### Important Questions | Answers | Why this Matters:

| **What is the overall deductible?** | $0 per individual / $0 per family Does not apply to preventive care and prescription drugs. | 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, per individual/per family: $1,000/$3,000 for medical only, $1,500/$2,500 for prescription drugs | 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. This limit helps you plan for health care expenses. |
| **What is not included in the out-of-pocket limit?** | Premiums, balance-billed charges, some copayments, 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/sisc or call 1-800-642-6155 | 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 6. See your policy or plan document for additional information about excluded services. |

### Questions: Call 1-800-642-6155 or visit us at www.blueshieldca.com/sisc.
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Blue Shield of California is an independent member of the Blue Shield Association.
**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.

<table>
<thead>
<tr>
<th>Common Medical Event</th>
<th>Services You May Need</th>
<th>Your Cost If You Use a Preferred Provider</th>
<th>Your Cost If You Use a Non-Preferred Provider</th>
<th>Limitations &amp; Exceptions</th>
</tr>
</thead>
<tbody>
<tr>
<td>If you visit a health care provider’s office or clinic</td>
<td>Primary care visit to treat an injury or illness</td>
<td>$20 / visit</td>
<td>50% <strong>coinsurance</strong></td>
<td>---------None-------------</td>
</tr>
<tr>
<td></td>
<td><strong>Specialist</strong> visit</td>
<td>$20 / visit</td>
<td>50% <strong>coinsurance</strong></td>
<td>---------None-------------</td>
</tr>
<tr>
<td></td>
<td>Other practitioner office visit</td>
<td>No Charge for chiropractic</td>
<td>Chiropractic: Not Covered</td>
<td>Acupuncture: Covers up to 12 visits per calendar year.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>No Charge for acupuncture</td>
<td>Acupuncture: 50% <strong>coinsurance</strong></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Preventive care/screening/immunization</td>
<td>No Charge</td>
<td>Not Covered</td>
<td>---------None-------------</td>
</tr>
<tr>
<td>If you have a test</td>
<td>Diagnostic test (x-ray, blood work)</td>
<td>No Charge at freestanding lab/x-ray center</td>
<td>Not Covered</td>
<td>---------None-------------</td>
</tr>
<tr>
<td></td>
<td>Imaging (CT/PET scans, MRIs)</td>
<td>No Charge at freestanding diagnostic center</td>
<td>50% <strong>coinsurance</strong> at freestanding diagnostic center</td>
<td>Prior authorization is required. Failure to prior authorize may result in reduced or nonpayment of benefits.</td>
</tr>
</tbody>
</table>
## Summary of Benefits and Coverage: What this Plan Covers & What it Costs

**Plan Type:** PPO  
**Coverage Period:** 10/01/2015 - 09/30/2016  
**Coverage for:** Family

### Common Medical Event

#### If you need drugs to treat your illness or condition

<table>
<thead>
<tr>
<th>Services You May Need</th>
<th>Your Cost If You Use a Preferred Provider</th>
<th>Your Cost If You Use a Non-Preferred Provider</th>
<th>Limitations &amp; Exceptions</th>
</tr>
</thead>
</table>
| Generic drugs         | Retail 30-Days: Costco: $0/Rx  
Other: $5/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 copay at Costco and 3 times the regular copay at Mail. |
| Brand drugs           | Brand: Retail 30-Days: Costco: $20/Rx  
Other: $20/Rx  
Mail 90-Days: $50/Rx | | |
| Specialty drugs       | Specialty: 30-Days: $20/Rx | Not Covered | |

More information about **prescription drug coverage** is available at www.blueshieldca.com/sisc.

#### If you have outpatient surgery

<table>
<thead>
<tr>
<th>Services You May Need</th>
<th>Your Cost If You Use a Preferred Provider</th>
<th>Limitations &amp; Exceptions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Facility fee (e.g., ambulatory surgery center)</td>
<td>No Charge</td>
<td></td>
</tr>
<tr>
<td>Physician/surgeon fees</td>
<td>No Charge</td>
<td>50% <strong>coinsurance</strong></td>
</tr>
</tbody>
</table>

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.

#### If you need immediate medical attention

<table>
<thead>
<tr>
<th>Services You May Need</th>
<th>Your Cost If You Use a Preferred Provider</th>
<th>Limitations &amp; Exceptions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Emergency room services</td>
<td>$100 / visit</td>
<td></td>
</tr>
<tr>
<td>Emergency medical transportation</td>
<td>No Charge</td>
<td>No Charge</td>
</tr>
</tbody>
</table>

**Urgent care**

<table>
<thead>
<tr>
<th>Services You May Need</th>
<th>Your Cost If You Use a Preferred Provider</th>
<th>Limitations &amp; Exceptions</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>$20 / visit at freestanding <strong>urgent care</strong> center</td>
<td>50% <strong>coinsurance</strong></td>
</tr>
</tbody>
</table>

