



Summary of Benefits

Schools Insurance Group
Effective July 1, 2021
PPO Savings Plan

Custom PPO Savings Embedded Deductible 4000

This Summary of Benefits shows the amount you will pay for Covered Services under this Blue Shield of California Plan. It is only a summary and it is included as part of the Evidence of Coverage (EOC).¹ Please read both documents carefully for details.

Medical Provider Network:

Full PPO Network

This Plan uses a specific network of Health Care Providers, called the Full PPO provider network. Providers in this network are called Participating Providers. You pay less for Covered Services when you use a Participating Provider than when you use a Non-Participating Provider. You can find Participating Providers in this network at blueshieldca.com.

Pharmacy Network:

Rx Ultra

Drug Formulary:

Plus Formulary

Calendar Year Deductibles (CYD)²

A Calendar Year Deductible (CYD) is the amount a Member pays each Calendar Year before Blue Shield pays for Covered Services under the Plan. Blue Shield pays for some Covered Services before the Calendar Year Deductible is met, as noted in the Benefits chart below.

When using a Participating³ or Non-Participating⁴ Provider

Calendar Year medical and pharmacy Deductible	<i>Individual coverage</i>	\$4,000
<i>This Plan combines medical and pharmacy Deductibles into one Calendar Year Deductible</i>	<i>Family coverage</i>	\$4,000: individual
		\$8,000: Family

Calendar Year Out-of-Pocket Maximum⁵

An Out-of-Pocket Maximum is the most a Member will pay for Covered Services each Calendar Year. Any exceptions are listed in the Notes section at the end of this Summary of Benefits.

No Annual or Lifetime Dollar Limit

Under this Plan there is no annual or lifetime dollar limit on the amount Blue Shield will pay for Covered Services.

	When using a Participating Provider ³	When using a Non-Participating Provider ⁴
<i>Individual coverage</i>	\$5,500	\$10,000
<i>Family coverage</i>	\$5,500: individual	\$10,000: individual
	\$11,000: Family	\$20,000: Family

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Benefits⁶

Your payment

	When using a Participating Provider ³	CYD ² applies	When using a Non-Participating Provider ⁴	CYD ² applies
Preventive Health Services⁷				
Preventive Health Services	\$0		Not covered	
California Prenatal Screening Program	\$0		\$0	
Physician services				
Primary care office visit	20%	✓	50%	✓
Specialist care office visit	20%	✓	50%	✓
Physician home visit	20%	✓	50%	✓
Physician or surgeon services in an Outpatient Facility	20%	✓	50%	✓
Physician or surgeon services in an inpatient facility	20%	✓	50%	✓
Other professional services				
Other practitioner office visit <i>Includes nurse practitioners, Physician assistants, and therapists.</i>	20%	✓	50%	✓
Acupuncture services <i>Up to 20 visits per Member, per Calendar Year.</i>	20%	✓	50%	✓
Chiropractic services <i>Up to 20 visits per Member, per Calendar Year.</i>	20%	✓	50%	✓
Teladoc consultation	\$0		Not covered	
Family planning				
• Counseling, consulting, and education	\$0		Not covered	
• Injectable contraceptive, diaphragm fitting, intrauterine device (IUD), implantable contraceptive, and related procedure.	\$0		Not covered	
• Tubal ligation	\$0		Not covered	
• Vasectomy	20%	✓	Not covered	
Podiatric services	20%	✓	50%	✓
Pregnancy and maternity care				
Physician office visits: prenatal and postnatal	20%	✓	50%	✓
Physician services for pregnancy termination	20%	✓	50%	✓

