



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 or by calling 1-800-642-6155.
 For your Pharmacy benefits through Express-Scripts (Medco) go to www.express-scripts.com or call 1-877-554-3091.

| Important Questions | Answers | Why this Matters: |
|---|--|--|
| What is the overall <u>deductible</u> ? | \$0. | See the chart starting on page 3 for your costs for services this plan covers. |
| Are there other <u>deductibles</u> for specific services? | \$100 per individual / \$300 per family on brand drugs for Pharmacy Benefit Does not apply to preventive care. | You must pay all the costs up to the <u>deductible</u> amount before this plan begins to pay for any brand drugs on the pharmacy benefit. Check your policy to see when the <u>deductible</u> starts over (usually, but not always, January 1st). Refer to the pharmacy portion of this document for all co-pays after the pharmacy deductible has been met. |
| Is there an <u>out-of-pocket limit</u> on my expenses? | Medical: Yes. \$1,000 per individual / \$2,000 per family Prescription: Yes. \$5,600 per individual / \$11,200 per family | The <u>out-of-pocket limit</u> 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 <u>plan</u> for health care expenses. |
| What is not included in the <u>out-of-pocket limit</u> ? | Prescription Drug cost shares out-of-network, any member prescription penalties (if applicable), <u>Premiums</u> , <u>balance-billed</u> charges, some <u>copayments</u> , cost sharing for certain services listed in formal contract of coverage, and health care this plan doesn't cover. | Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u> . |
| Is there an overall annual limit on what the plan pays? | No. | The chart starting on page 3 describes any limits on what the <u>plan</u> will pay for specific covered services, such as office visits. |

Questions: Call 1-800-642-6155 or visit us at www.blueshieldca.com/csac.
 If you aren't clear about any of the underlined terms used in this form, see the Glossary.
 You can view the Glossary at www.dol.gov/ebsa/healthreform or call 1-866-444-3272 to request a copy.

Blue Shield of California is an independent member of the Blue Shield Association.

| Important Questions | Answers | Why this Matters: |
|--|---|---|
| <p>Does this plan use a <u>network of providers</u>?</p> | <p>Yes. See www.blueshieldca.com/csac or call 1-800-642-6155 for a list of plan providers.</p> | <p>If you use an <u>in-network</u> doctor or other health care <u>provider</u>, this <u>plan</u> will pay some or all of the costs of covered services. Be aware, your <u>in-network</u> doctor or hospital may use an <u>out-of-network provider</u> for some services. <u>Plans</u> use the term <u>in-network, preferred</u>, or participating for <u>providers</u> in their <u>network</u>. See the chart starting on page 3 for how this <u>plan</u> pays different kinds of <u>providers</u>.</p> |
| <p>Do I need a referral to see a <u>specialist</u>?</p> | <p>Yes. Members need written approval to see a specialist except for OB/GYN or pediatrician serving as Primary Care Physician. Members may self refer using the Access+ Self Referral feature or for OB/GYN services. Please see the formal contract of coverage for details.</p> | <p>You can see the <u>specialist</u> you choose without permission from this <u>plan</u>.</p> |
| <p>Are there services this <u>plan</u> doesn't cover?</p> | <p>Yes.</p> | <p>Some of the services this <u>plan</u> doesn't cover are listed on page 13. See your policy or <u>plan</u> document for additional information about <u>excluded services</u>.</p> |

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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 a Preferred Provider | Your Cost If You Use a 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 | \$15 copayment / visit | Not Covered | For other services received during the office visit, additional member cost-share may apply. |
| | Specialist visit | \$15 copayment / visit | Not Covered | For other services received during the office visit, additional member cost-share may apply. \$30 copayment per visit for Access+ Specialist Self Referral. |
| | Other practitioner office visit | Not Covered | Not Covered | -----None----- |
| | Preventive care/screening /immunization | No Charge | Not Covered | Preventive health services are only covered when provided by plan providers. Coverage for services consistent with ACA requirements and California laws. Please refer to your plan contract for details. |

