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/policies or by calling **1-855-256-9404**.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	For HMO plan providers (Signature Level I): **$0** per individual. For participating providers (Signature Level II): **$0** per individual. Does not apply to preventive care and prescription drug 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.
Is there an out–of–pocket limit on my expenses?	Yes. For HMO plan providers (Signature Level I): **$1,500** per individual / **$3,000** per family. For participating providers (Signature Level II): **$0** per individual.	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, balance-billed charges, some cost sharing, 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. See www.blueshieldca.com or **call 1-855-256-9404** for a list of participating 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

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Important Questions	Answers	Why this Matters:
		page 3 for how this plan pays different kinds of **providers**.
Do I need a referral to see a specialist?	Yes. For HMO plan providers (Signature Level I): 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. For participating providers (Signature Level II): Members do not need a referral.	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**.
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 participating **providers** by charging you lower **deductibles**, **copayments** and **coinsurance** amounts.

Common Medical Event	Services You May Need	Your cost if you use		Limitations & Exceptions
		Signature Level I HMO Plan Providers	Signature Level II Participating Providers	
If you visit a health care <u>provider's</u> office or clinic	Primary care visit to treat an injury or illness	$10 copayment / visit	$30 copayment / visit	For other services received during the office visit, additional member cost-share may apply.
	Specialist visit	$10 copayment / visit	$30 copayment / visit	For other services received during the office visit, additional member cost-share may apply.
	Other practitioner office visit	Not Covered	Not Covered	--------------------None------------------
	Preventive care/screening /immunization	No Charge	$30 copayment / visit	Preventive health services are only covered when provided by participating providers. Coverage for services consistent with ACA requirements and California laws. Please refer to your plan contract for details.

Common Medical Event	Services You May Need	Your cost if you use		Limitations & Exceptions
		Signature Level I HMO Plan Providers	Signature Level II Participating Providers	
If you have a test	Diagnostic test (x-ray, blood work)	Lab & Path at Free Standing Location: No Charge X-Ray & Imaging at Free Standing Radiology Center: No Charge Other Diagnostic Examination at Free Standing Location: No Charge X-Ray, Lab & Other Examination at Outpatient Hospital: No Charge	Lab & Path at Free Standing Location: No Charge X-Ray & Imaging at Free Standing Radiology Center: Not Covered Other Diagnostic Examination at Free Standing Location: No Covered X-Ray, Lab & Other Examination at Outpatient Hospital: Not Covered	Benefits in this section are for diagnostic, non-preventive health services. For Signature Level I HMO plan providers: Failure to obtain pre-authorization for non-emergency procedures may result in non-payment of benefits. For Signature Level II HMO providers: In Physician's office only- excludes CT, MRI, MUGA, PET, & SPECT.
	Imaging (CT/PET scans, MRIs)	Radiological & Nuclear Imaging at Free Standing Radiology Center: No Charge Radiological & Nuclear Imaging at Outpatient Hospital: No Charge	Radiological & Nuclear Imaging at Free Standing Radiology Center: Not Covered Radiological & Nuclear Imaging at Outpatient Hospital: Not Covered	Benefits in this section are for diagnostic, non-preventive health services. For Signature Level I HMO plan providers: Failure to obtain pre-authorization from primary care provider and medical plan may result in non-payment of benefits..

Common Medical Event	Services You May Need	Your cost if you use Signature Level I HMO Plan Providers	Your cost if you use Signature Level II Participating Providers	Limitations & Exceptions
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.blueshieldca.com.	Tier 1	From participating pharmacy providers: Retail: $5 copayment / prescription Mail Order: $10 copayment / prescription	From non-participating pharmacy providers: Mail Order: Not Covered	Retail: Covers up to a 30-day supply; Mail Order: Covers up to a 90-day supply. Select formulary and non-formulary drugs require pre-authorization.
	Tier 2	From participating pharmacy providers: Retail: $10 copayment / prescription Mail Order: $20 copayment / prescription	From non-participating pharmacy providers: Not Covered	
	Tier 3	From participating pharmacy providers: Retail: $25 copayment / prescription Mail Order: $50 copayment / prescription	From non-participating pharmacy providers: Not Covered	
	Tier 4	From participating pharmacy providers: Applicable Retail Drug Cost-Share Applies per Prescription	From non-participating pharmacy providers: Not Covered	