Benefits⁶

Your payment

	When using a Participating Provider³	CYD² applies	When using a Non-Participating Provider⁴	CYD² applies
Emergency services				
Emergency room services	\$100/visit plus 20%	✓	\$100/visit plus 20%	✓
<i>If admitted to the Hospital, this payment for emergency room services does not apply. Instead, you pay the Participating Provider payment under Inpatient facility services/ Hospital services and stay.</i>				
Emergency room Physician services	20%	✓	20%	✓
Urgent care center services	20%	✓	50%	✓
Ambulance services	20%	✓	20%	✓
<i>This payment is for emergency or authorized transport.</i>				
Outpatient Facility services				
Ambulatory Surgery Center	10%	✓	50% of up to \$350/day plus 100% of additional charges	✓
Outpatient Department of a Hospital: surgery	20%	✓	50% of up to \$350/day plus 100% of additional charges	✓
Outpatient Department of a Hospital: treatment of illness or injury, radiation therapy, chemotherapy, and necessary supplies	20%	✓	50% of up to \$350/day plus 100% of additional charges	✓
Inpatient facility services				
Hospital services and stay	\$100/admission plus 20%	✓	50% of up to \$600/day plus 100% of additional charges	✓
Transplant services				
<i>This payment is for all covered transplants except tissue and kidney. For tissue and kidney transplant services, the payment for Inpatient facility services/ Hospital services and stay applies.</i>				
• Special transplant facility inpatient services	\$100/admission plus 20%	✓	Not covered	
• Physician inpatient services	20%	✓	Not covered	

Benefits⁶

Your payment

	When using a Participating Provider³	CYD² applies	When using a Non-Participating Provider⁴	CYD² applies
<p>Bariatric surgery services, designated California counties</p> <p><i>This payment is for bariatric surgery services for residents of designated California counties. For bariatric surgery services for residents of non-designated California counties, the payments for Inpatient facility services/ Hospital services and stay and Physician inpatient and surgery services apply for inpatient services; or, if provided on an outpatient basis, the Outpatient Facility services and Outpatient Physician services payments apply.</i></p>				
Inpatient facility services	\$100/admission plus 20%	✓	Not covered	
Outpatient Facility services	20%	✓	Not covered	
Physician services	20%	✓	Not covered	
<p>Diagnostic x-ray, imaging, pathology, and laboratory services</p> <p><i>This payment is for Covered Services that are diagnostic, non-Preventive Health Services, and diagnostic radiological procedures, such as CT scans, MRIs, MRAs, and PET scans. For the payments for Covered Services that are considered Preventive Health Services, see Preventive Health Services.</i></p> <p>Laboratory services</p> <p><i>Includes diagnostic Papanicolaou (Pap) test.</i></p>				
<ul style="list-style-type: none"> Laboratory center 	20%	✓	50%	✓
<ul style="list-style-type: none"> Outpatient Department of a Hospital 	\$25/visit plus 20%	✓	50% of up to \$350/day plus 100% of additional charges	✓
<p>X-ray and imaging services</p> <p><i>Includes diagnostic mammography.</i></p>				
<ul style="list-style-type: none"> Outpatient radiology center 	20%	✓	50%	✓
<ul style="list-style-type: none"> Outpatient Department of a Hospital 	\$25/visit plus 20%	✓	50% of up to \$350/day plus 100% of additional charges	✓

Benefits⁶

Your payment

	When using a Participating Provider³	CYD² applies	When using a Non-Participating Provider⁴	CYD² applies
Other outpatient diagnostic testing				
<i>Testing to diagnose illness or injury such as vestibular function tests, EKG, ECG, cardiac monitoring, non-invasive vascular studies, sleep medicine testing, muscle and range of motion tests, EEG, and EMG.</i>				
• Office location	20%	✓	50%	✓
• Outpatient Department of a Hospital	\$25/visit plus 20%	✓	50% of up to \$350/day plus 100% of additional charges	✓
Radiological and nuclear imaging services				
• Outpatient radiology center	20%	✓	50%	✓
• Outpatient Department of a Hospital	\$100/visit plus 20%	✓	50% of up to \$350/day plus 100% of additional charges	✓
Rehabilitative and Habilitative Services				
<i>Includes physical therapy, occupational therapy, respiratory therapy, and speech therapy services.</i>				
Office location	20%	✓	50%	✓
Outpatient Department of a Hospital	20%	✓	50% of up to \$350/day plus 100% of additional charges	✓
Durable medical equipment (DME)				
DME	20%	✓	50%	✓
Breast pump	\$0		Not covered	
Orthotic equipment and devices	20%	✓	50%	✓
Prosthetic equipment and devices	20%	✓	50%	✓

