## Important Questions

| What is the overall deductible? | $0. | See the Common Medical Events chart below for your costs for services this plan covers. |
| Are there services covered before you meet your deductible? | Yes. Preventive care and services listed in your complete terms of coverage. | 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 healthcare.gov/coverage/preventive-care-benefits. |
| Are there other deductibles for specific services? | No. | You don’t have to meet deductibles for specific services. |
| What is the out-of-pocket limit for this plan? | $1,500 per individual / $3,000 per family for participating providers. | 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, 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. See blueshieldca.com/fad or call 1-855-829-3566 for a list of network providers. | 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? | Yes. | This plan will pay some or all of the costs to see a specialist for covered services but only if you have a referral before you see the specialist. |
All **copayment** and **coinsurance** costs shown in this chart are after your **deductible** has been met, if a **deductible** applies.

<table>
<thead>
<tr>
<th>Common Medical Event</th>
<th>Services You May Need</th>
<th>Participating Provider (You will pay the least)</th>
<th>Non-Participating Provider (You will pay the most)</th>
<th>Limitations, Exceptions, &amp; Other Important Information</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>If you visit a health care provider’s office or clinic</strong></td>
<td>Primary care visit to treat an injury or illness</td>
<td>$20/visit</td>
<td>Not Covered</td>
<td>None</td>
</tr>
</tbody>
</table>
|                      | Specialist visit                                                                      | *Trio+ Specialist*: $20/visit  
*Other Specialist*: $20/visit                      | Not Covered                                       | Self-referral is available for Trio+ Specialist visits. |
|                      | Preventive care/screening /immunization                                               | No Charge                                        | 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)                                                   | *Lab & Path*: No Charge  
*X-Ray & Imaging*: No Charge  
*Other Diagnostic Examination*: No Charge | *Lab & Path*: Not Covered  
*X-Ray & Imaging*: Not Covered  
*Other Diagnostic Examination*: Not Covered | Preauthorization is required. Failure to obtain preauthorization may result in non-payment of benefits. The services listed are at a freestanding location. |
|                      | Imaging (CT/PET scans, MRIs)                                                         | *Outpatient Radiology Center*: No Charge  
*Outpatient Hospital*: No Charge | *Outpatient Radiology Center*: Not Covered  
*Outpatient Hospital*: Not Covered | Preauthorization is required. Failure to obtain preauthorization may result in non-payment of benefits. |
| **If you need drugs to treat your illness or condition** | Tier 1                                                                                | *Retail*: $10/prescription  
*Mail Service*: $10/prescription | *Retail*: Not Covered  
*Mail Service*: Not Covered | Preauthorization is required for select drugs. Failure to obtain preauthorization may result in non-payment of benefits.  
*Retail*: Covers up to a 30-day supply; 90-days may be covered with a copayment for each 30-day supply;  
*Mail Service*: Covers up to a 90-day supply. |
|                      | Tier 2                                                                                | *Retail*: $30/prescription  
*Mail Service*: $60/prescription | *Retail*: Not Covered  
*Mail Service*: Not Covered | |
|                      | Tier 3                                                                                | *Retail*: $50/prescription  
*Mail Service*: $100/prescription | *Retail*: Not Covered  
*Mail Service*: Not Covered | |

* For more information about limitations and exceptions, see the plan or policy document at [bsca.com/policies/W8002996-M0035481EOC_COI202401.pdf](http://bsca.com/policies/W8002996-M0035481EOC_COI202401.pdf).
### Common Medical Event

