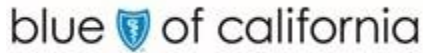


Summary of Benefits and Coverage: What this Plan Covers & What You Pay For Covered Services



Coverage Period: Beginning On or After 1/1/2020


Coverage for: Individual + Family | Plan Type: PPO

Platinum Full PPO 250/15 OffEx

⚠️ 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/M0019944_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?	\$250 per individual / \$500 per family for <u>participating providers</u> ; \$1,000 per individual / \$2,000 per family for <u>non-participating providers</u> .	Generally, you must pay all of the costs from <u>providers</u> 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 deductible?	Yes. <u>Preventive care</u> and services listed in your complete terms of coverage.	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 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?	\$4,300 per individual / \$8,600 per family for <u>participating providers</u> ; \$8,600 per individual / \$17,200 per family for <u>non-participating providers</u> .	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 out-of-pocket limit?	<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 network provider?	Yes. See blueshieldca.com/fad or call 1-888-319-5999 for a list of <u>network providers</u> .	This <u>plan</u> uses a <u>provider network</u> . You will pay less if you use a <u>provider</u> in the <u>plan's</u> network. 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 <u>provider's</u> 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 referral to see a specialist?	No.	You can see the <u>specialist</u> you choose without a <u>referral</u> .

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 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
		Participating Provider (You will pay the least)	Non-Participating 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	\$15/visit; <u>deductible</u> does not apply	40% <u>coinsurance</u>	-----None-----
	<u>Specialist</u> visit	\$30/visit; <u>deductible</u> does not apply	40% <u>coinsurance</u>	-----None-----
	<u>Preventive care/screening</u> /immunization	No Charge; <u>deductible</u> does not apply	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: \$15/visit; <u>deductible</u> does not apply X-Ray & Imaging: \$30/visit; <u>deductible</u> does not apply Other Diagnostic Examination: \$30/visit; <u>deductible</u> does not apply</i>	<i>Lab & Path: 40% <u>coinsurance</u> X-Ray & Imaging: 40% <u>coinsurance</u> Other Diagnostic Examination: 40% <u>coinsurance</u></i>	The services listed are at a freestanding location.
	Imaging (CT/PET scans, MRIs)	<i>Outpatient Radiology Center: 10% <u>coinsurance</u> Outpatient Hospital: \$100/visit+ 10% <u>coinsurance</u></i>	<i>Outpatient Radiology Center: 40% <u>coinsurance</u> Outpatient Hospital: 40% <u>coinsurance</u> of up to \$350/day plus 100% of additional charges</i>	<u>Preauthorization</u> is required. Failure to obtain <u>preauthorization</u> may result in non-payment of benefits.
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at blueshieldca.com/	Tier 1	<i>Retail: \$5/prescription Mail Service: \$10/prescription</i>	<i>Retail: Not Covered Mail Service: Not Covered</i>	<u>Preauthorization</u> is required for select drugs. Failure to obtain <u>preauthorization</u> may result in non-payment of benefits. <i>Retail: Covers up to a 30-day supply; Mail Service: Covers up to a 90-day supply.</i>
	Tier 2	<i>Retail: \$30/prescription Mail Service: \$60/prescription</i>	<i>Retail: Not Covered Mail Service: Not Covered</i>	
	Tier 3	<i>Retail: \$50/prescription Mail Service: \$100/prescription</i>	<i>Retail: Not Covered Mail Service: Not Covered</i>	

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Participating Provider (You will pay the least)	Non-Participating Provider (You will pay the most)	
formulary	Tier 4	<i>Retail and Network Specialty Pharmacies: 30% <u>coinsurance</u> up to \$250/prescription</i> <i>Mail Service: 30% <u>coinsurance</u> up to \$500/prescription</i>	<i>Retail: Not Covered</i> <i>Mail Service: Not Covered</i>	<u>Preauthorization</u> is required. Failure to obtain <u>preauthorization</u> may result in non-payment of benefits. <i>Retail and Network Specialty Pharmacies: Covers up to a 30-day supply; Specialty drugs must be obtained at a Network Specialty Pharmacy. Mail Service: Covers up to a 90-day supply.</i>
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	<i>Ambulatory Surgery Center: 10% <u>coinsurance</u></i> <i>Outpatient Hospital: \$100/surgery+ 10% <u>coinsurance</u></i>	<i>Ambulatory Surgery Center: 40% <u>coinsurance</u> of up to \$350/day plus 100% of additional charges</i> <i>Outpatient Hospital: 40% <u>coinsurance</u> of up to \$350/day plus 100% of additional charges</i>	-----None-----
	Physician/surgeon fees	10% <u>coinsurance</u>	40% <u>coinsurance</u>	-----None-----
If you need immediate medical attention	<u>Emergency room care</u>	<i>Facility Fee: \$150/visit+ 10% <u>coinsurance</u></i> <i>Physician Fee: 10% <u>coinsurance</u></i>	<i>Facility Fee: \$150/visit+ 10% <u>coinsurance</u></i> <i>Physician Fee: 10% <u>coinsurance</u></i>	-----None-----
	<u>Emergency medical transportation</u>	10% <u>coinsurance</u>	10% <u>coinsurance</u>	This payment is for emergency or authorized transport.
	<u>Urgent care</u>	\$15/visit; <u>deductible</u> does not apply	40% <u>coinsurance</u>	-----None-----
If you have a hospital stay	Facility fee (e.g., hospital room)	10% <u>coinsurance</u>	40% <u>coinsurance</u> of up to \$2000/day plus 100% of additional charges	<u>Preauthorization</u> is required. Failure to obtain <u>preauthorization</u> may result in non-payment of benefits.
	Physician/surgeon fees	10% <u>coinsurance</u>	40% <u>coinsurance</u>	-----None-----

