


Summary of Benefits and Coverage: What this Plan Covers & What You Pay For Covered Services




Coverage Period: Beginning On or After 1/1/2018
 Coverage for: Individual + Family | Plan Type: HMO

Platinum Trio HMO 0/30 OffEx INF

 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 bsca.com/policies/M0014188_EOC.pdf or call 1-888-319-5999. 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. <u>Preventive care</u> and 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 <u>copayment</u> or <u>coinsurance</u> may apply. For example, this plan covers certain <u>preventive services</u> without <u>cost-sharing</u> and before you meet your deductible. See a list of covered <u>preventive services</u> at healthcare.gov/coverage/preventive-care-benefits . |
| Are there other deductibles for specific services? | No. | You don't have to meet <u>deductibles</u> for specific services. |
| What is the out-of-pocket limit for this plan? | \$2,250 per individual / \$4,500 per family for <u>participating providers</u> . | The <u>out-of-pocket</u> limit is the most you could pay in a year for covered services. If you have other family members in this plan, the overall family <u>out-of-pocket</u> limit must be met. |
| What is not included in the out-of-pocket limit? | <u>Copayments</u> for certain services, <u>premiums</u> , and health care this plan doesn't cover. | Even though you pay these expenses, they don't count toward the <u>out-of-pocket</u> limit. |
| Will you pay less if you use a network provider? | Yes. See blueshieldca.com/fap or call 1-888-319-5999 for a list of <u>network providers</u> . | This plan uses a <u>provider network</u> . You will pay less if you use a <u>provider</u> in the plan's network. You will pay the most if you use an <u>out-of-network</u> provider, and you might receive a bill from a <u>provider</u> for the difference between the <u>provider's</u> charge and what your plan pays (<u>balance billing</u>). Be aware, your <u>network provider</u> might use an <u>out-of-network</u> provider for some services (such as lab work). Check with your <u>provider</u> 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 <u>specialist</u> for covered services but only if you have a <u>referral</u> before you see the <u>specialist</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 |
|--|--|---|--|---|
| | | <u>Participating Provider</u> (You will pay the least) | <u>Non-Participating Provider</u> (You will pay the most) | |
| If you visit a health care <u>provider's</u> office or clinic | Primary care visit to treat an injury or illness | \$30/visit | Not Covered | -----None----- |
| | <u>Specialist</u> visit | <i>Trio+ Specialist:</i> \$50/visit <i>Other Specialist:</i> \$50/visit | Not Covered | |
| | <u>Preventive care/screening</u> /immunization | No Charge | Not Covered | You may have to pay for services that aren't <u>preventive</u> . Ask your <u>provider</u> if the services needed are <u>preventive</u> . Then check what your <u>plan</u> will pay for. |
| If you have a test | <u>Diagnostic test</u> (x-ray, blood work) | <i>Lab & Path:</i> \$30/visit <i>X-Ray & Imaging:</i> \$50/visit <i>Other Diagnostic Examination:</i> \$50/visit | <i>Lab & Path:</i> Not Covered <i>X-Ray & Imaging:</i> Not Covered <i>Other Diagnostic Examination:</i> Not Covered | <u>Preauthorization</u> is required. Failure to obtain <u>preauthorization</u> may result in non-payment of benefits. The services listed are at a freestanding location. |
| | Imaging (CT/PET scans, MRIs) | <i>Outpatient Radiology Center:</i> \$50/visit <i>Outpatient Hospital:</i> \$250/visit | <i>Outpatient Radiology Center:</i> Not Covered <i>Outpatient Hospital:</i> Not Covered | <u>Preauthorization</u> is required. Failure to obtain <u>preauthorization</u> may result in non-payment of benefits. |