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Common Medical Event	Services You May Need	Your cost if you use		Limitations & Exceptions
		Signature Level I HMO Plan Providers	Signature Level II Participating Providers	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	No Charge at a free-standing ambulatory surgery center No Charge at a hospital-affiliated ambulatory surgery center	Not Covered	-------------------None-------------------.
	Physician/surgeon fees	No Charge	Not Covered	-------------------None-------------------
If you need immediate medical attention	Emergency room services	$50 copayment / visit	$50 copayment / visit	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.
	Emergency medical transportation	No Charge	No Charge	-------------------None-------------------
	Urgent care	$10 copayment / visit at freestanding urgent care center	$10 copayment / visit at freestanding urgent care center	For Signature Level I HMO plan providers: Pre-authorization from primary care physician and medical plan is required.
If you have a hospital stay	Facility fee (e.g., hospital room)	No Charge	Not Covered	Pre-authorization is required for all services. Failure to obtain pre-authorization for special transplant services may result in non-payment of benefits.
	Physician/surgeon fee	No Charge	Not Covered	-------------------None-------------------

Common Medical Event	Services You May Need	Your cost if you use		Limitations & Exceptions
		Signature Level I HMO Plan Providers	Signature Level II Participating Providers	
If you have mental health, behavioral health, or substance use disorder needs	Mental/Behavioral health outpatient services	Mental Health Routine Outpatient Services: No Charge / visits 1-3, then $10 copayment / visit Mental Health Non-Routine Outpatient Services: No Charge / visits 1-3, then $10 copayment / visit	Mental Health Routine Outpatient Services: No Charge / visits 1-3, then $10 copayment / visit Mental Health Non-Routine Outpatient Services: No Charge / visits 1-3, then $10 copayment / visit	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, psychological testing, and transcranial magnetic stimulation. Failure to obtain prior authorization for any Non-Routine Outpatient Mental Health Services will result in denial of coverage if Blue Shield determines the services provided were not a plan Benefit or were not medically necessary.
	Mental/Behavioral health inpatient services	Mental Health Inpatient Hospital Services: No Charge Mental Health Residential Services: No Charge Mental Health Inpatient Physician Services: No Charge	Mental Health Inpatient Hospital Services: Not Covered Mental Health Residential Services: Not Covered Mental Health Inpatient Physician Services: Not Covered	Failure to obtain prior authorization for a Mental Health Inpatient Admission will result in denial of coverage if Blue Shield determines the services provided were not a plan Benefit or were not medically necessary.

Common Medical Event	Services You May Need	Your cost if you use		Limitations & Exceptions
		Signature Level I HMO Plan Providers	Signature Level II Participating Providers	
	Substance use disorder outpatient services	Substance Use Disorder Routine Outpatient Services: No Charge / visits 1-3, then $10 copayment / visit Substance Use Disorder Non-Routine Outpatient Services: No Charge / visits 1-3, then $10 copayment / visit	Substance Use Disorder Routine Outpatient Services: No Charge / visits 1-3, then $10 copayment / visit Substance Use Disorder Non-Routine Outpatient Services: No Charge / visits 1-3, then $10 copayment / visit	Substance Abuse Routine Outpatient Services: Services include professional/physician office visits. Substance Abuse Non-Routine Outpatient Services: 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 abuse services.
	Substance use disorder inpatient services	Substance Use Disorder Inpatient Hospital Services: No Charge Substance Use Disorder Residential Services: No Charge Substance Use Disorder Inpatient Physician Services: No Charge	Substance Use Disorder Inpatient Hospital Services: Not Covered Substance Use Disorder Residential Services: Not Covered Substance Use Disorder Inpatient Physician Services: Not Covered	Pre-authorization from Mental Health Service Administrator (MHSA) is required