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Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Participating Provider (You will pay the least)	Non-Participating Provider (You will pay the most)	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Office Visit: \$15/visit; deductible does not apply Other Outpatient Services: 10% coinsurance Partial Hospitalization: 10% coinsurance Psychological Testing: 10% coinsurance	Office Visit: 40% coinsurance Other Outpatient Services: 40% coinsurance Partial Hospitalization: 40% coinsurance of up to \$350/day plus 100% of additional charges Psychological Testing: 40% coinsurance	Preauthorization is required except for office visits. Failure to obtain preauthorization may result in non-payment of benefits.
	Inpatient services	Physician Inpatient Services: 10% coinsurance Hospital Services: 10% coinsurance Residential Care: 10% coinsurance	Physician Inpatient Services: 40% coinsurance Hospital Services: 40% coinsurance of up to \$2000/day plus 100% of additional charges Residential Care: 40% coinsurance of up to \$2000/day plus 100% of additional charges	Preauthorization is required. Failure to obtain preauthorization may result in non-payment of benefits.
If you are pregnant	Office visits	No Charge; deductible does not apply	40% coinsurance	-----None-----
	Childbirth/delivery professional services	10% coinsurance	40% coinsurance	
	Childbirth/delivery facility services	10% coinsurance	40% coinsurance of up to \$2000/day plus 100% of additional charges	-----None-----
If you need help recovering or have other special health needs	Home health care	10% coinsurance	Not Covered	Preauthorization is required. Failure to obtain preauthorization may result in non-payment of benefits. Coverage limited to 100 visits per member per calendar year.

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Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Participating Provider (You will pay the least)	Non-Participating Provider (You will pay the most)	
	<u>Rehabilitation services</u>	Office Visit: 10% <u>coinsurance</u> Outpatient Hospital: 10% <u>coinsurance</u>	Office Visit: 40% <u>coinsurance</u> Outpatient Hospital: 40% <u>coinsurance</u> of up to \$350/day plus 100% of additional charges	-----None-----
	<u>Habilitation services</u>	Office Visit: 10% <u>coinsurance</u> Outpatient Hospital: 10% <u>coinsurance</u>	Office Visit: 40% <u>coinsurance</u> Outpatient Hospital: 40% <u>coinsurance</u> of up to \$350/day plus 100% of additional charges	
	<u>Skilled nursing care</u>	Freestanding SNF: 10% <u>coinsurance</u> Hospital-based SNF: 10% <u>coinsurance</u>	Freestanding SNF: 10% <u>coinsurance</u> Hospital-based SNF: 40% <u>coinsurance</u> of up to \$2000/day plus 100% of additional charges	<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>deductible</u> does not apply	<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; <u>deductible</u> does not apply	All charges above \$30; <u>deductible</u> does not apply	Coverage limited to one exam per member per calendar year.
	Children's glasses	No Charge; <u>deductible</u> does not apply	All charges above \$25; <u>deductible</u> does not apply	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; <u>deductible</u> does not apply	20% <u>coinsurance</u> ; <u>deductible</u> does not apply	Coverage for prophylaxis services (cleaning) is limited to once in a six month period.

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
- Infertility Treatment
- 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

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 shíka' at'oowoł nínízingo, kwijí' 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): Հայերեն կարգադրման և օգնության համար կոչվում է 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): پنجابی وج مدد لئی مہربانی کر کے 1-866-346-7198 تے مفت کال کرو۔

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

Arabic (العربية): للحصول على المساعدة في اللغة العربية مجاناً ، تفضل باتصال 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): 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.* —————

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 \$250
- Specialist copayment \$30
- Hospital (facility) coinsurance 10%
- Other copayment \$15

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:

Cost Sharing	
Deductibles	\$250
Copayments	\$230
Coinsurance	\$1,160
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 \$250
- Specialist copayment \$30
- Hospital (facility) coinsurance 10%
- Other copayment \$15

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:

Cost Sharing	
Deductibles	\$250
Copayments	\$930
Coinsurance	\$890
What isn't covered	
Limits or exclusions	\$60
The total Joe would pay is	\$2,130

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

- The plan's overall deductible \$250
- Specialist copayment \$30
- Hospital (facility) coinsurance 10%
- Other copayment \$30

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:

Cost Sharing	
Deductibles	\$250
Copayments	\$50
Coinsurance	\$210
What isn't covered	
Limits or exclusions	\$0
The total Mia would pay is	\$510

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



Notice Informing Individuals about Nondiscrimination and Accessibility Requirements

Discrimination is against the law

Blue Shield of California complies with applicable state laws and federal civil rights laws, and does not discriminate on the basis of race, color, national origin, ancestry, religion, sex, marital status, gender, gender identity, sexual orientation, age or disability. Blue Shield of California does not exclude people or treat them differently because of race, color, national origin, ancestry, religion, sex, marital status, gender, gender identity, sexual orientation, age, or disability.

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, ancestry, religion, sex, marital status, gender, gender identity, sexual orientation, age, or disability, 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: (844) 696-6070

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**.