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|---|--|---|--|--|
| | | <u>Participating Provider</u> (You will pay the least) | <u>Non-Participating Provider</u> (You will pay the most) | |
| If you need drugs to treat your illness or condition More information about prescription drug coverage is available at blueshieldca.com/formulary | Tier 1 | <i>Retail:</i> \$5/prescription <i>Mail Service:</i> \$10/prescription | <i>Retail:</i> Not Covered <i>Mail Service:</i> Not Covered | <u>Preauthorization</u> is required for select drugs. Failure to obtain <u>preauthorization</u> may result in non-payment of benefits. <i>Retail:</i> Covers up to a 30-day supply; <i>Mail Service:</i> Covers up to a 90-day supply. |
| | Tier 2 | <i>Retail:</i> \$15/prescription <i>Mail Service:</i> \$30/prescription | <i>Retail:</i> Not Covered <i>Mail Service:</i> Not Covered | |
| | Tier 3 | <i>Retail:</i> \$25/prescription <i>Mail Service:</i> \$50/prescription | <i>Retail:</i> Not Covered <i>Mail Service:</i> Not Covered | |
| | Tier 4 | <i>Retail and Network Specialty Pharmacies:</i> 20% <u>coinsurance</u> up to \$250/prescription <i>Mail Service:</i> 20% <u>coinsurance</u> up to \$500/prescription | <i>Retail:</i> Not Covered <i>Mail Service:</i> Not Covered | |
| If you have outpatient surgery | Facility fee (e.g., ambulatory surgery center) | <i>Ambulatory Surgery Center:</i> \$100/surgery <i>Outpatient Hospital:</i> \$150/surgery | <i>Ambulatory Surgery Center:</i> Not Covered <i>Outpatient Hospital:</i> Not Covered | -----None----- |
| | Physician/surgeon fees | No Charge | Not Covered | -----None----- |
| If you need immediate medical attention | <u>Emergency room care</u> | <i>Facility Fee:</i> \$250/visit <i>Physician Fee:</i> No Charge | <i>Facility Fee:</i> \$250/visit <i>Physician Fee:</i> No Charge | -----None----- |
| | <u>Emergency medical transportation</u> | \$100/transport | \$100/transport | -----None----- |

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|--|---|--|---|--|
| | | <u>Participating Provider</u> (You will pay the least) | <u>Non-Participating Provider</u> (You will pay the most) | |
| | <u>Urgent care</u> | <i>Within Plan Service Area:</i> \$30/visit <i>Outside Plan Service Area:</i> \$30/visit | <i>Within Plan Service Area:</i> Not Covered <i>Outside Plan Service Area:</i> \$30/visit | -----None----- |
| If you have a hospital stay | Facility fee (e.g., hospital room) | \$500/day | Not Covered | <u>Preauthorization</u> is required. Failure to obtain <u>preauthorization</u> may result in 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 | <i>Office Visit:</i> \$30/visit <i>Other Outpatient Services:</i> No Charge <i>Partial Hospitalization:</i> No Charge <i>Psychological Testing:</i> No Charge | <i>Office Visit:</i> Not Covered <i>Other Outpatient Services:</i> Not Covered <i>Partial Hospitalization:</i> Not Covered <i>Psychological Testing:</i> Not Covered | <u>Preauthorization</u> is required except for office visits. Failure to obtain <u>preauthorization</u> may result in non-payment of benefits. |
| | Inpatient services | <i>Physician Inpatient Services:</i> No Charge <i>Hospital Services:</i> \$500/day <i>Residential Care:</i> \$500/day | <i>Physician Inpatient Services:</i> Not Covered <i>Hospital Services:</i> Not Covered <i>Residential Care:</i> Not Covered | <u>Preauthorization</u> is required. Failure to obtain <u>preauthorization</u> may result in 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 | \$500/day | Not Covered | |
| If you need help recovering or have other special health needs | <u>Home health care</u> | \$30/visit | Not Covered | <u>Preauthorization</u> is required. Failure to obtain <u>preauthorization</u> may result in non-payment of benefits. Coverage limited to 100 visits per member per calendar year. |

