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, call 1-833-702-1210. 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 or call Keenan Customer Service at 1-833-702-1210 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	$100 individual / $300 family. Applies to all services unless otherwise noted. Deductible applies on a calendar year.	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 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 services. Refer to plan document for more information.	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply.
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?	$100 individual / $400 family. Out of pocket applies on a calendar year.	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?	Premiums, balance-billing charges, health care this plan doesn't cover, and penalties for failure to obtain pre-authorization.	Even though you pay these expenses, they don't count toward the out-of-pocket limit.
Will you pay less if you use a non-network provider?	Yes. Visit www.blueshieldca.com/networkPPO to find a PPO provider.	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.

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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
		In 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	No Charge; after deductible	20% after deductible	Includes chiropractic & acupuncture. Teledoc Telemedicine is No Charge. Contact 1-800-835-2362 for information or refer to your ID card.
	Specialist visit	No Charge; after deductible	20% after deductible	
	Preventive care/screening/ immunization	No Charge (deductible waived)	Not Covered	See your plan document for additional benefits and limitations. You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what the plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	No Charge; after deductible	20% after deductible	None
	Imaging (CT/PET scans, MRIs)	No Charge; after deductible	20% after deductible	None
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.express-scripts.com	Generic drugs	Express Scripts Retail: $2 copay Mail Order: $4 copay		Prescription Individual Out-of-Pocket limit is $200. Prescription Family Out-of-Pocket limit is $400 (separate from Medical). Deductible does not apply to prescriptions. All specialty prescriptions require prior authorization review through the Keenan Pharmacy Care Management Program. Contact Accredo at 1-800-803-2523. Retail maximum supply is 34-days or 100 units (whichever is greater). Mail order is 90-days.
	Preferred brand drugs	Express Scripts Retail: $10 copay Mail Order: $20 copay		
	Non-preferred brand drugs	Express Scripts Retail: $10 copay Mail Order: $20 copay		
	Specialty drugs	Express Scripts Retail: $10 copay Mail Order: $20 copay		
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	No Charge; after deductible	No Charge; after deductible	None

* For more information about limitations and exceptions, see the plan or policy document by calling 1-833-702-1210 for information.

Common Medical Event	Services You May Need	What you will pay		Limitations, Exceptions, & Other Important Information
		In Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
	Physician/surgeon fees	No Charge; after deductible	No Charge; after deductible	None
If you need immediate medical attention	Emergency room care	No Charge; after deductible	No Charge; after deductible	None
	Emergency medical transportation	10% after deductible	10% after deductible	None
	Urgent care	No Charge; after deductible	20% after deductible	None
If you have a hospital stay	Facility fee (e.g., hospital room)	No Charge; after deductible	No Charge; after deductible	Preauthorization required. Failure to obtain authorization may result in denial of benefits.
	Physician/surgeon fees	No Charge; after deductible	No Charge; after deductible	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	No Charge; after deductible	20% after deductible	None
	Inpatient services	No Charge; after deductible	20% after deductible	Preauthorization required. Failure to obtain authorization may result in denial of benefits.
If you are pregnant	Office visits	No Charge; after deductible	20% after deductible	Cost sharing does not apply to certain preventive services. Depending on the type of services, coinsurance may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound).
	Childbirth/delivery professional services	No Charge; after deductible	No Charge; after deductible	
	Childbirth/delivery facility services	No Charge; after deductible	No Charge; after deductible	
If you need help recovering or have other special health needs	Home health care	20% after deductible	20% after deductible	Limited to 1 visit/day specialty.
	Rehabilitation services	No Charge; after deductible	20% after deductible	Includes physical, occupational, speech, and other rehabilitative therapies.
	Habilitation services	Not Covered	Not Covered	None
	Skilled nursing care	No Charge; after deductible	20% after deductible	Preauthorization required. Failure to obtain authorization may result in denial of benefits.
	Durable medical equipment	20% after deductible	20% after deductible	None
	Hospice services	20% after deductible	20% after deductible	None
If your child needs dental or eye care	Children's eye exam	Not Covered		None
	Children's glasses	Not Covered		None
	Children's dental check-up	Not Covered		None

* For more information about limitations and exceptions, see the plan or policy document by calling 1-833-702-1210 for information.

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)	• Long-term care • Non-emergency care when traveling outside the U.S.	• 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 • Hearing aids	• Infertility treatment • Private duty nursing

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 Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/heathreform. 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: Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.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.

The Plan and Plan Sponsor:

- ➲ Provide free aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters; and
  - Written information in other formats (large print, audio, accessible electronic formats, other formats).
- ➲ Provide free language services to people whose primary language is not English, such as:
  - Qualified interpreters; and
  - Information written in other languages.

* For more information about limitations and exceptions, see the plan or policy document by calling 1-833-702-1210 for information.

If you need these services, contact the Civil Rights Coordinator named in your Benefits Guide.

If you believe that the Plan or Plan Sponsor has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with the Civil Rights Coordinator named in your Benefits Guide. Contact information of the Civil Rights Coordinator can be found in the Benefits Guide.

You can file a grievance by mail or in person or fax or email. If you need help filing a grievance contact the Civil Rights Coordinator named in the Benefits Guide.

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, D.C. 20201 1-800-368-1019, 800-537-7697 (TDD). Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html

Language Access Services:

Spanish

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-833-702-1210

Chinese

注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-833-702-1210

Vietnamese

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-833-702-1210

Tagalog - Filipino

PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-833-702-1210

Korean

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 번으로 전화해 주십시오. 1-833-702-1210

Japanese

注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。まで、電話にてご連絡ください。1-833-702-1210

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To see examples of how this plan might cover costs for a sample medical situation, see the next section.

* For more information about limitations and exceptions, see the plan or policy document by calling 1-833-702-1210 for information.

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	$100
Specialist coinsurance	0%
Hospital (facility) coinsurance	0%
Other coinsurance	20%

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	$100
Copayments	$0
Coinsurance	$0
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$160**

Managing Joe's type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

The plan's overall deductible	$100
Specialist coinsurance	0%
Hospital (facility) coinsurance	0%
Other coinsurance	20%

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	$100
Copayments	$140
Coinsurance	$0
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$260**

Mia's Simple Fracture
(in-network emergency room visit and follow up care)

The plan's overall deductible	$100
Specialist coinsurance	0%
Hospital (facility) coinsurance	0%
Other coinsurance	20%

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	$100
Copayments	$0
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$100**

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