Benefits⁶

Your payment

	When using a Participating Provider ³	CYD ² applies	When using a Non-Participating Provider ⁴	CYD ² applies
<p>Home health care services</p> <p><i>Up to 100 visits per Member, per Calendar Year, by a home health care agency. All visits count towards the limit, including visits during any applicable Deductible period. Includes home visits by a nurse, Home Health Aide, medical social worker, physical therapist, speech therapist, or occupational therapist, and medical supplies.</i></p>	20%	✓	Not covered	
<p>Home infusion and home injectable therapy services</p> <p>Home infusion agency services <i>Includes home infusion drugs and medical supplies.</i></p> <p>Home visits by an infusion nurse</p> <p>Hemophilia home infusion services <i>Includes blood factor products.</i></p>	20%	✓	Not covered	
<p>Skilled Nursing Facility (SNF) services</p> <p><i>Up to 100 days per Member, per Benefit Period, except when provided as part of a Hospice program. All days count towards the limit, including days during any applicable Deductible period and days in different SNFs during the Calendar Year.</i></p> <p>Freestanding SNF</p> <p>Hospital-based SNF</p>	20%	✓	20%	✓
<p>Hospice program services</p> <p><i>Includes pre-Hospice consultation, routine home care, 24-hour continuous home care, short-term inpatient care for pain and symptom management, and inpatient respite care.</i></p>	\$0	✓	Not covered	
<p>Other services and supplies</p> <p>Diabetes care services</p> <ul style="list-style-type: none"> Devices, equipment, and supplies Self-management training 	20%	✓	50%	✓
	20%	✓	50%	✓

Benefits⁶

Your payment

	When using a Participating Provider³	CYD² applies	When using a Non-Participating Provider⁴	CYD² applies
Dialysis services	20%	✓	50% of up to \$350/day plus 100% of additional charges	✓
PKU product formulas and Special Food Products	20%	✓	20%	✓
Allergy serum billed separately from an office visit	20%	✓	50%	✓

Mental Health and Substance Use Disorder Benefits

Your payment

<i>Mental health and substance use disorder Benefits are provided through Blue Shield's Mental Health Service Administrator (MHSA).</i>	When using a MHSA Participating Provider³	CYD² applies	When using a MHSA Non-Participating Provider⁴	CYD² applies
Outpatient services				
Office visit, including Physician office visit	20%	✓	50%	✓
Teladoc behavioral health	\$0		Not covered	
Other outpatient services, including intensive outpatient care, electroconvulsive therapy, transcranial magnetic stimulation, Behavioral Health Treatment for pervasive developmental disorder or autism in an office setting, home, or other non-institutional facility setting, and office-based opioid treatment	20%	✓	50%	✓
Partial Hospitalization Program	20%	✓	50% of up to \$350/day plus 100% of additional charges	✓
Psychological Testing	20%	✓	50%	✓
Inpatient services				
Physician inpatient services	\$0	✓	50%	✓
Hospital services	\$100/admission plus 20%	✓	50% of up to \$600/day plus 100% of additional charges	✓
Residential Care	\$100/admission plus 20%	✓	50% of up to \$600/day plus 100% of additional charges	✓

Prescription Drug Benefits^{8,9}

Your payment

	When using a Participating Pharmacy³	CYD² applies	When using a Non-Participating Pharmacy⁴	CYD² applies
<i>Retail pharmacy prescription Drugs</i> <i>Per prescription, up to a 30-day supply.</i>				
Contraceptive Drugs and devices	\$0		Applicable Tier 1, Tier 2, or Tier 3 Copayment	
Tier 1 Drugs	\$10/prescription	✓	25% plus \$10/prescription	✓
Tier 2 Drugs	\$25/prescription	✓	25% plus \$25/prescription	✓
Tier 3 Drugs	\$40/prescription	✓	25% plus \$40/prescription	✓
Tier 4 Drugs	30% up to \$250/prescription	✓	30% up to \$250/prescription plus 25% of purchase price	✓
Mail service pharmacy prescription Drugs <i>Per prescription, up to a 90-day supply.</i>				
Contraceptive Drugs and devices	\$0		Not covered	
Tier 1 Drugs	\$20/prescription	✓	Not covered	
Tier 2 Drugs	\$50/prescription	✓	Not covered	
Tier 3 Drugs	\$80/prescription	✓	Not covered	
Tier 4 Drugs	30% up to \$500/prescription	✓	Not covered	
Oral Anticancer Drugs <i>Per prescription, up to a 30-day supply.</i>	Applicable Tier 1, Tier 2, Tier 3, or Tier 4 Copayment up to \$250/prescription	✓	Not covered	

Prior Authorization

The following are some frequently-utilized Benefits that require prior authorization:

- Radiological and nuclear imaging services
- Outpatient mental health services, except office visits
- Inpatient facility services
- Hospice program services
- Some prescription Drugs (see blueshieldca.com/pharmacy)

Please review the Evidence of Coverage for more about Benefits that require prior authorization.