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</tr>
</thead>
<tbody>
<tr>
<td><strong>If you have outpatient surgery</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
| Facility fee (e.g., ambulatory surgery center) | Ambulatory Surgery Center: $30/surgery  
Outpatient Hospital: $30/surgery | Ambulatory Surgery Center: Not Covered  
Outpatient Hospital: Not Covered | Preauthorization is required. Failure to obtain preauthorization may result in non-payment of benefits. |
| Physician/surgeon fees | No Charge | Not Covered | |
| **If you need immediate medical attention** |
| Emergency room care | Facility Fee: $100/visit  
Physician Fee: No Charge | Facility Fee: $100/visit  
Physician Fee: No Charge | Preauthorization is required. Failure to obtain preauthorization may result in non-payment of benefits. |
| Emergency medical transportation | $50/transport | $50/transport | Preauthorization is required except for office visits and office-based opioid treatment. Failure to obtain preauthorization may result in non-payment of benefits. |
| Urgent care | $20/visit | Within Plan Service Area: Not Covered  
Outside Plan Service Area: $20/visit | |
| **If you have a hospital stay** |
| Facility fee (e.g., hospital room) | $300/admission | Not Covered | Preauthorization is required. Failure to obtain preauthorization may result in non-payment of benefits. |
| Physician/surgeon fees | No Charge | Not Covered | |
| **If you need mental health, behavioral health, or substance abuse services** |
| Outpatient services | Office Visit: $20/visit  
Other Outpatient Services: No Charge  
Partial Hospitalization: No Charge  
Psychological Testing: No Charge | Office Visit: Not Covered  
Other Outpatient Services: Not Covered  
Partial Hospitalization: Not Covered  
Psychological Testing: Not Covered | Preauthorization is required except for office visits and office-based opioid treatment. Failure to obtain preauthorization may result in non-payment of benefits. |

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</thead>
<tbody>
<tr>
<td></td>
<td>Inpatient services</td>
<td>Physician Inpatient Services: No Charge</td>
<td>Physician Inpatient Services: Not Covered</td>
<td>Preauthorization is required. Failure to obtain preauthorization may result in non-payment of benefits.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Hospital Services: $300/admission</td>
<td>Hospital Services: Not Covered</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Residential Care: $300/admission</td>
<td>Residential Care: Not Covered</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Office visits</td>
<td>No Charge</td>
<td>Not Covered</td>
<td></td>
</tr>
<tr>
<td>If you are pregnant</td>
<td>Childbirth/delivery professional services</td>
<td>No Charge</td>
<td>Not Covered</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Childbirth/delivery facility services</td>
<td>$300/admission</td>
<td>Not Covered</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Home health care</td>
<td>$20/visit</td>
<td>Not Covered</td>
<td></td>
</tr>
<tr>
<td>If you need help recovering or have other special health needs</td>
<td>Rehabilitation services</td>
<td>Office Visit: $20/visit</td>
<td>Office Visit: Not Covered</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Outpatient Hospital: $20/visit</td>
<td>Outpatient Hospital: Not Covered</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Habilitation services</td>
<td>Office Visit: $20/visit</td>
<td>Office Visit: Not Covered</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Outpatient Hospital: $20/visit</td>
<td>Outpatient Hospital: Not Covered</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Skilled nursing care</td>
<td>Freestanding SNF: No Charge</td>
<td>Freestanding SNF: Not Covered</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Hospital-based SNF: No Charge</td>
<td>Hospital-based SNF: Not Covered</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Durable medical equipment</td>
<td>No Charge</td>
<td>Not Covered</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Hospice services</td>
<td>No Charge</td>
<td>Not Covered</td>
<td></td>
</tr>
<tr>
<td>If your child needs</td>
<td>Children’s eye exam</td>
<td>Not Covered</td>
<td>Not Covered</td>
<td></td>
</tr>
</tbody>
</table>

* For more information about limitations and exceptions, see the plan or policy document at [bsca.com/policies/W8002996-M0035481EOC_COI202401.pdf](http://bsca.com/policies/W8002996-M0035481EOC_COI202401.pdf).
### 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)
- Infertility Treatment

**Services Your Plan Generally Does COVER (Check your policy or plan document for more information and a list of any other covered services.)**

- Long-term care
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing
- Routine foot care
- Routine eye care (Adult)
- 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

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**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 1-855-829-3566 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.

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Language Access Services:

English: For assistance in English at no cost, call 1-866-346-7198.


Navajo (Dine): Diné k'ehjí doo báágh ilínígí shíika' a't'oowóól nińízingó, kwí'íí hodíílníi 1-866-346-7198.

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


Armenian (Հայերեն): Հայերեն օգնություն կազմակերպենքներից հետևի համար կազմակերպեք 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 اطلاعاتی در مورد هزینه‌های 1-866-346-7198 نام بگوید. (فارسی)

Punjabi (ਪੰਜਾਬੀ): ਪੰਜਾਬੀ ਦੀ ਮੰਚਡ ਸਰਿੱਖ਼ਤ ਦੀ ਵਿਚਕਾਰ ਵਧਾੜੀ 1-866-346-7198 ਦੇ ਵਧਾਓ ਵਧਾੜੀ।

Khmer (ខ្មែរ): សុខភាពយឺតសំរេចពីការជៀងសំរេចអនកស្តង់ដាន តាមរយៈលេខ 1-866-346-7198


Hmong (Hmoob): Xav tau kew pab dowb lub Hmoob. thov hu iau 1-866-346-7198.

