription	Not Covered	Retail Pharmacies: Covers up to a 30-day supply. Mail Service Pharmacies: Covers up to 90-day supply, except Specialty Drugs. Select formulary and non-formulary drugs require Prior Authorization. Blue Shield's Short Cycle Specialty Drug Program allows initial prescriptions for select Tier 4 drugs to be dispensed for a 15-day trial supply. In such circumstances the Tier 4 cost share will be pro-rated. Prior Authorization is required.
	Tier 2 Drugs	Retail Pharmacies: $30 copayment / prescription Mail Service Pharmacies: $60 copayment / prescription	Not Covered	
	Tier 3 Drugs	Retail Pharmacies: $50 copayment / prescription Mail Service Pharmacies: $100 copayment / prescription	Not Covered	
	Tier 4 Drugs	Network Specialty Pharmacies and Retail Pharmacies: 20% coinsurance up to $250 maximum / prescription Mail Service Pharmacies: 20% coinsurance up to $500 maximum / prescription	Not Covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance	Not Covered	-----------------None-----------------
	Physician/surgeon fees	No Charge	Not Covered	-----------------None-----------------

Common Medical Event	Services You May Need	Your Cost If You Use a Plan Provider	Your Cost If You Use a Non-Plan Provider	Limitations & Exceptions
If you need immediate medical attention	Emergency room services	ER Facility Fee: $250 copayment / visit ER Physician Fee: No Charge	ER Facility Fee: $250 copayment / visit ER Physician Fee: No Charge	Copayment waived if admitted; standard inpatient hospital facility benefits apply. This is for the hospital/facility charge only. The ER physician charge is separate. Coverage outside of California under BlueCard. Subject to calendar year deductible for facility services.
	Emergency medical transportation	$100 copayment / transport	$100 copayment / transport	------------------None------------------
	Urgent care	Within Plan service area: $35 copayment / visit Outside Plan service area: $35 copayment / visit	Within Plan service area: Not Covered Outside Plan service area: $35 copayment / visit	Pre-authorization from primary care physician and medical plan is required. Failure to obtain pre-authorization for non-emergency procedures may result in non-payment of benefits.
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance	Not Covered	Pre-authorization from primary care physician and medical plan is required. Failure to obtain pre-authorization for non-emergency procedures may result in non-payment of benefits. Subject to calendar year deductible for facility services.
	Physician/surgeon fee	No Charge	Not Covered	------------------None------------------

Common Medical Event	Services You May Need	Your Cost If You Use a Plan Provider	Your Cost If You Use a Non-Plan Provider	Limitations & Exceptions
If you have mental health, behavioral health, or substance use disorder needs	Mental/Behavioral health outpatient services	Mental Health Routine Outpatient Services: $35 copayment / visit Mental Health Non-Routine Outpatient Services: No Charge	Not Covered	Mental Health Routine Outpatient Services: Services include professional/physician office visits. Mental Health Non-Routine Outpatient Services: Services include behavioral health treatment, electroconvulsive therapy, intensive outpatient programs, partial hospitalization programs, and transcranial magnetic stimulation. Higher copayment and facility charges per episode of care may apply for partial hospitalization programs. Pre-authorization from Mental Health Service Administrator (MHSA) is required for non-routine outpatient mental health services. Failure to obtain pre-authorization may result in non-payment of benefits.

Common Medical Event	Services You May Need	Your Cost If You Use a Plan Provider	Your Cost If You Use a Non-Plan Provider	Limitations & Exceptions
	Mental/Behavioral health inpatient services	Mental Health Inpatient Hospital Services: 20% coinsurance Mental Health Residential Services: 20% coinsurance Mental Health Inpatient Physician Services: No Charge	Not Covered	Mental Health Inpatient Hospital Services: Subject to calendar year deductible for facility services. Mental Health Residential Services: Pre-authorization from Mental Health Service Administrator (MHSA) is required. Failure to obtain pre-authorization may result in non-payment of benefits. Subject to calendar year deductible for facility services.
	Substance use disorder outpatient services	Substance Use Disorder Routine Outpatient Services: $35 copayment / visit Substance Use Disorder Non-Routine Outpatient Services: No Charge	Not Covered	Substance Use Disorder Routine Outpatient Services: Services include professional/physician office visits. Substance Use Disorder Non-Routine Outpatient Services: Services include partial hospitalization program, intensive outpatient program, and office-based opioid detoxification and/or maintenance therapy. Higher copayment and facility charges per episode of care may apply for partial hospitalization programs. Pre-authorization from Mental Health Service Administrator (MHSA) is required for non-routine outpatient substance use disorder services. Failure to obtain pre-authorization may result in non-payment of benefits.

