blue of california

Coverage Period: Beginning On or After 1/1/2019

Silver Full PPO 1700/55 OffEx **Coverage for: Individual + Family | Plan Type: PPO**

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/M0016499_EOC.pdf or call **1-888-319-5999**. 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?	**$1,700** per individual / **$3,400** per family for participating providers; **$3,400** per individual / **$6,800** per family for non-participating providers.	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. 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?	Yes. Prescription drugs -- **$300** per individual / **$600** per family. There are no other specific deductibles.	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?	**$7,550** per individual / **$15,100** per family for participating providers; **$12,550** per individual / **$25,100** per family for non-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, the overall family out-of-pocket limit must be 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. See blueshieldca.com/fap or call **1-888-319-5999** 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?	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
		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	$55/visit; Calendar year medical deductible does not apply	50% coinsurance	----------None----------
	Specialist visit	$70/visit; Calendar year medical deductible does not apply	50% coinsurance	
	Preventive care/screening /immunization	No Charge; Calendar year medical 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)	*Lab & Path*: $55/visit; Calendar year medical deductible does not apply *X-Ray & Imaging*: $70/visit; Calendar year medical deductible does not apply *Other Diagnostic Examination*: $70/visit; Calendar year medical deductible does not apply	*Lab & Path*: 50% coinsurance *X-Ray & Imaging*: 50% coinsurance *Other Diagnostic Examination*: 50% coinsurance	The services listed are at a freestanding location.
	Imaging (CT/PET scans, MRIs)	*Outpatient Radiology Center*: 35% coinsurance *Outpatient Hospital*: $100/visit+ 35% coinsurance	*Outpatient Radiology Center*: 50% coinsurance *Outpatient Hospital*: 50% coinsurance up to $350/day plus 100% of additional charges	Preauthorization is required. Failure to obtain preauthorization may result in non-payment of benefits.

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 drugs to treat your illness or condition More information about prescription drug coverage is available at blueshieldca.com/formulary	Tier 1	*Retail*: $15/prescription; Calendar year pharmacy deductible does not apply *Mail Service*: $30/prescription; Calendar year pharmacy deductible does not apply	*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; *Mail Service*: Covers up to a 90-day supply.
	Tier 2	*Retail*: $50/prescription *Mail Service*: $100/prescription	*Retail*: Not Covered *Mail Service*: Not Covered	
	Tier 3	*Retail*: $80/prescription *Mail Service*: $160/prescription	*Retail*: Not Covered *Mail Service*: Not Covered	
	Tier 4	*Retail and Network Specialty Pharmacies*: 30% coinsurance up to $250/prescription *Mail Service*: 30% coinsurance up to $500/prescription	*Retail*: Not Covered *Mail Service*: Not Covered	Preauthorization is required. Failure to obtain preauthorization may result in non-payment of benefits. *Retail and Network Specialty Pharmacies*: Covers up to a 30-day supply; Specialty Drugs must be obtained at a Network Specialty Pharmacy. *Mail Service*: Covers up to a 90-day supply.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	*Ambulatory Surgery Center*: 35% coinsurance *Outpatient Hospital*: $150/surgery+ 35% coinsurance	*Ambulatory Surgery Center*: 50% coinsurance up to $350/day plus 100% of additional charges *Outpatient Hospital*: 50% coinsurance up to $350/day plus 100% of additional charges	----------None----------
	Physician/surgeon fees	35% coinsurance	50% coinsurance	----------None----------

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 immediate medical attention	Emergency room care	*Facility Fee*: $250/visit+ 35% coinsurance *Physician Fee*: 35% coinsurance	*Facility Fee*: $250/visit+ 35% coinsurance *Physician Fee*: 35% coinsurance	----------None----------
	Emergency medical transportation	35% coinsurance	35% coinsurance	This payment is for emergency or authorized transport.
	Urgent care	$55/visit; Calendar year medical deductible does not apply	50% coinsurance	----------None----------
If you have a hospital stay	Facility fee (e.g., hospital room)	35% coinsurance	50% coinsurance up to $2,000/day plus 100% of additional charges	Preauthorization is required. Failure to obtain preauthorization may result in non-payment of benefits.
	Physician/surgeon fees	35% coinsurance	50% coinsurance	----------None----------
If you need mental health, behavioral health, or substance abuse services	Outpatient services	*Office Visit*: $55/visit; Calendar year medical deductible does not apply *Other Outpatient Services*: 35% coinsurance *Partial Hospitalization*: 35% coinsurance *Psychological Testing*: 35% coinsurance	*Office Visit*: 50% coinsurance *Other Outpatient Services*: 50% coinsurance *Partial Hospitalization*: 50% coinsurance up to $350/day plus 100% of additional charges *Psychological Testing*: 50% coinsurance	Preauthorization is required except for office visits, electroconvulsive therapy, and psychological testing. Failure to obtain preauthorization may result in non-payment of benefits.
	Inpatient services	*Physician Inpatient Services*: 35% coinsurance *Hospital Services*: 35% coinsurance *Residential Care*: 35% coinsurance	*Physician Inpatient Services:* 50% coinsurance *Hospital Services:* 50% coinsurance up to $2,000/day plus 100% of additional charges *Residential Care:* 50% coinsurance up to $2,000/day plus 100% of additional charges	Preauthorization is required. Failure to obtain preauthorization may result in non-payment of benefits.

