blue of california | COVERED CALIFORNIA

Platinum 90 PPO – Network Name: Exclusive

Coverage Period: Beginning on or after 1/1/2016

Summary of Benefits and Coverage: What this Plan Covers & What it Costs

Coverage for: Individual + Family | **Plan Type:** PPO

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 **1-855-836-9705**.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	**$0.**	See the chart starting on page 2 for your costs for services this plan covers.
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. For participating providers: **$4,000** per individual / **$8,000** per family. For non-participating providers: **$7,000** per individual / **$14,000** per family. Pediatric dental benefit out-of-pocket limit accumulates to the overall out-of-pocket limit.	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, charges in excess of specified benefit maximums, 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. See **www.blueshieldca.com or call 1-855-836-9705** for a list of participating providers.	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**.

Questions: Call **1-855-836-9705** or visit us at **www.blueshieldca.com**.
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.

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Important Questions	Answers	Why this Matters:
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 11. See your policy or plan document for additional information about **excluded services**.

- **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 a non-participating **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if a non-participating 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 participating **providers** by charging you lower **deductibles**, **copayments** and **coinsurance** amounts.

Common Medical Event	Services You May Need	Your Cost If You Use a Participating Provider	Your Cost If You Use a Non-Participating Provider	Limitations & Exceptions
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$20 copayment / visit	50% coinsurance	For other services received during the office visit, additional member cost-share may apply.
	Specialist visit	$40 copayment / visit	50% coinsurance	For other services received during the office visit, additional member cost-share may apply.
	Other practitioner office visit	Acupuncture: $20 copayment / visit	Acupuncture: 50% coinsurance	----------None----------
	Preventive care/screening /immunization	No Charge	Not Covered	Preventive health services are only covered when provided by participating providers. Coverage for services consistent with ACA requirements and California laws. Please refer to your plan contract for details.

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Common Medical Event	Services You May Need	Your Cost If You Use a Participating Provider	Your Cost If You Use a Non-Participating Provider	Limitations & Exceptions
If you have a test	Diagnostic test (x-ray, blood work)	Lab & Path at Free Standing Location: $20 copayment / visit X-Ray & Imaging at Free Standing Radiology Center: $40 copayment / visit Other Diagnostic Examination at Free Standing Location: 10% coinsurance Other Diagnostic Examination at Outpatient Hospital: 10% coinsurance	Lab & Path at Free Standing Location: 50% coinsurance X-Ray & Imaging at Free Standing Radiology Center: 50% coinsurance Other Diagnostic Examination at Free Standing Location: 50% coinsurance Other Diagnostic Examination at Outpatient Hospital: 50% coinsurance of up to $500 / day	Benefits in this section are for diagnostic, non-preventive health services. Other Diagnostic Examination at Outpatient Hospital: The maximum allowed amount for non-participating providers is $500 per day. Members are responsible for 50% of this $500 per day, plus all charges in excess of $500.
	Imaging (CT/PET scans, MRIs)	Radiological & Nuclear Imaging at Free Standing Radiology Center: 10% coinsurance Radiological & Nuclear Imaging (CT, MRI, MRA, and PET scans, etc.) – Outpatient Hospital: 10% coinsurance	Radiological & Nuclear Imaging at Free Standing Radiology Center: 50% coinsurance Radiological & Nuclear Imaging (CT, MRI, MRA, and PET scans, etc.) – Outpatient Hospital: 50% coinsurance of up to $500 / day	Benefits are for diagnostic, non-preventive health services. Radiological & Nuclear Imaging (CT, MRI, MRA, and PET scans, etc.) – Outpatient Hospital: The maximum allowed amount for non-participating providers is $500 per day. Members are responsible for 50% of this $500 per day, plus all charges in excess of $500. Pre-authorization is required.

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Common Medical Event	Services You May Need	Your Cost If You Use a Participating Provider	Your Cost If You Use a Non-Participating Provider	Limitations & Exceptions
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.blueshieldca.com/bsca/pharmacy	Tier 1 Drugs	Retail Pharmacies: $5 copayment / prescription Mail Service Pharmacies: $15 copayment/ prescription	Not Covered	Retail Pharmacies: Covers up to a 30-day supply; Mail Service Pharmacies: Covers up to 90-day supply. Select formulary and non-formulary drugs require pre-authorization. Failure to obtain prior authorization may result in non-payment of benefits.
	Tier 2 Drugs	Retail Pharmacies: $15 copayment / prescription Mail Service Pharmacies: $45 copayment / prescription	Not Covered	
	Tier 3 Drugs	Retail Pharmacies: $25 copayment / prescription Mail Service Pharmacies: $75 copayment / prescription	Not Covered	
	Tier 4 Drugs (excluding Specialty Drugs)	Retail Pharmacies:10% coinsurance up to $250 / prescription Mail Service Pharmacies: 10% coinsurance up to $750 / prescription	Not Covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	10% coinsurance	50% coinsurance of up to $300 / day	The maximum allowed amount for non-participating providers is $300 per day. Members are responsible for 50% of this $300 per day, plus all charges in excess of $300.
	Physician/surgeon fees	10% coinsurance	50% coinsurance	----------None----------

