**Summary of Benefits and Coverage:** What this Plan Covers & What You Pay For Covered Services

blue of california

**Coverage Period: Beginning On or After 1/1/2025**

**Gold Tandem PPO 500/30 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/M0037535_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?** | **$500** per individual / **$1,000** per family for participating providers; **$1,000** per individual / **$2,000** 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 -- **$150** per individual / **$300** 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?** | **$7,900** per individual / **$15,800** per family for participating providers; **$15,800** per individual / **$31,600** 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, 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?** | 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/fad 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. |

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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 |
|---|---|---|---|---|
| | | 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 | $30/visit; deductible does not apply | 40% coinsurance | ----------None---------- |
| | Specialist visit | $60/visit; deductible does not apply | 40% coinsurance | |
| | Preventive care/screening /immunization | No Charge; 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*: $30/visit; deductible does not apply<br>*X-Ray & Imaging*: $50/visit; deductible does not apply<br>*Other Diagnostic Examination*: $50/visit; deductible does not apply | *Lab & Path*: 40% coinsurance<br>*X-Ray & Imaging*: 40% coinsurance<br>*Other Diagnostic Examination*: 40% coinsurance | The services listed are at a freestanding location. |
| | Imaging (CT/PET scans, MRIs) | *Outpatient Radiology Center*: 20% coinsurance<br>*Outpatient Hospital*: $100/visit + 20% coinsurance | *Outpatient Radiology Center*: 40% coinsurance<br>*Outpatient Hospital*: 40% coinsurance subject to a benefit maximum of $350/day | Preauthorization is required. Failure to obtain preauthorization may result in non-payment of benefits. |
| **If you need drugs to treat your illness or condition**<br>More information about **prescription drug coverage** is available at blueshieldca.com/formulary | Tier 1 | *Retail*:<br>Level A: $15/prescription; deductible does not apply<br>Level B: $20/prescription; deductible does not apply<br>*Mail Service*: $30/prescription; deductible does not apply | *Retail*: Not Covered<br>*Mail Service*: Not Covered | Preauthorization is required for select drugs. Failure to obtain preauthorization may result in non-payment of benefits.<br>*Retail*: Covers up to a 30-day supply; 90-days may be covered with a copayment for each 30-day supply;<br>*Mail Service*: Covers up to a 90-day supply. |
| | Tier 2 | *Retail*:<br>Level A: $50/prescription<br>Level B: $70/prescription<br>*Mail Service*: $100/prescription | *Retail*: Not Covered<br>*Mail Service*: Not Covered | |

*** For more information about limitations and exceptions, see the plan or policy document at bsca.com/policies/M0037535_EOC.pdf.**

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| 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) | |
| | Tier 3 | *Retail*: Level A: $80/prescription Level B: $110/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*: 20% coinsurance *Outpatient Hospital*: $150/surgery + 20% coinsurance | *Ambulatory Surgery Center*: 40% coinsurance subject to a benefit maximum of $350/day *Outpatient Hospital*: 40% coinsurance subject to a benefit maximum of $350/day | ----------None---------- |
| | Physician/surgeon fees | 20% coinsurance | 40% coinsurance | |
| **If you need immediate medical attention** | Emergency room care | *Facility Fee*: $250/visit + 20% coinsurance *Physician Fee*: 20% coinsurance | *Facility Fee*: $250/visit + 20% coinsurance *Physician Fee*: 20% coinsurance | ----------None---------- |
| | Emergency medical transportation | 20% coinsurance | 20% coinsurance | This payment is for emergency or authorized transport. |
| | Urgent care | $30/visit; deductible does not apply | 40% coinsurance | ----------None---------- |
| **If you have a hospital stay** | Facility fee (e.g., hospital room) | 20% coinsurance | 40% coinsurance subject to a benefit maximum of $2,000/day | Preauthorization is required. Failure to obtain preauthorization may result in non-payment of benefits. |

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| 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) | |
| | Physician/surgeon fees | 20% coinsurance | 40% coinsurance | ----------None---------- |
| **If you need mental health, behavioral health, or substance abuse services** | Outpatient services | *Office Visit*: $30/visit; deductible does not apply<br>*Other Outpatient Services*: 20% coinsurance<br>*Partial Hospitalization*: 20% coinsurance<br>*Psychological Testing*: 20% coinsurance | *Office Visit*: 40% coinsurance<br>*Other Outpatient Services*: 40% coinsurance<br>*Partial Hospitalization*: 40% coinsurance subject to a benefit maximum of $350/day<br>*Psychological Testing*: 40% coinsurance | Preauthorization is required except for office visits and office-based opioid treatment. Failure to obtain preauthorization may result in non-payment of benefits. |
| | Inpatient services | *Physician Inpatient Services*: 20% coinsurance<br>*Hospital Services*: 20% coinsurance<br>*Residential Care*: 20% coinsurance | *Physician Inpatient Services:* 40% coinsurance<br>*Hospital Services:* 40% coinsurance subject to a benefit maximum of $2,000/day<br>*Residential Care:* 40% coinsurance subject to a benefit maximum of $2,000/day | Preauthorization is required. Failure to obtain preauthorization may result in non-payment of benefits. |
| **If you are pregnant** | Office visits | No Charge; deductible does not apply | 40% coinsurance | ----------None---------- |
| | Childbirth/delivery professional services | 20% coinsurance | 40% coinsurance | |
| | Childbirth/delivery facility services | 20% coinsurance | 40% coinsurance subject to a benefit maximum of $2,000/day | |
| **If you need help recovering or have other special health needs** | Home health care | 20% 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. |