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|---|----------------------------------|--|--|---|
| | | <u>Participating Provider</u> (You will pay the least) | <u>Non-Participating Provider</u> (You will pay the most) | |
| | <u>Rehabilitation services</u> | Office Visit: \$30/visit Outpatient Hospital: \$30/visit | Office Visit: Not Covered Outpatient Hospital: Not Covered | -----None----- |
| | <u>Habilitation services</u> | Office Visit: \$30/visit Outpatient Hospital: \$30/visit | Office Visit: Not Covered Outpatient Hospital: Not Covered | |
| | <u>Skilled nursing care</u> | Freestanding SNF: \$100/day Hospital-based SNF: \$100/day | Freestanding SNF: Not Covered Hospital-based SNF: Not Covered | <u>Preauthorization</u> is required. Failure to obtain <u>preauthorization</u> may result in non-payment of benefits. Coverage limited to 100 days per member per benefit period. |
| | <u>Durable medical equipment</u> | 50% <u>coinsurance</u> | Not Covered | <u>Preauthorization</u> is required. Failure to obtain <u>preauthorization</u> may result in non-payment of benefits. |
| | <u>Hospice services</u> | No Charge | Not Covered | <u>Preauthorization</u> is required except for pre-hospice consultation. Failure to obtain <u>preauthorization</u> may result in non-payment of benefits. |
| If your child needs dental or eye care | Children's eye exam | No Charge | Not Covered | Coverage limited to one exam per member per calendar year. |
| | Children's glasses | No Charge | Not Covered | Coverage is limited to one eyeglass frame and eyeglass lenses or contact lenses instead of eyeglasses, up to the benefit per calendar year. The cost listed is for Single Vision. |
| | Children's dental check-up | No Charge | Not Covered | Coverage for prophylaxis services (cleaning) is limited to two visits per member per calendar year. |

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)
- Hearing Aids
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing
- Routine eye care (Adult)
- 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.)

- Acupuncture
- Bariatric surgery
- Chiropractic Care
- Infertility Treatment

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: Blue Shield Customer Service at 1-888-319-5999 or the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or dol.gov/ebsa/healthreform. Additionally, you can contact the California Department of Managed Health Care Help at 1-888-466-2219 or visit helpline@dmhc.ca.gov or visit <http://www.healthhelp.ca.gov>.

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 tulong sa 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 shika' at'oowoł nínízingo, kwiji' hodíílnih 1-866-346-7198.

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

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

Armenian (Հայերեն): Հայերենի օգնությունը անվճարով է ապահովվում հայերենով 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 (ਪੰਜਾਬੀ): ਪੰਜਾਬੀ ਉੱਚ ਮੱਦ ਲਈ ਮੋਹਰੀਆਂ ਕਰ ਕੇ 1-866-346-7198 ਤੇ ਮੁਫਤ ਕਾਲ ਕਰੋ.

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

Arabic (العربية): للحصول على المساعدة في اللغة العربية مجاناً، اتصل بنا على هذا الرقم: 1-866-346-7198.

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

Hindi (हिन्दी): हिन्दीमें बिना खर्च के सहायता के लिए, 1-866-346-7198 पर कॉल करें।

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.

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 participating pre-natal care and a hospital delivery)

- The plan's overall deductible \$0
- Specialist copayment \$50
- Hospital (facility) copayment \$500
- Other copayment \$30

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 | \$1,640 |
| Coinsurance | \$0 |
| What isn't covered | |
| Limits or exclusions | \$60 |
| The total Peg would pay is | \$1,700 |

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

- The plan's overall deductible \$0
- Specialist copayment \$50
- Hospital (facility) copayment \$500
- Other copayment \$30

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 | \$1,170 |
| Coinsurance | \$0 |
| What isn't covered | |
| Limits or exclusions | \$1,783 |
| The total Joe would pay is | \$2,953 |

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

- The plan's overall deductible \$0
- Specialist copayment \$50
- Hospital (facility) copayment \$500
- Other copayment \$50

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 | \$620 |
| Coinsurance | \$18 |
| What isn't covered | |
| Limits or exclusions | \$37 |
| The total Mia would pay is | \$675 |

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

Blue Shield of California is an independent member of the Blue Shield Association.



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.