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Common Medical Event	Services You May Need	Your Cost If You Use a Participating Provider	Your Cost If You Use a Non-Participating Provider	Limitations & Exceptions
If you need immediate medical attention	Emergency room services	ER Facility Fee: $150 copayment / visit ER Physician Fee: 10% coinsurance	ER Facility Fee: $150 copayment / visit ER Physician Fee: 10% coinsurance	Copayment waived if admitted; standard inpatient hospital facility benefits apply. This is for the hospital/facility charge only. The ER physician fee is separate.
	Emergency medical transportation	$150 copayment / transport	$150 copayment / transport	----------None----------
	Urgent care	$40 copayment / visit at freestanding urgent care center	50% coinsurance at freestanding urgent care center	----------None----------
If you have a hospital stay	Facility fee (e.g., hospital room)	10% coinsurance	50% coinsurance of up to $2,000 / day	The maximum allowed amount for non-participating providers is $2,000 per day. Members are responsible for 50% of this $2,000 per day, plus all charges in excess of $2,000. Pre-authorization is required for all services. Failure to obtain pre-authorization for special transplant services may result in non-payment of benefits.
	Physician/surgeon fee	10% coinsurance	50% coinsurance	----------None----------

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Common Medical Event	Services You May Need	Your Cost If You Use a Participating Provider	Your Cost If You Use a Non-Participating Provider	Limitations & Exceptions
If you have mental health, behavioral health, or substance use disorder needs	Mental/Behavioral health outpatient services	Mental Health Routine Outpatient Office Visits: $20 copayment / visit Mental Health Non-Routine Outpatient Services 10% coinsurance	Mental Health Routine Outpatient Office Visits: 50% coinsurance Mental Health Non-Routine Outpatient Services: 50% coinsurance	Mental Health Routine Outpatient Office Visits: Services include professional/physician office visits. Mental Health Non-Routine Outpatient Services: Services include behavioral health treatment, electroconvulsive therapy, intensive outpatient programs, post-discharge ancillary care services, partial hospitalization programs, and transcranial magnetic stimulation. 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 mental health services.
	Mental/Behavioral health inpatient services	Mental Health Inpatient Hospital Facility Fee: 10% coinsurance Mental Health Residential Facility Fee: 10% coinsurance Mental Health Inpatient Physician Fee: 10% coinsurance	Mental Health Inpatient Hospital Facility Fee: 50% coinsurance of up to $2,000 / day Mental Health Residential Facility Fee: 50% coinsurance of up to $2,000 / day Mental Health Inpatient Physician Fee: 50% coinsurance	The maximum allowed amount for non-participating providers is $2,000 per day. Members are responsible for 50% of this $2,000 per day, plus all charges in excess of $2,000. Pre-authorization from Mental Health Service Administrator (MHSA) is required.

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Common Medical Event	Services You May Need	Your Cost If You Use a Participating Provider	Your Cost If You Use a Non-Participating Provider	Limitations & Exceptions
	Substance use disorder outpatient services	Substance Use Disorder Routine Outpatient Office Visits: $20 copayment / visit Substance Use Disorder Non-Routine Outpatient Services: 10% coinsurance	Substance Use Disorder Routine Outpatient Office Visits: 50% coinsurance Substance Use Disorder Non-Routine Outpatient Services: 50% coinsurance	Substance Use Disorder Routine Outpatient Office Visits: Services include professional/physician office visits. Substance Use Disorder Non-Routine Outpatient Services: Services include partial hospitalization program, intensive outpatient program, post-discharge ancillary care service, 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 substance use disorder services.
	Substance use disorder inpatient services	Substance Use Disorder Inpatient Hospital Facility Fees: 10% coinsurance Substance Use Disorder Residential Facility Fee: 10% coinsurance Substance Use Disorder Inpatient Physician Fee: 10% coinsurance	Substance Use Disorder Inpatient Hospital Facility Fee: 50% coinsurance of up to $2,000 / day Substance Use Disorder Residential Facility Fee: 50% coinsurance of up to $2,000 / day Substance Use Disorder Inpatient Physician Fee: 50% coinsurance	The maximum allowed amount for non-participating providers is $2,000 per day. Members are responsible for 50% of this $2,000 per day, plus all charges in excess of $2,000. Pre-authorization from Mental Health Service Administrator (MHSA) is required.