Notes

1 Evidence of Coverage (EOC):

The Evidence of Coverage (EOC) describes the Benefits, limitations, and exclusions that apply to coverage under this Plan. Please review the EOC for more details of coverage outlined in this Summary of Benefits. You can request a copy of the EOC at any time.

Capitalized terms are defined in the EOC. Refer to the EOC for an explanation of the terms used in this Summary of Benefits.

2 Calendar Year Deductible (CYD):

Calendar Year Deductible explained. A Deductible is the amount you pay each Calendar Year before Blue Shield pays for Covered Services under the Plan.

If this Plan has any Calendar Year Deductible(s), Covered Services subject to that Deductible are identified with a check mark (✓) in the Benefits chart above.

Covered Services not subject to the Calendar Year combined medical and pharmacy Deductible. Some Covered Services received from Participating Providers are paid by Blue Shield before you meet any Calendar Year combined medical and pharmacy Deductible. These Covered Services do not have a check mark (✓) next to them in the "CYD applies" column in the Benefits chart above.

This Plan has a combined Participating Provider and Non-Participating Provider Calendar Year Deductible.

Family coverage has an individual Deductible within the Family Deductible. This means that the Deductible will be met for an individual with Family coverage who meets the individual Deductible prior to the Family meeting the Family Deductible within a Calendar Year. Once the individual Deductible or Family Deductible is reached, cost sharing applies until the Out-of-Pocket Maximum is reached.

3 Using Participating Providers:

Participating Providers have a contract to provide health care services to Members. When you receive Covered Services from a Participating Provider, you are only responsible for the Copayment or Coinsurance, once any Calendar Year Deductible has been met.

Teladoc. Teladoc mental health and substance use disorder (behavioral health) consultations are provided through Teladoc. These services are not administered by Blue Shield's Mental Health Service Administrator (MHSA).

"Allowable Amount" is defined in the EOC. In addition:

- Coinsurance is calculated from the Allowable Amount or Benefit maximum, whichever is less.
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4 Using Non-Participating Providers:

Non-Participating Providers do not have a contract to provide health care services to Members. When you receive Covered Services from a Non-Participating Provider, you are responsible for:

- the Copayment or Coinsurance (once any Calendar Year Deductible has been met), and
- any charges above the Allowable Amount, or
- any charges above the stated dollar amount, which is the Benefit maximum.

“Allowable Amount” is defined in the EOC. In addition:

- Coinsurance is calculated from the Allowable Amount or Benefit maximum, whichever is less.
- Charges above the Allowable Amount or Benefit maximum do not count towards the Out-of-Pocket Maximum, and are your responsibility for payment to the provider. This out-of-pocket expense can be significant.

5 Calendar Year Out-of-Pocket Maximum (OOPM):

Calendar Year Out-of-Pocket Maximum explained. The Out-of-Pocket Maximum is the most you are required to pay for Covered Services in a Calendar Year. Once you reach your Out-of-Pocket Maximum, Blue Shield will pay 100% of the Allowable Amount for Covered Services for the rest of the Calendar Year.

Your payment after you reach the Calendar Year OOPM. You will continue to pay all charges for services that are not covered, charges above the Allowable Amount, and charges for services above any Benefit maximum.

Any Deductibles count towards the OOPM. Any amounts you pay that count towards the medical Calendar Year Deductible also count towards the Calendar Year Out-of-Pocket Maximum.

This Plan has a separate Participating Provider OOPM and Non-Participating Provider OOPM. Covered Drugs obtained at Non-Participating Pharmacies. Any amounts you pay for Covered Drugs at Non-Participating Pharmacies count towards the Participating Provider OOPM.

Family coverage has an individual OOPM within the Family OOPM. This means that the OOPM will be met for an individual with Family coverage who meets the individual OOPM prior to the Family meeting the Family OOPM within a Calendar Year.

