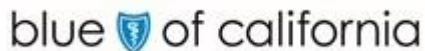



Summary of Benefits and Coverage: What this Plan Covers & What You Pay For Covered Services




Coverage Period: Beginning On or After 1/1/2018
 Coverage for: Individual + Family | Plan Type: PPO

Evans Analytical Group Custom PPO Split Deductible 25-1100 80/60

 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 blueshieldca.com/policies or call 1-855-599-2650. 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?	\$1,100 per individual / \$2,200 per family for <u>participating providers</u> ; \$2,200 per individual / \$4,400 per family for <u>non-participating providers</u> .	Generally, you must pay all of the costs from <u>providers</u> up to the <u>deductible</u> amount before this <u>plan</u> begins to pay. If you have other family members on the <u>plan</u> each family member must meet their own individual <u>deductible</u> until the total amount of <u>deductible</u> expenses paid by all family members meets the overall family <u>deductible</u> .
Are there services covered before you meet your deductible?	Yes. <u>Preventive care</u> and other services listed in your complete terms of coverage.	This <u>plan</u> covers some items and services even if you haven't yet met the <u>deductible</u> amount. But a <u>copayment</u> or <u>coinsurance</u> may apply. For example, this <u>plan</u> covers certain <u>preventive services</u> without <u>cost-sharing</u> and before you meet your <u>deductible</u> . See a list of covered <u>preventive services</u> at healthcare.gov/coverage/preventive-care-benefits/ .
Are there other deductibles for specific services?	No.	You don't have to meet <u>deductibles</u> for specific services.
What is the out-of-pocket limit for this plan?	\$4,750 per individual / \$9,500 per family for <u>participating providers</u> ; \$9,500 per individual / \$19,000 per family for <u>non-participating providers</u> .	The <u>out-of-pocket limit</u> is the most you could pay in a year for covered services. If you have other family members in this <u>plan</u> , they have to meet their own <u>out-of-pocket limits</u> until the overall family <u>out-of-pocket limit</u> has been met.
What is not included in the out-of-pocket limit?	<u>Copayments</u> for certain services, <u>premiums</u> , <u>balance-billing</u> charges, and health care this <u>plan</u> doesn't cover.	Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u> .
Will you pay less if you use a network provider?	Yes. See blueshieldca.com/fap or call 1-855-599-2650 for a list of <u>network providers</u> .	This <u>plan</u> uses a <u>provider network</u> . You will pay less if you use a <u>provider</u> in the <u>plan's network</u> . You will pay the most if you use an <u>out-of-network provider</u> , and you might receive a bill from a <u>provider</u> for the difference between the <u>provider's</u> charge and what your <u>plan</u> pays (<u>balance billing</u>). Be aware, your <u>network provider</u> might use an <u>out-of-network provider</u> for some services (such as lab work). Check with your <u>provider</u> before you get services.
Do you need a referral to see a specialist?	No.	You can see the <u>specialist</u> you choose without a <u>referral</u> .

 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 Participating Provider (You will pay the least)	What You Will Pay Non-Participating Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	\$25/visit; calendar year deductible does not apply	40% coinsurance	-----None-----
	Specialist visit	\$25/visit; calendar year deductible does not apply	40% coinsurance	
	Preventive care/ screening/immunization	No Charge; calendar year 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)	<i>Lab & Path:</i> \$25/visit <i>X-Ray & Imaging:</i> \$25/visit <i>Other Diagnostic Examination:</i> \$50/visit	<i>Lab & Path:</i> 40% coinsurance <i>X-Ray & Imaging:</i> 40% coinsurance <i>Other Diagnostic Examination:</i> 40% coinsurance up to \$350 per day plus 100% of additional charges	The services listed are at a freestanding location.
	Imaging (CT/PET scans, MRIs)	<i>Outpatient Radiology Center:</i> 20% coinsurance <i>Outpatient Hospital:</i> 20% coinsurance	<i>Outpatient Radiology Center:</i> 40% coinsurance <i>Outpatient Hospital:</i> 40% coinsurance up to \$350 per day plus 100% of additional charges	Preauthorization is required. Failure to obtain preauthorization may result in reduction or non-payment of benefits.