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|----------------------|-------------------------------------|--|--|--|
| If you have a test | Diagnostic test (x-ray, blood work) | <u>Lab & Path at Free Standing Location:</u> No Charge <u>X-Ray & Imaging at Free Standing Radiology Center:</u> No Charge <u>Other Diagnostic Examination at Free Standing Location:</u> No Charge <u>X-Ray, Lab & Other Examination at Outpatient Hospital:</u> No Charge | Not Covered | Benefits in this section are for diagnostic, non-preventive health services. Pre-authorization from primary care physician and medical plan is required. Failure to obtain pre-authorization may result in non-payment of benefits. |
| | Imaging (CT/PET scans, MRIs) | <u>Radiological & Nuclear Imaging at Free Standing Radiology Center:</u> No Charge <u>Radiological & Nuclear Imaging at Outpatient Hospital:</u> No Charge | Not Covered | Benefits in this section are for diagnostic, non-preventive health services. Pre-authorization from primary care physician and medical plan is required. Failure to obtain pre-authorization may result in non-payment of benefits. |

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|--|----------------------------------|--|---|--|
| <p>If you need drugs to treat your illness or condition</p> <p>More information about <u>prescription drug coverage</u> is available at www.express-scripts.com.</p> | <p>Generic drugs</p> | <p>\$10 copay/ prescription (retail)</p> <p>\$20 copay/ prescription (mail order)</p> | <p>\$10 copay/prescription (retail)</p> <p>Not covered for mail order scripts</p> | <p>Covers up to a 30-day supply (retail prescription); up to a 90-day supply (mail order prescription).</p> <p>For brand drugs that have a generic equivalent available: Member may pay the generic co-pay plus the difference in cost between the brand and generic drugs.</p> |
| | <p>Preferred brand drugs</p> | <p>\$30 copay/ prescription (retail)</p> <p>\$60 copay/ prescription (mail order)</p> | <p>\$30 copay/prescription (retail)</p> <p>Not covered for mail order scripts</p> | <p>For prepackaged drugs that have more than a 30 day supply, members will be charged up to 3 copays at a retail pharmacy per fill.</p> |
| | <p>Non-preferred brand drugs</p> | <p>\$50 copay/ prescription (retail)</p> <p>\$100 copay/ prescription (mail order)</p> | <p>\$50 copay/prescription (retail)</p> <p>Not covered for mail order scripts</p> | <p>Prior Authorization / Coverage Management programs may apply to some drugs.</p> <p>Out of Pocket Maximum (OOPM): Member penalties including generic equivalent and retail refill allowance do not apply to the OOPM.</p> |

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|--|--|---|---|--|
| | Specialty drugs | 20% | Not covered | <p>This category is covered under the appropriate drug tier and all limitations and exceptions apply.</p> <p>Most specialty drugs must be obtained through Accredo Specialty Pharmacy.</p> <p>Specialty meds have a co-pay maximum of \$100 per script filled at retail and a \$100 per script filled at mail order.</p> <p>Out of Pocket Maximum (OOPM): Member penalties including generic equivalent and retail refill allowance do not apply to the OOPM.</p> |
| If you have outpatient surgery | Facility fee (e.g., ambulatory surgery center) | No Charge | Not Covered | -----None----- |
| | Physician/surgeon fees | No Charge | Not Covered | -----None----- |
| If you need immediate medical attention | Emergency room services | \$200 copayment / visit | \$200 copayment / visit | <p>Copayment waived if admitted; standard inpatient hospital facility benefits apply.</p> <p>This is for the hospital/facility charge only. The ER physician charge is separate.</p> <p>Coverage outside of California under BlueCard.</p> |

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|------------------------------------|------------------------------------|---|--|--|
| | Emergency medical transportation | No Charge | No Charge | -----None----- |
| | <u>Urgent care</u> | <u>Within Plan service area:</u> \$15 copayment / visit <u>Outside Plan service area:</u> \$15 copayment / visit | <u>Within Plan service area:</u> Not Covered <u>Outside Plan service area:</u> \$15 copayment / visit | Pre-authorization from primary care physician and medical plan is required. Failure to obtain pre-authorization may result in non-payment of benefits. |
| If you have a hospital stay | Facility fee (e.g., hospital room) | \$100 copayment / admission | Not Covered | Pre-authorization from primary care physician and medical plan is required. Failure to obtain pre-authorization may result in non-payment of benefits. |
| | Physician/surgeon fee | No Charge | Not Covered | -----None----- |