6 Separate Member Payments When Multiple Covered Services are Received:

Each time you receive multiple Covered Services, you might have separate payments (Copayment or Coinsurance) for each service. When this happens, you may be responsible for multiple Copayments or Coinsurance. For example, you may owe an office visit payment in addition to an allergy serum payment when you visit the doctor for an allergy shot.

7 Preventive Health Services:

If you only receive Preventive Health Services during a Physician office visit, there is no Copayment or Coinsurance for the visit. If you receive both Preventive Health Services and other Covered Services during the Physician office visit, you may have a Copayment or Coinsurance for the visit.

8 Outpatient Prescription Drug Coverage:

Medicare Part D-creditable coverage-

This Plan's prescription drug coverage is on average equivalent to or better than the standard benefit set by the federal government for Medicare Part D (also called creditable coverage). Because this plan's prescription drug coverage is creditable, you do not have to enroll in Medicare Part D while you maintain this coverage; however, you

Notes

should be aware that if you do not enroll in Medicare Part D within 63 days following termination of this coverage, you could be subject to Medicare Part D premium penalties.

9 Outpatient Prescription Drug Coverage:

Brand Drug coverage when a Generic Drug is available. If you select a Brand Drug when a Generic Drug equivalent is available, you are responsible for the difference between the cost to Blue Shield for the Brand Drug and its Generic Drug equivalent plus the tier 1 Copayment or Coinsurance. This difference in cost will not count towards any Calendar Year pharmacy Deductible, medical Deductible, or the Calendar Year Out-of-Pocket Maximum. If your Physician or Health Care Provider prescribes a Brand Drug and indicates that a Generic Drug equivalent should not be substituted, you pay your applicable tier Copayment or Coinsurance. If your Physician or Health Care Provider does not indicate that a Generic Drug equivalent should not be substituted, you may request a Medical Necessity Review. If approved, the Brand Drug will be covered at the applicable Drug tier Copayment or Coinsurance.

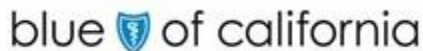
Short-Cycle Specialty Drug program. This program allows initial prescriptions for select Specialty Drugs to be filled for a 15-day supply with your approval. When this occurs, the Copayment or Coinsurance will be pro-rated.

Specialty Drugs. Specialty Drugs are only available from a Network Specialty Pharmacy, up to a 30-day supply.

High Deductible Health Plan (HDHP) preventive Drugs. HDHP preventive Drugs obtained from a Participating Pharmacy are covered at the applicable Drug tier Copayment but are not subject to the Deductible. HDHP preventive Drugs do not include those preventive Drugs that are required by Health Care Reform to be covered at no charge. Visit blueshieldca.com/pharmacy for lists of these Drugs.

Plans may be modified to ensure compliance with State and Federal requirements.


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



Coverage Period: Beginning On or After 7/1/2021


Coverage for: Individual + Family | Plan Type: PSP

Custom PPO Savings Embedded Deductible 4000

 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/ or call 1-888-256-1915. 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?	\$4,000 per individual / \$8,000 per family for <u>participating providers</u> and <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?	\$5,500 per individual / \$11,000 per family for <u>participating providers</u> ; \$10,000 per individual / \$20,000 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 1-888-256-1915 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	20% <u>coinsurance</u>	50% <u>coinsurance</u>	-----None-----
	Specialist visit	20% <u>coinsurance</u>	50% <u>coinsurance</u>	
	Preventive care/screening /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	Diagnostic test (x-ray, blood work)	Lab & Path: 20% <u>coinsurance</u> X-Ray & Imaging: 20% <u>coinsurance</u> Other Diagnostic Examination: 20% <u>coinsurance</u>	Lab & Path: 50% <u>coinsurance</u> X-Ray & Imaging: 50% <u>coinsurance</u> Other Diagnostic Examination: 50% <u>coinsurance</u>	The services listed are at a freestanding location.
	Imaging (CT/PET scans, MRIs)	Outpatient Radiology Center: 20% <u>coinsurance</u> Outpatient Hospital: \$100/visit + 20% <u>coinsurance</u>	Outpatient Radiology Center: 50% <u>coinsurance</u> Outpatient Hospital: 50% <u>coinsurance</u> of up to \$350/day plus 100% of additional charges	<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/formulary	Tier 1	Retail: \$10/prescription Mail Service: \$20/prescription	Retail: 25% <u>coinsurance</u> + \$10/prescription Mail Service: Not Covered	<u>Preauthorization</u> is required for select drugs. Failure to obtain <u>preauthorization</u> may result in non-payment of benefits. Retail: Covers up to a 30-day supply; Mail Service: Covers up to a 90-day supply.
	Tier 2	Retail: \$25/prescription Mail Service: \$50/prescription	Retail: 25% <u>coinsurance</u> + \$25/prescription Mail Service: Not Covered	
	Tier 3	Retail: \$40/prescription Mail Service: \$80/prescription	Retail: 25% <u>coinsurance</u> + \$40/prescription Mail Service: Not Covered	