Hindi (हिंदी): हिंदी में बिना खर्च के सहायता के लिए, 1-866-346-7198 पर कॉल करें।

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

Laotian (ລາວ): ຂ່າວເດືອນແກ້ມສະໝັ້ນຄວາມສາມາດໂທລ່ຽກ, ນາຍແມ່ນີ້ 1-866-346-7198.

PRA Disclosure Statement

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1146. The time required to complete this information collection is estimated to average 0.08 hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

* For more information about limitations and exceptions, see the plan or policy document at bsc.com/policies/W8002996-M0035481EOC_COI202401.pdf.
The plan would be responsible for the other costs of these EXAMPLE covered services.

---

### 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: $0
- Specialist copayment: $20
- Hospital (facility) copayment: $300
- Other copayment: $0

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:**

<table>
<thead>
<tr>
<th>Cost Sharing</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Deductibles</td>
<td>$0</td>
</tr>
<tr>
<td>Copayments</td>
<td>$300</td>
</tr>
<tr>
<td>Coinsurance</td>
<td>$0</td>
</tr>
</tbody>
</table>

**What isn't covered**
- Limits or exclusions: $60

**The total Peg would pay is:** $360

---

#### Managing Joe’s Type 2 Diabetes
(a year of routine participating care of a well-controlled condition)

- The plan’s overall deductible: $0
- Specialist copayment: $20
- Hospital (facility) copayment: $300
- Other copayment: $0

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:**

<table>
<thead>
<tr>
<th>Cost Sharing</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Deductibles</td>
<td>$0</td>
</tr>
<tr>
<td>Copayments</td>
<td>$700</td>
</tr>
<tr>
<td>Coinsurance</td>
<td>$0</td>
</tr>
</tbody>
</table>

**What isn't covered**
- Limits or exclusions: $20

**The total Joe would pay is:** $720

---

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

- The plan’s overall deductible: $0
- Specialist copayment: $20
- Hospital (facility) copayment: $300
- Other copayment: $0

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:**

<table>
<thead>
<tr>
<th>Cost Sharing</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Deductibles</td>
<td>$0</td>
</tr>
<tr>
<td>Copayments</td>
<td>$200</td>
</tr>
<tr>
<td>Coinsurance</td>
<td>$0</td>
</tr>
</tbody>
</table>

**What isn't covered**
- Limits or exclusions: $0

**The total Mia would pay is:** $200

---

Blue Shield of California is an independent member of the Blue Shield Association.
NOTICES AVAILABLE ONLINE

Nondiscrimination and Language Assistance Services

Blue Shield complies with applicable state and federal civil rights laws. We also offer language assistance services at no additional cost. View our nondiscrimination notice and language assistance notice: blueshieldca.com/notices. You can also call for language assistance services: (866) 346-7198 (TTY: 711).

If you are unable to access the website above and would like to receive a copy of the nondiscrimination notice and language assistance notice, please call Customer Care at (888) 256-3650 (TTY: 711).

Servicios de asistencia en idiomas y avisos de no discriminación

Blue Shield cumple con las leyes de derechos civiles federales y estatales aplicables. También, ofrecemos servicios de asistencia en idiomas sin costo adicional.


Si no puede acceder al sitio web que aparece arriba y desea recibir una copia del aviso de no discriminación y del aviso de asistencia en idiomas, llame a Atención al Cliente al (888) 256-3650 (TTY: 711).

非歧視通知和語言協助服務

Blue Shield 遵守適用的州及聯邦政府的民權法。同時，我們免費提供語言協助服務。
如需檢視我司的非歧視通知和語言幫助通知，請造訪 blueshieldca.com/notices。您還可致電尋求語言協助服務：(866) 346-7198 (TTY: 711)。
如果您無法造訪上述網站，且希望收到一份非歧視通知和語言幫助通知的副本，請致電客戶服務部，電話：(888) 256-3650 (TTY: 711)。