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<table>
<thead>
<tr>
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<th>Services You May Need</th>
<th>Your Cost If You Use a Preferred Provider</th>
<th>Your Cost If You Use a Non-Preferred Provider</th>
<th>Limitations &amp; Exceptions</th>
</tr>
</thead>
<tbody>
<tr>
<td>If you have a hospital stay</td>
<td>Facility fee (e.g., hospital room)</td>
<td>No Charge</td>
<td>0% coinsurance with $600/day max</td>
<td>The maximum plan payment for non-emergency hospital services received from a non-preferred hospital is $600 per day. Members are responsible for all charges in excess of $600. Failure to prior authorize may result in reduced or nonpayment of benefits.</td>
</tr>
<tr>
<td></td>
<td>Physician/surgeon fee</td>
<td>No Charge</td>
<td>50% coinsurance</td>
<td>None</td>
</tr>
<tr>
<td>If you have mental health, behavioral health, or substance abuse needs</td>
<td>Mental/Behavioral health outpatient services</td>
<td>$20 / visit</td>
<td>50% coinsurance</td>
<td>The maximum plan payment for non-emergency hospital services received from a non-preferred hospital is $600 per day. Members are responsible for all charges in excess of $600. Failure to prior authorize may result in reduced or nonpayment of benefits.</td>
</tr>
<tr>
<td></td>
<td>Mental/Behavioral health inpatient services</td>
<td>No Charge</td>
<td>0% coinsurance with $600/day max</td>
<td>None</td>
</tr>
<tr>
<td></td>
<td>Substance use disorder outpatient services</td>
<td>$20 / visit</td>
<td>50% coinsurance</td>
<td>None</td>
</tr>
<tr>
<td></td>
<td>Substance use disorder inpatient services</td>
<td>No Charge</td>
<td>0% coinsurance with $600/day max</td>
<td>None</td>
</tr>
<tr>
<td>If you are pregnant</td>
<td>Prenatal and postnatal care</td>
<td>$20 / visit</td>
<td>50% coinsurance</td>
<td>Non-Preferred facility are subject to a maximum benefit payment up to $600 per day.</td>
</tr>
<tr>
<td></td>
<td>Delivery and all inpatient services</td>
<td>No Charge</td>
<td>0% coinsurance with $600/day max</td>
<td></td>
</tr>
</tbody>
</table>

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<th>Your Cost If You Use a Preferred Provider</th>
<th>Your Cost If You Use a Non-Preferred Provider</th>
<th>Limitations &amp; Exceptions</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>If you need help recovering or have other special health needs</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td><strong>Home health care</strong></td>
<td>No Charge</td>
<td>Not Covered</td>
<td>Covers up to 100 visits per calendar year. Non-preferred home health care and home infusion are not covered unless pre-authorized. When these services are pre-authorized, you pay the preferred provider copayment. Prior authorization is required. Failure to prior authorize may result in reduced or nonpayment of benefits.</td>
</tr>
<tr>
<td></td>
<td><strong>Rehabilitation services</strong></td>
<td>No Charge</td>
<td>Not Covered</td>
<td>------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td></td>
<td><strong>Habilitation services</strong></td>
<td>No Charge</td>
<td>Not Covered</td>
<td>------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td></td>
<td><strong>Skilled nursing care</strong></td>
<td>No Charge at freestanding SNF</td>
<td>No Charge at freestanding SNF</td>
<td>Covers up to 100 days per calendar year combined with Hospital Skilled Nursing Facility Unit. Prior authorization is required. Failure to prior authorize may result in reduced or nonpayment of benefits.</td>
</tr>
<tr>
<td></td>
<td><strong>Durable medical equipment</strong></td>
<td>No Charge</td>
<td>Not Covered</td>
<td>Prior authorization is required. Therapeutic shoes &amp; inserts for members with diabetes (2 pairs each/calendar year).</td>
</tr>
<tr>
<td></td>
<td><strong>Hospice service</strong></td>
<td>No Charge</td>
<td>Not Covered</td>
<td>Prior authorization is required. Failure to prior authorize may result in reduced or nonpayment of benefits.</td>
</tr>
<tr>
<td><strong>If your child needs dental or eye care</strong></td>
<td><strong>Eye exam</strong></td>
<td>No Charge</td>
<td>Not Covered</td>
<td>------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td></td>
<td><strong>Glasses</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td><strong>Dental check-up</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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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
- Non-emergency care when traveling outside the U.S.
- Services not deemed medically necessary
- Dental care (Adult/Child)
- Private-duty nursing
- Weight loss programs
- Infertility treatment
- Routine eye care (Adult/Child)
- Long-term care
- Routine foot care

**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 care
- Hearing aids

**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 1-800-642-6155. 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:**

Questions: Call 1-800-642-6155 or visit us at www.blueshieldca.com/sisc.

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Does this Coverage Provide Minimum Essential Coverage?

The Affordable Care Act requires most people to have health care coverage that qualifies as "minimum essential coverage." This plan or policy does provide minimum essential coverage.

Does this Coverage Meet the Minimum Value Standard?

The Affordable Care Act establishes a minimum value standard of benefits of a health plan. The minimum value standard is 60% (actuarial value). This health coverage does meet the minimum value standard for the benefits it provides.

Language Access Services:


Navajo (Dine): Dine'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:** $7,040  
**Patient pays:** $500

**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:** $0
- **Copays:** $300
- **Coinsurance:** $0
- **Limits or exclusions:** $200

**Total:** $500

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

**Amount owed to providers:** $5,400  
**Plan pays:** $4,600  
**Patient pays:** $800

**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:** $0
- **Copays:** $700
- **Coinsurance:** $0
- **Limits or exclusions:** $100

**Total:** $800

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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.
- Plan and patient payments are based on a single person enrolled on the plan or policy.

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.