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 1-855-599-2657. 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 1-866-444-3272 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	$1,700 Self only enrollment, $3,400 for an entire 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. Preventative 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?	$3,400 Self only enrollment, $3,400 for any one member within a Family enrollment, $6,800 for an entire 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 network providers, see blueshieldca.com/fad or call 1-855-599-2657.	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 Deductible does not apply	Not Covered	You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	10% coinsurance	Not Covered	The services listed are at a freestanding location.
	Imaging (CT/PET scans, MRIs)	10% coinsurance	*Outpatient Radiology Center*: 50% coinsurance *Outpatient Hospital*: 50% coinsurance of up to $350/day plus 100% of additional charges	Preauthorization is required. Failure to obtain preauthorization may result in non-payment of benefits. The following maximums are for services received from a participating outpatient hospital. Colonoscopy: $1,500/procedure Upper GI Endoscopy with Biopsy: $1,250/procedure Upper GI Endoscopy: $1,000/procedure
If you need drugs to treat your illness or condition **More information about prescription drug coverage is available at www.navitus.com**	Generic drugs	Retail 30-Days: Costco: $0/Rx Other: $9/Rx Mail 90-Days: $0/Rx	Member must pay the entire cost up front and apply for reimbursement. Net cost may be greater than if member uses an in-network provider.	Some narcotic pain medications and cough medications require the regular retail copayment at Costco and 3 times the regular copayment at Mail.
	Preferred brand drugs	Retail 30-Days: Costco: $35/Rx Other: $35/Rx Mail 90-Days: $90/Rx		If a brand drug is dispensed when a generic equivalent is available, then the member will be responsible for the generic copayment plus the cost difference between the generic and brand.
	Specialty drugs	30-Days: $35/Rx	Not Covered	Member must use Navitus Specialty Rx. Supplies of more than 30 days are not allowed

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	No Charge up to $350 per day plus 100% of additional charges	The following maximums are for services received from a participating outpatient hospital. Arthroscopy: $4,500/procedure Cataract Surgery: $2,000/procedure
	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	None
	Emergency medical transportation	$100 / trip +10% coinsurance	$100 / trip +10% coinsurance	This payment is for emergency or authorized transport.
	Urgent care	10% coinsurance	50% coinsurance	None
If you have a hospital stay	Facility fee (e.g., hospital room)	10% coinsurance	No Charge up to $600 per day plus 100% of additional charges	Preauthorization is required. Failure to obtain preauthorization may result in non-payment of benefits.
	Physician/surgeon fees	10% coinsurance	50% coinsurance	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	10% coinsurance	*Office Visit*: 50% coinsurance *Other Outpatient Services*: 50% coinsurance *Partial Hospitalization*: 50% coinsurance of up to $350/day plus 100% of additional charges *Psychological Testing*: 50% coinsurance	Preauthorization is required except for office visits. Failure to obtain preauthorization may result in non-payment of benefits.
	Inpatient services	10% coinsurance	*Physician Inpatient Services:* 50% coinsurance *Hospital Services/Residential Care:* No Charge up to $600 per 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	10% coinsurance	50% coinsurance	None
	Childbirth/delivery professional services	10% coinsurance	50% coinsurance	None
	Childbirth/delivery facility	10% coinsurance	No Charge up to $600 per	Non-Preferred facility are subject to a

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)	
	services		day plus 100% of additional charges	maximum benefit payment up to $600 per day.
If you need help recovering or have other special health needs	Home health care	10% coinsurance	50% coinsurance	Preauthorization is required. Failure to obtain preauthorization may result in non-payment of benefits. Coverage limited to 100 visits per member per calendar year.
	Rehabilitation services	10% coinsurance	Not Covered	None
	Habilitation services	10% coinsurance	Not Covered	None
	Skilled nursing care	10% coinsurance	*Freestanding SNF*: 10% coinsurance *Hospital-based SNF*: No Charge up to $600 per day plus 100% of additional charges	Preauthorization is required. Failure to obtain preauthorization may result in non-payment of benefits. Coverage limited to 150 days per member per benefit period.
	Durable medical equipment	10% coinsurance	Not Covered	Preauthorization is required. Failure to obtain preauthorization may result in non-payment of benefits.
	Hospice services	No Charge	50% coinsurance	Preauthorization is required except for pre-hospice consultation. Failure to obtain preauthorization 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	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	• Long-term care	• Routine eye care (Adult/Child)
• Dental care (Adult/Child)	• Routine foot care	• Services not deemed medically necessary
• Infertility treatment	• Private -duty nursing	• 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: 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 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 Customer Service at 1-855-599-2657 or the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or dol.gov/ebsa/healthreform.

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.

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): Diné k'ehjí doo bąąh ílínígó shíka' at'oowoł nínízingo, kwijį' 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): 한국어도움이필요하시면, 1-866-346-7198 무료전화 로전화하십시오.

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 ਕਾੱਲ ਕਰੋ।

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

Arabic (العربية): للحصول 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): 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.

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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 in-network pre-natal care and a hospital delivery)

- **The plan's overall deductible** **$1,700**
- **Specialist coinsurance** **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	**$12,700**

In this example, Peg would pay:

Cost sharing	
Deductibles	$1,700
Copayments	$20
Coinsurance	$1,100
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$2,880**

Managing Joe's Type 2 Diabetes

(a year of routine in-network care of a well-controlled condition)

- **The plan's overall deductible** **$1,700**
- **Specialist coinsurance** **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	**$5,600**

In this example, Joe would pay:

Cost sharing	
Deductibles	$1,700
Copayments	$500
Coinsurance	$0
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$2,220**

Mia's Simple Fracture

(in-network emergency room visit and follow up care)

- **The plan's overall deductible** **$1,700**
- **Specialist coinsurance** **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	**$2,800**

In this example, Mia would pay:

Cost sharing	
Deductibles	$1,700
Copayments	$210
Coinsurance	$100
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$2,010**

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