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|--|---|---|--|--|
| <p>If you have mental health, behavioral health, or substance abuse needs</p> | <p>Mental/Behavioral health outpatient services</p> | <p><u>Mental Health Routine Outpatient Services:</u> \$15 copayment / visit</p> <p><u>Mental Health Non-Routine Outpatient Services:</u> \$15 copayment / visit</p> | <p>Not Covered</p> | <p><u>Mental Health Routine Outpatient Services:</u> Services include professional/physician office visits.</p> <p><u>Mental Health Non-Routine Outpatient Services:</u> Services include behavioral health treatment, electroconvulsive therapy, intensive outpatient programs, partial hospitalization programs, and transcranial magnetic stimulation. Higher copayment and facility charges per episode of care may apply for partial hospitalization programs.</p> <p>Pre-authorization from Mental Health Service Administrator (MHSA) is required for non-routine outpatient mental health services. Failure to obtain pre-authorization may result in non-payment of benefits.</p> |

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|----------------------|---|--|--|---|
| | Mental/Behavioral health inpatient services | <u>Mental Health Inpatient Hospital Services:</u> \$100 copayment / admission <u>Mental Health Residential Services:</u> \$100 copayment / admission <u>Mental Health Inpatient Physician Services:</u> No Charge | Not Covered | Pre-authorization from Mental Health Service Administrator (MHSA) is required. Failure to obtain pre-authorization may result in non-payment of benefits. |

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|----------------------|--|---|--|---|
| | Substance use disorder outpatient services | <p><u>Substance Abuse Routine Outpatient Services:</u> \$15 copayment / visit</p> <p><u>Substance Abuse Non-Routine Outpatient Services:</u> \$15 copayment / visit</p> | Not Covered | <p><u>Substance Abuse Routine Outpatient Services:</u> Services include professional/physician office visits.</p> <p><u>Substance Abuse Non-Routine Outpatient Services:</u> Services include partial hospitalization program, intensive outpatient program, and office-based opioid treatment. Higher copayment and facility charges per episode of care may apply for partial hospitalization programs. Pre-authorization from Mental Health Service Administrator (MHSA) is required for non-routine outpatient substance abuse services. Failure to obtain pre-authorization may result in non-payment of benefits.</p> |

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|----------------------|---|--|---|---|
| | Substance use disorder inpatient services | <u>Substance Abuse Inpatient Hospital Services:</u> \$100 copayment / admission <u>Substance Abuse Residential Services:</u> \$100 copayment / admission <u>Substance Abuse Inpatient Physician Services:</u> No Charge | Not Covered | Pre-authorization from Mental Health Service Administrator (MHSA) is required. Failure to obtain pre-authorization may result in non-payment of benefits. |
| If you are pregnant | Prenatal and postnatal care | <u>Prenatal:</u> No Charge <u>Postnatal:</u> No Charge | Not Covered | <u>Prenatal:</u> \$15 copayment for initial visit only. |
| | Delivery and all inpatient services | \$100 copayment / admission | Not Covered | -----None----- |

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|--|----------------------------------|---|---|---|
| If you need help recovering or have other special health needs | <u>Home health care</u> | No Charge | Not Covered | Coverage limited to 100 visits per member per calendar year. Pre-authorization from primary care physician and medical plan is required. Failure to obtain pre-authorization may result in non-payment of benefits. |
| | <u>Rehabilitation services</u> | Office visit: \$15 copayment / visit Outpatient hospital: \$15 copayment / visit | Not Covered | Coverage for physical, occupational and respiratory therapy services. |
| | <u>Habilitation services</u> | Office visit: \$15 copayment / visit Outpatient hospital: \$15 copayment / visit | Not Covered | |
| | <u>Skilled nursing care</u> | No Charge | Not Covered | Coverage limited to 100 days per member per calendar year combined with hospital/free-standing skilled nursing facility. Pre-authorization from primary care physician and medical plan is required. Failure to obtain preauthorization may result in nonpayment of benefits. |
| | <u>Durable medical equipment</u> | No Charge | Not Covered | Pre-authorization from primary care physician and medical plan is required. Failure to obtain pre-authorization may result in non-payment of benefits. |

