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/oc or by calling 1-888-235-1767.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	For preferred and non-preferred **$5,000** per family Doesn't apply to preventive care.	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 2 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 2 for other costs for services this plan covers.
Is there an out–of–pocket limit on my expenses?	Yes. **$10,000** in allowable charges per Individual including Family **deductible**	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.
What is not included in the out–of–pocket limit?	Premiums, balanced-billed 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.**
Is there an overall annual limit on what the plan pays?	No.	The chart starting on page 2 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. For a list of preferred providers, see www.blueshieldca.com	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 page 2 for how this plan pays different kinds of **providers.**
Do I need a referral to see a specialist?	No.	You can see the **specialist** you choose without permission from this plan.
Are there services this plan doesn't cover?	Yes.	Some of the services this plan doesn't cover are listed on page 5. See your policy or plan document for additional information about **excluded services**.

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- **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 preferred **providers** by charging you lower **deductibles**, **copayments** and **coinsurance** amounts.

Common Medical Event	Services You May Need	Your Cost If You Use an Preferred Provider	Your Cost If You Use an Non-Preferred Provider	Limitations & Exceptions
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	10% coinsurance	20% coinsurance	——none——
	Specialist visit	10% coinsurance	20% coinsurance	——none——
	Other practitioner office visit	10% coinsurance per visit	20% coinsurance for chiropractic	Chiropractic: Plan payment up to $1,000 maximum per person per year.
	Preventive care/screening/immunization	No Charge	Not Covered	Refer to the plan document for covered services.
If you have a test	Diagnostic test (x-ray, blood work)	10% coinsurance	20% coinsurance	——none——
	Imaging (CT/PET scans, MRIs)	10% coinsurance	20% coinsurance	——none——
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.blueshieldca.com/oc	Generic drugs	20% prescription	20% prescription	Covers up to a 30 day supply at retail. Prior authorization is required on select formulary and non-formulary drugs.
	Preferred brand drugs	20% prescription	20% prescription	
	Non-preferred brand drugs	20% prescription	20% prescription	
	Specialty drugs	20% prescription	20% prescription	

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Common Medical Event	Services You May Need	Your Cost If You Use an Preferred Provider	Your Cost If You Use an Non-Preferred Provider	Limitations & Exceptions
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	10% coinsurance	20% coinsurance	——none——
	Physician/surgeon fees	10% coinsurance	20% coinsurance	——none——
If you need immediate medical attention	Emergency room services	10% coinsurance	20% coinsurance	——none——
	Emergency medical transportation	10% coinsurance	10% coinsurance	——none——
	Urgent care	10% coinsurance	20% coinsurance	——none——
If you have a hospital stay	Facility fee (e.g., hospital room)	10% coinsurance	20% coinsurance	Penalty: Non-Preferred only - allowed amount is decreased by 20% of which the covered person is liable.
	Physician/surgeon fee	10% coinsurance	20% coinsurance	——none——
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	10% coinsurance	20% coinsurance	Limited to a maximum of 50 combined visits for Non-Severe Mental Health and Substance Abuse.
	Mental/Behavioral health inpatient services	10% coinsurance	20% coinsurance	Penalty: Non-Preferred only - allowed amount is decreased by 20% of which the covered person is liable.
	Substance use disorder outpatient services	10% coinsurance	20% coinsurance	Limited to a maximum of 50 combined visits for Non-Severe Mental Health and Substance Abuse.
	Substance use disorder inpatient services	10% coinsurance	20% coinsurance	Penalty: Non-Preferred only - allowed amount is decreased by 20% of which the covered person is liable.
If you are pregnant	Prenatal and postnatal care	10% coinsurance	20% coinsurance	——none——
	Delivery and all inpatient services	10% coinsurance	20% coinsurance	——none——

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Common Medical Event	Services You May Need	Your Cost If You Use an Preferred Provider	Your Cost If You Use an Non-Preferred Provider	Limitations & Exceptions
If you need help recovering or have other special health needs	Home health care	10% coinsurance	20% coinsurance	Prior authorization is required.
	Rehabilitation services	10% coinsurance	20% coinsurance	——none——
	Habilitation services	10% coinsurance	20% coinsurance	——none——
	Skilled nursing care	10% coinsurance	20% coinsurance	Combined maximum of up to 60 days per calendar year; semi-private accommodations.
	Durable medical equipment	10% coinsurance	20% coinsurance	Prior authorization required for equipment in excess of $5,000.
	Hospice service	Inpatient Respite Care 10% coinsurance	Inpatient Respite Care 20% coinsurance	Prior authorization is required.
If your child needs dental or eye care	Eye exam	No Charge	No Charge	——none——
	Glasses	Not Covered	Not Covered	——none——
	Dental check-up	Not Covered	Not Covered	——none——

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.)

- Cosmetic Surgery
- Dental care
- Hearing Aids
- Long Term Care
- Non-emergency care when traveling outside the U.S
- Private Duty Nursing
- Routine Eye Care (Adult)
- Routine Foot Care
- Services Deemed Not Medically-Necessary
- Weight loss programs

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.)

- Acupuncture
- Bariatric surgery
- Chiropractic Services
- Infertility Treatment

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 1-888-235-1767. 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:

- 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: 1-888-235-1767 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 helpline@dmhc.ca.gov or visit http://www.healthhelp.ca.gov.

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Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al 1-866-346-7198

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-866-346-7198

Chinese (中文): 如果需要中文的帮助，请拨打这个号码 1-866-346-7198

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-866-346-7198

To see examples of how this plan might cover costs for a sample medical situation, see the next 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** $2,160
- **Patient pays** $ 5,380

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	$5,000
Copays	$0
Coinsurance	$230
Limits or exclusions	$150
Total	**$5,380**

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

- **Amount owed to providers:** $5,400
- **Plan pays** $280
- **Patient pays** $5,120

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	$5,000
Copays	$0
Coinsurance	$40
Limits or exclusions	$80
Total	**$5,120**

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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.

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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