Common Medical Event	Services You May Need	Your cost if you use		Limitations & Exceptions
		Signature Level I HMO Plan Providers	Signature Level II Participating Providers	
If you are pregnant	Prenatal and postnatal care	Prenatal: No Charge Postnatal: No Charge	Not Covered	--------------------None----------------
	Delivery and all inpatient services	No Charge	Not Covered	--------------------None----------------

Common Medical Event	Services You May Need	Your cost if you use		Limitations & Exceptions
		Signature Level I HMO Plan Providers	Signature Level II Participating Providers	
If you need help recovering or have other special health needs	Home health care	No Charge	Not Covered	Coverage limited to 100 visits per member per calendar year. Non-participating home health care and home infusion are not covered unless pre-authorized. When these services are pre-authorized, you pay the participating provider member cost share. Pre-authorization is required.
	Rehabilitation services	Office visit: $10 copayment / visit Outpatient hospital: $10 copayment / visit	Office visit: $30 copayment / visit Outpatient hospital: Not Covered	Coverage for physical, occupational and respiratory therapy services.
	Habilitation services	Office visit: $10 copayment / visit Outpatient hospital: $10 copayment / visit	Office visit: $30 copayment / visit Outpatient hospital: Not Covered	
	Skilled nursing care	No Charge in a freestanding skilled nursing facility No Charge in a skilled nursing unit of a hospital	Not Covered	Signature Level I HMO plan providers: Coverage limited to 100 prior authorized days per calendar year. Pre-authorization is required.
	Durable medical equipment	No Charge	Not Covered	Signature Level II participating providers: Prior authorization is required. Failure to prior authorize may result in reduced or nonpayment of benefits.

Common Medical Event	Services You May Need	Your cost if you use		Limitations & Exceptions
		Signature Level I HMO Plan Providers	Signature Level II Participating Providers	
	Hospice service	No Charge	Not Covered	All Hospice Program Benefits must be pre-authorized by the Plan. (With the exception of Pre-hospice consultation.) Failure to obtain pre-authorization may result in non-payment of benefits.
If your child needs dental or eye care	Eye exam	$10 copayment / visit at vision plan administrator's providers	$10 copayment / visit at vision plan administrator's providers	Coverage limited to one self-referred comprehensive eye exam per 12 consecutive months (no age limit) for services provided by Vision Plan Administrator's providers. For visits by non-participating providers the maximum plan reimbursement for Ophthalmologic exam is $60 or $50 if the member has an Optometric exam.
	Glasses	Not Covered	Not Covered	--------------------None------------------
	Dental check-up	Not Covered	Not Covered	--------------------None------------------

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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.)		
• Acupuncture	• Hearing aids	• Private-duty nursing (unless enrolled in a participating hospice program)
• Chiropractic care	• Infertility treatment	• Routine foot care (unless for treatment of diabetes)
• Cosmetic surgery	• Long-term care	• Weight loss programs
• Dental care (Adult/Child)	• Non-emergency care when traveling outside the U.S.	

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.)	
• Bariatric surgery (pre-authorization is required. Failure to obtain pre-authorization may result in non-payment of benefits)	• Routine eye care (Adult/Child)

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 **1-855-256-9404**. 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:

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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: **1-855-256-9404** 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.**

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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 tulongsa 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): Din4 k'ehj7 doo b22h 7l7n7g0 sh7ka' at'oowo[n7n7zingo, kwij8' hod77lnih1-866-346-7198.

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

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

Armenian (Հայերեն): Հայերենլեզվովանվճարօգնությունստանալուհամարխնդրումենքզանգահարել 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(پنجابی): پنجابی وچ مدد لئی مہربانی کر کے 1-866-346-7198 تے مفت کال کرو۔

Khmer (ភាសាខ្មែរ): សូមជំនួយជាភាសាអង់គ្លេសដោយឥតគិតថ្លៃ សូមទាក់ទងមកលេខ1-866-346-7198.

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

Hmong (Hnoob): 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 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** $7,380
- **Patient pays** $160

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	$0
Copays	$10
Coinsurance	$0
Limits or exclusions	$150
Total	**$160**

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

- **Amount owed to providers:** $5,400
- **Plan pays** $5,020
- **Patient pays** $380

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	$300
Coinsurance	$0
Limits or exclusions	$80
Total	**$380**

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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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