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|--|------------------------|---|---|--|
| | <u>Hospice service</u> | No Charge | Not Covered | Pre-authorization from primary care physician and medical plan is required. Failure to obtain pre-authorization may result in non-payment of benefits. |
| If your child needs dental or eye care | Eye exam | Not Covered | Not Covered | -----None----- |
| | Glasses | Not Covered | Not Covered | -----None----- |
| | Dental check-up | Not Covered | Not Covered | -----None----- |

Excluded Services & Other Covered Services:

| Services Your <u>Plan</u> Does NOT Cover (This isn't a complete list. Check your policy or <u>plan</u> document for other <u>excluded services</u> .) | | |
|--|--|---|
| <ul style="list-style-type: none"> Acupuncture Chiropractic Care Cosmetic surgery Dental care (Adult/Child) | <ul style="list-style-type: none"> Long-term care Non-emergency care when traveling outside the U.S. Private-duty nursing (unless enrolled in a participating hospice program) | <ul style="list-style-type: none"> Routine eye care (Adult) Routine foot care (unless for treatment of diabetes) Weight loss programs |
| Pharmacy Benefit Exclusions | | |
| <ul style="list-style-type: none"> Allergy Serums Biologicals Blood or blood plasma products ACA Preventive Meds Aspirin (OTC)- Exception: Covered from age 45 through age 79 ACA Preventive Meds Folic Acid (OTC)- Exception: Covered for Females through age 50 | <ul style="list-style-type: none"> ACA Preventive Meds Iron (OTC)- Exception: Covered through 12 months of age ACA Preventive Meds Smoking Cessation- excluded under age 18 ACA Preventive Meds Fluoride- excluded for age 6 and older Drugs labeled "Caution-limited by Federal law to investigational use" or experimental drugs, even though a charge is made to the individual | <ul style="list-style-type: none"> Drugs used for cosmetic purposes Drugs used to promote or stimulate hair growth Insulin Pumps Non-Federal Legend Drugs Nutritional Supplements Ostomy Supplies Some or certain compounds are excluded |

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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.)

- Bariatric surgery (Pre-authorization from primary care physician and medical plan is required. Failure to obtain pre-authorization may result in non-payment of benefits.)
- Hearing aids (\$1,000 maximum allowance per member every 12 months.)
- Infertility treatment (coverage for diagnosis and treatment of cause of infertility only.)

Other Pharmacy Benefit Inclusions

- ACA Preventive Meds Aspirin (OTC)- covered from age 45 through age 79
- ACA Preventive Meds Folic Acid (OTC)- Covered for Females through age 50
- ACA Preventive Meds Iron (OTC)- Covered through 12 months of age
- ACA Preventive Meds Smoking Cessation- Covered from age 18
- ACA Preventive Meds Fluoride- Covered through age 5
- Federal Legend Drugs
- Insulin
- Needles and Syringes
- OTC Diabetic Supplies (except Insulin Pumps and Glucowatch products)
- Specialty Drugs
- State Restricted Drugs
- Vaccines
- Drugs to treat Impotency for males only age 18 and over
- Women have access at no cost to FDA-approved contraceptives, such as barrier methods (diaphragms), hormonal (oral contraceptives), emergency contraceptives and implanted devices (IUDs).

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.

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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: 1-800-642-6155 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 1-888-466-2219 or visit <http://www.healthhelp.ca.gov>.

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:

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, kwijigo holne' 1-866-346-7198.

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

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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** \$7,380
- **Patient pays** \$160

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:

| | |
|----------------------|--------------|
| <u>Deductibles</u> | \$0 |
| <u>Copays</u> | \$10 |
| <u>Coinsurance</u> | \$0 |
| Limits or exclusions | \$150 |
| Total | \$160 |

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

- **Amount owed to providers:** \$5,400
- **Plan pays** \$4,790
- **Patient pays** \$610

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:

| | |
|----------------------|--------------|
| <u>Deductibles</u> | \$0 |
| <u>Copays</u> | \$530 |
| <u>Coinsurance</u> | \$0 |
| Limits or exclusions | \$80 |
| Total | \$610 |

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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.

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

If you aren't clear about any of the underlined terms used in this form, see the Glossary.

You can view the Glossary at www.dol.gov/ebsa/healthreform or call 1-866-444-3272 to request a copy.