* For more information about limitations and exceptions, see the plan or policy document at www.bsca.com/policies/.

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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)	
	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: 30% <u>coinsurance</u> up to \$250/prescription + 25% of purchase price</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.</i> <i>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: 20% <u>coinsurance</u></i>	<i>Ambulatory Surgery Center: 50% <u>coinsurance</u> of up to \$350/day plus 100% of additional charges</i> <i>Outpatient Hospital: 50% <u>coinsurance</u> of up to \$350/day plus 100% of additional charges</i>	-----None-----
	Physician/surgeon fees	20% <u>coinsurance</u>	50% <u>coinsurance</u>	
If you need immediate medical attention	<u>Emergency room care</u>	<i>Facility Fee: \$100/visit + 20% <u>coinsurance</u></i> <i>Physician Fee: 20% <u>coinsurance</u></i>	<i>Facility Fee: \$100/visit + 20% <u>coinsurance</u></i> <i>Physician Fee: 20% <u>coinsurance</u></i>	-----None-----
	<u>Emergency medical transportation</u>	20% <u>coinsurance</u>	20% <u>coinsurance</u>	This payment is for emergency or authorized transport.
	<u>Urgent care</u>	20% <u>coinsurance</u>	50% <u>coinsurance</u>	-----None-----
If you have a hospital stay	Facility fee (e.g., hospital room)	\$100/admission + 20% <u>coinsurance</u>	50% <u>coinsurance</u> of up to \$600/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	20% <u>coinsurance</u>	50% <u>coinsurance</u>	-----None-----

* For more information about limitations and exceptions, see the plan or policy document at www.bsca.com/policies/.

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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: 20% <u>coinsurance</u> Other Outpatient Services: 20% <u>coinsurance</u> Partial Hospitalization: 20% <u>coinsurance</u> Psychological Testing: 20% <u>coinsurance</u>	Office Visit: 50% <u>coinsurance</u> Other Outpatient Services: 50% <u>coinsurance</u> Partial Hospitalization: 50% <u>coinsurance</u> of up to \$350/day plus 100% of additional charges Psychological Testing: 50% <u>coinsurance</u>	<u>Preauthorization</u> is required except for office visits. Failure to obtain <u>preauthorization</u> may result in non-payment of benefits.
	Inpatient services	Physician Inpatient Services: No Charge Hospital Services: \$100/admission + 20% <u>coinsurance</u> Residential Care: \$100/admission + 20% <u>coinsurance</u>	Physician Inpatient Services: 50% <u>coinsurance</u> Hospital Services: 50% <u>coinsurance</u> of up to \$600/day plus 100% of additional charges Residential Care: 50% <u>coinsurance</u> of up to \$600/day plus 100% of additional charges	
If you are pregnant	Office visits	20% <u>coinsurance</u>	50% <u>coinsurance</u>	-----None-----
	Childbirth/delivery professional services	20% <u>coinsurance</u>	50% <u>coinsurance</u>	
	Childbirth/delivery facility services	\$100/admission + 20% <u>coinsurance</u>	50% <u>coinsurance</u> of up to \$600/day plus 100% of additional charges	