Common Medical Event	Services You May Need	Your Cost If You Use a Plan Provider	Your Cost If You Use a Non-Plan Provider	Limitations & Exceptions
	Substance use disorder inpatient services	Substance Use Disorder Inpatient Hospital Services: 20% coinsurance Substance Use Disorder Residential Services: 20% coinsurance Substance Use Disorder Inpatient Physician Services: No Charge	Not Covered	Substance Use Disorder Inpatient Hospital Services: Subject to calendar year deductible for facility services. Substance Use Disorder Residential Services: Pre-authorization from Mental Health Service Administrator (MHSA) is required. Failure to obtain pre-authorization may result in non-payment of benefits. Subject to calendar year deductible for facility services.
If you are pregnant	Prenatal and postnatal care	Prenatal and preconception physician office visits: No Charge Postnatal physician office visit – initial visit: No Charge	Not Covered	Not subject to calendar year medical deductible at participating providers.
	Delivery and all inpatient services	20% coinsurance	Not Covered	Subject to calendar year deductible for facility services.
If you need help recovering or have other special health needs	Home health care	$35 copayment / visit	Not Covered	Coverage limited to 100 visits per member per calendar year. Pre-authorization from primary care physician and medical plan is required. Failure to obtain pre-authorization may result in non-payment of benefits.

Common Medical Event	Services You May Need	Your Cost If You Use a Plan Provider	Your Cost If You Use a Non-Plan Provider	Limitations & Exceptions
	Rehabilitation services	Office visit: $35 copayment / visit Outpatient hospital: $35 copayment / visit	Not Covered	Coverage for physical, occupational, and respiratory therapy services.
	Habilitative services	Office visit: $35 copayment / visit Outpatient hospital: $35 copayment / visit	Not Covered	
	Skilled nursing care	$300 copayment / day	Not Covered	Coverage limited to 100 days per member per benefit period combined with hospital/free-standing skilled nursing facility. Pre-authorization from primary care physician and medical plan is required. Failure to obtain pre-authorization may result in non-payment of benefits. Subject to calendar year deductible for facility services.
	Durable medical equipment	50% coinsurance	Not Covered	Pre-authorization from primary care physician and medical plan is required. Failure to obtain pre-authorization may result in non-payment of benefits.
	Hospice service	No Charge	Not Covered	Pre-authorization from primary care physician and medical plan is required. Failure to obtain pre-authorization may result in non-payment of benefits. Subject to calendar year facility deductible for inpatient facility services.

Common Medical Event	Services You May Need	Your Cost If You Use a Plan Provider	Your Cost If You Use a Non-Plan Provider	Limitations & Exceptions
If your child needs dental or eye care	Eye exam	No Charge	Not Covered	Coverage limited to one comprehensive eye exam per calendar year. Services provided by Blue Shield's Vision Plan Administrator (VPA).
	Glasses	No Charge	Not Covered	Coverage limited to one pair of eyeglasses (frames and lenses) or contact lenses in lieu of eyeglasses per calendar year. Greater quantities are available for certain kinds of contact lenses. Services provided by Blue Shield's Vision Plan Administrator (VPA).
	Dental check-up	No Charge	Not Covered	Pediatric dental benefits are available for members through the end of the month in which the member turns 19. Coverage for dental check-up is limited to 2 visits in a twelve month period. Please refer to your plan contract for details.

Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy or plan document for other excluded services.)		
• Cosmetic surgery	• Long-term care	• Routine eye care (Adult)
• Dental care (Adult)	• Non-emergency care when traveling outside the U.S.	• Routine foot care (unless for treatment of diabetes)
• Hearing aids	• Private-duty nursing	• Weight loss programs

Other Covered Services **(This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)**		
• Acupuncture	• Chiropractic care (coverage limited to 15 visits per calendar year.)	• Infertility treatment (coverage for diagnosis and treatment of cause of infertility only.)
• Bariatric surgery (Pre-authorization from primary care physician and medical plan is required. Failure to obtain pre-authorization may result in non-payment of benefits.)	• Dental care (Child) (Two dental check-ups in a twelve month period.)	• Routine eye care (Child) (one comprehensive eye exam per calendar year.)

