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 deductible?	**$3,000** per individual / **$5,200** per family	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.
Are there services covered before you meet your deductible?	Yes. Preventive care services are covered before you meet your deductible.	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 https://www.healthcare.gov/coverage/preventive-care-benefits/.
Are there other deductibles for specific services?	No.	You must pay all of the costs for these services up to the specific deductible amount before this plan begins to pay for these services.
What is the out–of–pocket limit for this plan?	For network providers: **$5,000** individual / **$10,000** 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, balance-billing charges, 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. For a list of PPO providers, see **www.blueshieldca.com/sisc** or call 1-855-256-9404.	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?	No.	You can see the specialist you choose without a referral.

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	10% coinsurance	50% coinsurance	None
	Specialist visit	10% coinsurance	50% coinsurance	None
	Preventive care/screening /immunization	No Charge	Not Covered	None
If you have a test	Diagnostic test (x-ray, blood work)	10% coinsurance	Not Covered	None
	Imaging (CT/PET scans, MRIs)	10% coinsurance	50% coinsurance	Preauthorization is required.
If you need drugs to treat your illness or condition **More information about prescription drug coverage is available at www.navitus.com**	Generic drugs	$9 / prescription (Retail) $18 / prescription (Mail Service)	$9 /prescription (Retail) Not Covered (Mail Service)	Covers up to a 30-day supply (retail prescriptions). Covers up to a 90-day supply (mail service prescriptions) Selected formulary drugs require preauthorization.
	Brand drugs	$35 / prescription (Retail) $90/prescription (Mail Service)	$35 / prescription (Retail) Not Covered (Mail Service)	
	Specialty drugs	$35 / prescription	Not Covered	Covers up to a 30-day supply. Preauthorization may be required.

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 have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	10% coinsurance	0% coinsurance with $350/day max	In-network hospital benefit limitations: Arthroscopy: $4,500/procedure Cataract Surgery: $2,000/procedure Colonoscopy: $1,500/procedure Upper GI Endoscopy w/Biopsy: $1,250/procedure Upper GI Endoscopy w/o Biopsy: $1,000/procedure Coverage is limited to **$350**/admit for out-of-network Ambulatory Surgery Centers.
	Physician/surgeon fees	10% coinsurance	50% coinsurance	None
If you need immediate medical attention	Emergency room care	$100 / visit +10% coinsurance	$100 / visit +10% coinsurance	$100 copayment waived if admitted. You are responsible for billed charges exceeding maximum allowed amount for out-of-network providers.
	Emergency medical transportation	$100 / visit +10% coinsurance	$100 / visit +10% coinsurance	None
	Urgent care	10% coinsurance	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 plan payment for non-emergency hospital services received from a non-preferred hospital is $600 per day. Members are responsible for all charges in excess of $600. Failure to preauthorize may result in reduced or nonpayment of benefits.
	Physician/surgeon fee	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)	
If you have mental health, behavioral health, or substance abuse needs	Outpatient services	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	10% coinsurance	50% coinsurance	Cost sharing does not apply for preventative services. Depending on the type of services, a copayment, coinsurance, or deductible 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
	Childbirth/delivery facility services	10% coinsurance	0% coinsurance with $600/day max	Non-Preferred facility are subject to a maximum benefit payment up to $600 per day.

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 help recovering or have other special health needs	Home health care	10% coinsurance	Not Covered	Covers up to 100 visits per calendar year. Non-preferred home health care and home infusion are not covered unless preauthorized. When these services are preauthorized, you pay the preferred provider copayment. Preauthorization is required. Failure to preauthorize may result in reduced or nonpayment of benefits.
	Rehabilitation services	10% coinsurance	Not Covered	None
	Habilitation services	10% coinsurance	Not Covered	None
	Skilled nursing care	10% coinsurance at freestanding SNF	10% coinsurance at freestanding SNF	Covers up to 100 days per calendar year combined with Hospital Skilled Nursing Facility Unit. Preauthorization is required. Failure to preauthorize may result in reduced or nonpayment of benefits.
	Durable medical equipment	10% coinsurance	Not Covered	Preauthorization is required. Therapeutic shoes & inserts for members with diabetes (2 pairs each/calendar year).
	Hospice service	No Charge	Not Covered	Preauthorization 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
- Bariatric surgery
- Chiropractic care
- Hearing aids

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, kwiijigo 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 plan's overall deductible	$3,000
Specialist copayment	10%
Hospital (facility) coinsurance	10%
Other coinsurance	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**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$3,000
Copayments	$10
Coinsurance	$1,000
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$4,070**

Managing Joe's type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

The plan's overall deductible	$3,000
Specialist copayment	10%
Hospital (facility) coinsurance	10%
Other coinsurance	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**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$3,000
Copayments	$600
Coinsurance	$100
What isn't covered	
Limits or exclusions	$70
The total Joe would pay is	**$3,770**

Mia's Simple Fracture
(in-network emergency room visit and follow up care)

The plan's overall deductible	$3,000
Specialist copayment	10%
Hospital (facility) coinsurance	10%
Other coinsurance	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**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$1,900
Copayments	$0
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,900**

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