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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 help recovering or have other special health needs	<u>Home health care</u>	20% <u>coinsurance</u>	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.
	<u>Rehabilitation services</u>	<u>Office Visit: 20% coinsurance</u> <u>Outpatient Hospital: 20% coinsurance</u>	<u>Office Visit: 50% coinsurance</u> <u>Outpatient Hospital: 50% coinsurance</u> of up to \$350/day plus 100% of additional charges	-----None-----
	<u>Habilitation services</u>	<u>Office Visit: 20% coinsurance</u> <u>Outpatient Hospital: 20% coinsurance</u>	<u>Office Visit: 50% coinsurance</u> <u>Outpatient Hospital: 50% coinsurance</u> of up to \$350/day plus 100% of additional charges	
	<u>Skilled nursing care</u>	<u>Freestanding SNF: 20% coinsurance</u> <u>Hospital-based SNF: 20% coinsurance</u>	<u>Freestanding SNF: 20% coinsurance</u> <u>Hospital-based SNF: 50% coinsurance</u> of up to \$600/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>	20% <u>coinsurance</u>	50% <u>coinsurance</u>	<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	Not Covered	Not Covered	-----None-----
	Children's glasses	Not Covered	Not Covered	
	Children's dental check-up	Not Covered	Not Covered	

* For more information about limitations and exceptions, see the plan or policy document at www.bsca.com/policies/.

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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 1-888-256-1915 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

Minimum Essential Coverage generally includes plans, health insurance available through the Marketplace or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of Minimum Essential Coverage, you may not be eligible for the premium tax credit.

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.

* For more information about limitations and exceptions, see the plan or policy document at www.bsca.com/policies/.

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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 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 ílnígó shíka' ar'oowoł nínízingo, kwiji' hodílnih 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): 한국어 도움이 필요하시면, 1-866-346-7198 무료전화 로 전화하십시오.

Armenian (Հայերեն): Հայերեն լեզվով անվճար օգնություն ստանալու համար խնդրում ենք զանգահարել 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 ਵਿਚ ਸਹਾਇਤਾ ਲਈ ਕਿਰਪਾ ਕਰਕੇ 1-866-346-7198 'ਤੇ ਕਾਲ ਕਰੋ।

Khmer (ភាសាខ្មែរ): សូមជំនួយភាសាអង់គ្លេសដោយឥតគិតថ្លៃ សូមទាក់ទងមកលេខ 1-866-346-7198។

Arabic (العربية): للحصول على المساعدة في اللغة العربية مجاناً، 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): हिन्दी में बिना खर्च के सहायता के लिए, 1-866-346-7198 पर कॉल करें।

Thai (ไทย): สำหรับความช่วยเหลือเป็นภาษาไทยโดยไม่มีค่าใช้จ่ายโปรดโทร 1-866-346-7198

Laotian (ພາສາລາວ): ສໍາລັບການຊ່ວຍເຫຼືອເປັນພາສາລາວແບບບໍ່ເສຍຄ່າ, ກະລຸນາໂທ1-866-346-7198.

————— *To see examples of how this [plan](#) might cover costs for a sample medical situation, see the next section.* —————

PRA Disclosure Statement

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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 \$4,000
- Specialist coinsurance 20%
- Hospital (facility) copay+coins \$100+20%
- Other coinsurance 20%

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	\$12,700
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In this example, Peg would pay:

Cost Sharing	
<u>Deductibles</u>	\$4,000
<u>Copayments</u>	\$100
<u>Coinsurance</u>	\$1,500
What isn't covered	
Limits or exclusions	\$60
The total Peg would pay is	\$5,660

Managing Joe's Type 2 Diabetes

(a year of routine participating care of a well-controlled condition)

- The plan's overall deductible \$4,000
- Specialist coinsurance 20%
- Hospital (facility) copay+coins \$100+20%
- Other coinsurance 20%

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	\$5,600
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In this example, Joe would pay:

Cost Sharing	
<u>Deductibles</u>	\$4,000
<u>Copayments</u>	\$200
<u>Coinsurance</u>	\$70
What isn't covered	
Limits or exclusions	\$20
The total Joe would pay is	\$4,290

Mia's Simple Fracture

(participating emergency room visit and follow up care)

- The plan's overall deductible \$4,000
- Specialist coinsurance 20%
- Hospital (facility) copay+coins \$100+20%
- Other coinsurance 20%

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	\$2,800
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In this example, Mia would pay:

Cost Sharing	
<u>Deductibles</u>	\$2,800
<u>Copayments</u>	\$0
<u>Coinsurance</u>	\$0
What isn't covered	
Limits or exclusions	\$0
The total Mia would pay is	\$2,800

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