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Common Medical Event	Services You May Need	Your Cost If You Use a Participating Provider	Your Cost If You Use a Non-Participating Provider	Limitations & Exceptions
If you are pregnant	Prenatal and postnatal care	Prenatal: No Charge Postnatal: $20 copayment / visit	Prenatal: 50% coinsurance Postnatal: 50% coinsurance	----------None----------
	Delivery and all inpatient services	10% coinsurance	50% coinsurance of up to $2,000 / day	The maximum allowed amount for non-participating providers is $2,000 per day. Members are responsible for 50% of this $2,000 per day, plus all charges in excess of $2,000.

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Common Medical Event	Services You May Need	Your Cost If You Use a Participating Provider	Your Cost If You Use a Non-Participating Provider	Limitations & Exceptions
If you need help recovering or have other special health needs	Home health care	10% coinsurance	Not Covered	Coverage limited to 100 visits per member per calendar year. Non-participating home health care and home infusion are not covered unless pre-authorized. When these services are pre-authorized, you pay the participating provider copayment. Pre-authorization is required.
	Rehabilitation services	Office visit: $20 copayment / visit Outpatient hospital: $20 copayment / visit	Office visit: 50% coinsurance Outpatient hospital: 50% coinsurance of up to $500 / day	Coverage for physical, occupational and respiratory therapy services. Outpatient hospital: The maximum allowed amount for non-participating providers is $500 per day. Members are responsible for 50% of this $500 per day, plus all charges in excess of $500.
	Habilitation services	Office visit: $20 copayment / visit Outpatient hospital: $20 copayment / visit	Office visit: 50% coinsurance Outpatient hospital: 50% coinsurance of up to $500 / day	
	Skilled nursing care	10% coinsurance at freestanding skilled nursing facility	10% coinsurance at freestanding skilled nursing facility	Coverage limited to 100 days per member per benefit period combined with Hospital Skilled Nursing Facility Unit. Pre-authorization is required.
	Durable medical equipment	10% coinsurance	50% coinsurance	Pre-authorization is required.
	Hospice service	No Charge	Not Covered	All Hospice Program Benefits must be pre-authorized by the Plan. (With the exception of Pre-hospice consultation.) Failure to obtain pre-authorization may result in reduction or non-payment of benefits.

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Common Medical Event	Services You May Need	Your Cost If You Use a Participating Provider	Your Cost If You Use a Non-Participating Provider	Limitations & Exceptions
If your child needs dental or eye care	Eye exam	No Charge	Coverage up to a maximum allowance of $30.	Coverage limited to one comprehensive eye exam per calendar year. Services provided by Blue Shield's Vision Plan Administrator (VPA).
	Glasses	No Charge	Coverage up to a maximum allowance of: $25 for single vision $35 for lined bifocal $45 for lined trifocal $45 for lenticular	Coverage limited to one pair of eyeglasses (frames and lenses) or one pair of contact lenses per calendar year. Services provided by Blue Shield's Vision Plan Administrator (VPA).
	Dental check-up	No Charge	20% coinsurance	Pediatric dental benefits are available for members through the end of the month in which the member turns 19. Coverage for prophylaxis services (cleaning) limited to two services per twelve month period. Please refer to your plan contract for details.

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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.)		
• Chiropractic care	• Infertility treatment	• Routine eye care (Adult)
• Cosmetic surgery	• Long-term care	• Routine foot care (unless for treatment of diabetes.)
• Dental care (Adult)	• Non-emergency care when traveling outside the U.S.	• Weight loss programs
• Hearing aids	• Private-duty nursing	

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 (pre-authorization is required. Failure to obtain pre-authorization may result in non-payment of benefits.)	• Dental care (Child) (coverage limited to two cleaning services per 12 month period.)
• Routine eye care (Child) (coverage limited to one comprehensive eye exam per calendar year.)	• Services related to Abortion: Coverage for Abortion services is provided in accordance with the requirements of state law	

Your Rights to Continue Coverage:

Federal and State laws may provide protections that allow you to keep this health insurance coverage as long as you pay your **premium**. There are exceptions, however, such as if:

- You commit fraud
- The insurer stops offering services in the State
- You move outside the coverage area

For more information on your rights to continue coverage, contact the insurer at **1-855-836-9705**. You may also contact your state insurance department at 1-888-466-2219.

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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: **1-855-836-9705** 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, 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.

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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** $6,590
- **Patient pays** $950

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	$350
Coinsurance	$450
Limits or exclusions	$150
Total	**$950**

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

- **Amount owed to providers:** $5,400
- **Plan pays** $4,650
- **Patient pays** $750

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	$540
Coinsurance	$130
Limits or exclusions	$80
Total	**$750**

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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 **1-855-836-9705** or visit us at **www.blueshieldca.com**.
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