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 are pregnant	Office visits	No Charge; Calendar year medical deductible does not apply	50% coinsurance	----------None----------
	Childbirth/delivery professional services	35% coinsurance	50% coinsurance	
	Childbirth/delivery facility services	35% coinsurance	50% coinsurance up to $2,000/day plus 100% of additional charges	----------None----------
If you need help recovering or have other special health needs	Home health care	35% coinsurance	Not Covered	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	*Office Visit*: 35% coinsurance *Outpatient Hospital*: 35% coinsurance	*Office Visit*: 50% coinsurance *Outpatient Hospital*: 50% coinsurance up to $350/day plus 100% of additional charges	----------None----------
	Habilitation services	*Office Visit*: 35% coinsurance *Outpatient Hospital*: 35% coinsurance	*Office Visit*: 50% coinsurance *Outpatient Hospital*: 50% coinsurance up to $350/day plus 100% of additional charges	
	Skilled nursing care	*Freestanding SNF*: 35% coinsurance *Hospital-based SNF*: 35% coinsurance	*Freestanding SNF*: 35% coinsurance *Hospital-based SNF*: 50% coinsurance up to $2,000/day plus 100% of additional charges	Preauthorization is required. Failure to obtain preauthorization may result in non-payment of benefits. Coverage limited to 100 days per member per benefit period.
	Durable medical equipment	50% coinsurance	Not Covered	Preauthorization is required. Failure to obtain preauthorization may result in non-payment of benefits.

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)	
	Hospice services	No Charge	Not Covered	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	No Charge; Calendar year medical deductible does not apply	Coverage up to a maximum allowance of $30; Calendar year medical deductible does not apply	Coverage limited to one exam per member per calendar year.
	Children's glasses	No Charge; Calendar year medical deductible does not apply	Coverage up to a maximum allowance of $25; Calendar year medical deductible does not apply	Coverage is limited to one eyeglass frame and eyeglass lenses or contact lenses instead of eyeglasses, up to the benefit per calendar year. The cost listed is for Single Vision.
	Children's dental check-up	No Charge; Calendar year medical deductible does not apply	20% coinsurance; Calendar year medical deductible does not apply	Coverage for prophylaxis services (cleaning) is limited to once in a six month period.

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 1-888-319-5999 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
If you don't have Minimum Essential Coverage for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

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, kwiji̧' hodíílnih 1-866-346-7198.

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): Հայերենլեզվովանվճարօգնությունստանալուհամարխնդրում ենքզանգահարել 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 section.

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	$1,700
Specialist copayment	$70
Hospital (facility) coinsurance	35%
Other copayment	$55

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	**$12,800**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$1,700
Copayments	$790
Coinsurance	$4,040
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$6,590**

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

The plan's overall deductible	$1,700
Specialist copayment	$70
Hospital (facility) coinsurance	35%
Other copayment	$55

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	**$7,400**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$1,330
Copayments	$2,390
Coinsurance	$950
What isn't covered	
Limits or exclusions	$60
The total Joe would pay is	**$4,730**

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

The plan's overall deductible	$1,700
Specialist copayment	$70
Hospital (facility) coinsurance	35%
Other copayment	$70

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	**$2,500**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$1,170
Copayments	$130
Coinsurance	$650
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,950**

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

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Notice Informing Individuals about Nondiscrimination and Accessibility Requirements

Discrimination is against the law

Blue Shield of California complies with applicable state laws and federal civil rights laws, and does not discriminate on the basis of race, color, national origin, ancestry, religion, sex, marital status, gender, gender identity, sexual orientation, age or disability. Blue Shield of California does not exclude people or treat them differently because of race, color, national origin, ancestry, religion, sex, marital status, gender, gender identity, sexual orientation, age, or disability.

Blue Shield of California:

- Provides aids and services at no cost to people with disabilities to communicate effectively with us such as:
  - Qualified sign language interpreters
  - Written information in other formats (including large print, audio, accessible electronic formats and other formats)
- Provides language services at no cost to people whose primary language is not English such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, contact the Blue Shield of California Civil Rights Coordinator.

If you believe that Blue Shield of California has failed to provide these services or discriminated in another way on the basis of race, color, national origin, ancestry, religion, sex, marital status, gender, gender identity, sexual orientation, age, or disability, you can file a grievance with:

Blue Shield of California
Civil Rights Coordinator
P.O. Box 629007
El Dorado Hills, CA 95762-9007

Phone: (844) 831-4133 (TTY: 711)
Fax: (844) 696-6070
Email: BlueShieldCivilRightsCoordinator@blueshieldca.com

You can file a grievance in person or by mail, fax or email. If you need help filing a grievance, our Civil Rights Coordinator is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at **https://ocrportal.hhs.gov/ocr/portal/lobby.jsf** or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue SW.
Room 509F, HHH Building
Washington, DC 20201
(800) 368-1019; TTY: (800) 537-7697

Complaint forms are available at **www.hhs.gov/ocr/office/file/index.html.**