Your Rights to Continue Coverage:

If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a **premium**, which may be significantly higher than the premium you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply.
For more information on your rights to continue coverage, contact the plan at **1-888-319-5999**. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa, or the U.S. Department of Health and Human Services at 1-877-267-2323 X 61565 or www.cciio.cms.gov.

Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to **appeal** or file a **grievance**. For questions about your rights, this notice, or assistance, you can contact: **1-888-319-5999** or the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform. Additionally, a consumer assistance program can help you file your **appeal**. Contact California Department of Managed Health Care Help at 1-888-466-2219 or visit http://www.healthhelp.ca.gov.

Does this Coverage Provide Minimum Essential Coverage?

The Affordable Care Act requires most people to have health care coverage that qualifies as "minimum essential coverage." **This plan or policy does provide minimum essential coverage.**

Does this Coverage Meet the Minimum Value Standard?

The Affordable Care Act establishes a minimum value standard of benefits of a health plan. The minimum value standard is 60% (actuarial value). **This health coverage does meet the minimum value standard for the benefits it provides.**

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, kwiijigo holne' 1-866-346-7198.

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

Korean (한국어): 한국어 도움이 필요하시면, 1-866-346-7198 로 전화하십시오.

Armenian (Հայերեն): Հայերեն լեզվով օգնություն ստանալու համար խնդրում ենք զանգահարել 1-866-346-7198.

Russian (Русский): если нужна 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。

Persian (فارسی): برای دریافت کمک به 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 کال کرو۔

Khmer (ភាសាខ្មែរ): សម្រាប់ជំនួយជាភាសាខ្មែរ សូមទាក់ទងមកលេខ 1-866-346-7198.

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

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

Hindi (हिन्दी): हिन्दी में सहायता के लिए, 1-866-346-7198 पर कॉल करें।.

Thai (ไทย): สำหรับความช่วยเหลือเป็นภาษาไทย โปรดโทร 1-866-346-7198.

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

About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.

This is not a cost estimator.

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

Having a baby
(normal delivery)

- **Amount owed to providers:** $7,540
- **Plan pays** $5,640
- **Patient pays** $1,900

Sample care costs:

Hospital charges (mother)	$2,700
Routine obstetric care	$2,100
Hospital charges (baby)	$900
Anesthesia	$900
Laboratory tests	$500
Prescriptions	$200
Radiology	$200
Vaccines, other preventive	$40
Total	**$7,540**

Patient pays:

Deductibles	$500
Copays	$460
Coinsurance	$790
Limits or exclusions	$150
Total	**$1,900**

Managing type 2 diabetes
(routine maintenance of a well-controlled condition)

- **Amount owed to providers:** $5,400
- **Plan pays** $3,590
- **Patient pays** $1,810

Sample care costs:

Prescriptions	$2,900
Medical Equipment and Supplies	$1,300
Office Visits and Procedures	$700
Education	$300
Laboratory tests	$100
Vaccines, other preventive	$100
Total	**$5,400**

Patient pays:

Deductibles	$0
Copays	$1,090
Coinsurance	$640
Limits or exclusions	$80
Total	**$1,810**

Questions and answers about the Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

- Costs don't include **premiums**.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network **providers**. If the patient had received care from out-of-network **providers**, costs would have been higher.
- Plan and patient payments are based on a single person enrolled on the plan or policy.

What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how **deductibles**, **copayments**, and **coinsurance** can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

Does the Coverage Example predict my own care needs?

✗ **No.** Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

Does the Coverage Example predict my future expenses?

✗ **No.** Coverage Examples are **not** cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your **providers** charge, and the reimbursement your health plan allows.

Can I use Coverage Examples to compare plans?

✓ **Yes.** When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

Are there other costs I should consider when comparing plans?

✓ **Yes.** An important cost is the **premium** you pay. Generally, the lower your **premium**, the more you'll pay in out-of-pocket costs, such as **copayments**, **deductibles**, and **coinsurance**. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.

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