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| 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) | |
| | Rehabilitation services | *Office Visit*: 20% coinsurance<br>*Outpatient Hospital*: 20% coinsurance | *Office Visit*: 40% coinsurance<br>*Outpatient Hospital*: 40% coinsurance subject to a benefit maximum of $350/day | ----------None---------- |
| | Habilitation services | *Office Visit*: 20% coinsurance<br>*Outpatient Hospital*: 20% coinsurance | *Office Visit*: 40% coinsurance<br>*Outpatient Hospital*: 40% coinsurance subject to a benefit maximum of $350/day | |
| | Skilled nursing care | *Freestanding SNF*: 20% coinsurance<br>*Hospital-based SNF*: 20% coinsurance | *Freestanding SNF*: 40% coinsurance<br>*Hospital-based SNF*: 40% coinsurance subject to a benefit maximum of $2,000/day | 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; deductible does not apply | Preauthorization is required. Failure to obtain preauthorization may result in non-payment of benefits. |
| | 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; deductible does not apply | All charges above $30; deductible does not apply | Coverage limited to one exam per member per Calendar Year. |
| | Children's glasses | No Charge; deductible does not apply | All charges above $25; 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; deductible does not apply | 20% coinsurance; deductible does not apply | Coverage for prophylaxis services (cleaning) is limited to once in a six month period. |

*** For more information about limitations and exceptions, see the plan or policy document at bsca.com/policies/M0037535_EOC.pdf.**

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## 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**

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.

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## 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, kwiji' hodíílnih 1-866-346-7198.

Vietnamese (Tiếng Việt): Để được 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): Հայերեն լեզվով անվճար օգնություն ստանալու համար խնդրում ենք զանգահարել 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 (ਪੰਜਾਬੀ): ਪੰਜਾਬੀ ਵਿਚ ਸਹਾਇਤਾ ਲਈ ਕਿਰਪਾ ਕਰਕੇ 1-866-346-7198 'ਤੇ ਕਾੱਲ ਕਰੋ।

Khmer (ភាសាខ្មែរ)៖ សូមជំនួយភាសាអង់គ្លេសដោយឥតគិតថ្លៃ សូមទាក់ទងមកលេខ 1-866-346-7198។

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): हिन्दी में बिना खर्च के सहायता के लिए, 1-866-346-7198 पर कॉल करें।

Thai (ไทย): สำหรับความช่วยเหลือเป็นภาษาไทยโดยไม่มีค่าใช้จ่ายโปรดโทร 1-866-346-7198

Laotian (ພາສາລາວ): ສໍາລັບການຊ່ວຍເຫຼືອເປັນພາສາລາວແບບບໍ່ເສຍຄ່າ, ກະລຸນາໂທ1-866-346-7198.

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

**PRA Disclosure Statement**

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is **0938-1146**. The time required to complete this information collection is estimated to average **0.08** hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

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## 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 | $500 |
| Specialist copayment | $60 |
| Hospital (facility) coinsurance | 20% |
| Other copayment | $30 |

**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 | $500 |
| Copayments | $500 |
| Coinsurance | $2,100 |
| *What isn't covered* | |
| Limits or exclusions | $60 |
| **The total Peg would pay is** | **$3,200** |

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

| | |
|---|---|
| The plan's overall deductible | $500 |
| Specialist copayment | $60 |
| Hospital (facility) coinsurance | 20% |
| Other copayment | $30 |

**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 | $650 |
| Copayments | $1,300 |
| Coinsurance | $100 |
| *What isn't covered* | |
| Limits or exclusions | $20 |
| **The total Joe would pay is** | **$2,100** |

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

| | |
|---|---|
| The plan's overall deductible | $500 |
| Specialist copayment | $60 |
| Hospital (facility) coinsurance | 20% |
| Other copayment | $50 |

**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 | $500 |
| Copayments | $100 |
| Coinsurance | $400 |
| *What isn't covered* | |
| Limits or exclusions | $0 |
| **The total Mia would pay is** | **$1,000** |

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

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# NOTICES AVAILABLE ONLINE

## Nondiscrimination and Language Assistance Services

Blue Shield complies with applicable state and federal civil rights laws. We also offer language assistance services at no additional cost.

View our nondiscrimination notice and language assistance notice: **blueshieldca.com/notices**. You can also call for language assistance services: **(866) 346-7198 (TTY: 711)**.

If you are unable to access the website above and would like to receive a copy of the nondiscrimination notice and language assistance notice, please call Customer Care at **(888) 256-3650 (TTY: 711)**.

## Servicios de asistencia en idiomas y avisos de no discriminación

Blue Shield cumple con las leyes de derechos civiles federales y estatales aplicables. También, ofrecemos servicios de asistencia en idiomas sin costo adicional.

Vea nuestro aviso de no discriminación y nuestro aviso de asistencia en idiomas en **blueshieldca.com/notices**. Para obtener servicios de asistencia en idiomas, también puede llamar al **(866) 346-7198 (TTY: 711)**.

Si no puede acceder al sitio web que aparece arriba y desea recibir una copia del aviso de no discriminación y del aviso de asistencia en idiomas, llame a Atención al Cliente al **(888) 256-3650 (TTY: 711)**.

## 非歧視通知和語言協助服務

Blue Shield 遵守適用的州及聯邦政府的民權法。同時，我們免費提供語言協助服務。

如需檢視我司的非歧視通知和語言幫助通知，請造訪 **blueshieldca.com/notices**。您還可致電尋求語言協助服務：**(866) 346-7198 (TTY: 711)**。

如果您無法造訪上述網站，且希望收到一份非歧視通知和語言幫助通知的副本，請致電客戶服務部，電話：**(888) 256-3650 (TTY: 711)**。