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Common Medical Event	Services You May Need	What You Will Pay Participating Provider (You will pay the least)	What You Will Pay Non-Participating Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information
<p>If you need drugs to treat your illness or condition</p> <p>More information about prescription drug coverage is available at blueshieldca.com/formulary</p>	Tier 1	<i>Retail:</i> \$15/prescription <i>Mail Service:</i> \$30/prescription	<i>Retail:</i> 25% of purchase price + \$15/prescription <i>Mail Service:</i> Not covered	<p><u>Preauthorization</u> is required for select drugs. Failure to obtain <u>preauthorization</u> may result in reduction or non-payment of benefits.</p> <p><i>Retail:</i> Covers up to a 30-day supply; <i>Mail Service:</i> Covers up to a 90-day supply.</p>
	Tier 2	<i>Retail:</i> \$30/prescription <i>Mail Service:</i> \$60/prescription	<i>Retail:</i> 25% of purchase price + \$30/prescription <i>Mail Service:</i> Not covered	
	Tier 3	<i>Retail:</i> \$45/prescription <i>Mail Service:</i> \$90/prescription	<i>Retail:</i> 25% of purchase price + \$45/prescription <i>Mail Service:</i> Not covered	
	Tier 4	<i>Retail and Network Specialty Pharmacies:</i> 30% coinsurance up to \$200/prescription <i>Mail Service:</i> 30% coinsurance up to \$400/prescription	<i>Retail:</i> 25% of purchase price + 30% <u>coinsurance</u> up to \$200 maximum/prescription <i>Mail Service:</i> Not covered	
<p>If you have outpatient surgery</p>	Facility fee (e.g., ambulatory surgery center)	<i>Ambulatory Surgery Center:</i> 20% <u>coinsurance</u> <i>Outpatient Hospital:</i> 20% <u>coinsurance</u>	<i>Ambulatory Surgery Center:</i> 40% <u>coinsurance</u> up to \$350 per day plus 100% of additional charges <i>Outpatient Hospital:</i> 40% <u>coinsurance</u> up to \$350 per day plus 100% of additional charges	<p>-----None-----</p>
	Physician/surgeon fees	20% <u>coinsurance</u>	40% <u>coinsurance</u>	
<p>If you need immediate medical attention</p>	<u>Emergency room care</u>	<i>Facility Fee:</i> \$100/visit + 20% <u>coinsurance</u> ; calendar year <u>deductible</u> does not apply <i>Physician Fees:</i> 20% <u>coinsurance</u>	<i>Facility Fee:</i> \$100/visit + 20% <u>coinsurance</u> ; calendar year <u>deductible</u> does not apply <i>Physician Fees:</i> 20% <u>coinsurance</u>	<p>-----None-----</p>

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Common Medical Event	Services You May Need	What You Will Pay Participating Provider (You will pay the least)	What You Will Pay Non-Participating Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information
	<u>Emergency medical transportation</u>	20% <u>coinsurance</u>	20% <u>coinsurance</u>	
	<u>Urgent care</u>	\$25/visit; calendar year <u>deductible</u> does not apply	40% <u>coinsurance</u>	
If you have a hospital stay	Facility fee (e.g., hospital room)	\$100/admission + 20% <u>coinsurance</u>	40% <u>coinsurance</u> up to \$600 per day plus 100% of additional charges	<u>Preauthorization</u> is required. Failure to obtain <u>preauthorization</u> may result in reduction or non-payment of benefits.
	Physician/surgeon fees	20% <u>coinsurance</u>	40% <u>coinsurance</u>	-----None-----
If you need mental health, behavioral health, or substance abuse services	Outpatient services	<i>Office Visit:</i> \$25/visit; calendar year <u>deductible</u> does not apply <i>Outpatient Services:</i> 20% <u>coinsurance</u> <i>Partial Hospitalization:</i> 20% <u>coinsurance</u> <i>Psychological Testing:</i> 20% <u>coinsurance</u>	<i>Office Visit:</i> 40% <u>coinsurance</u> <i>Outpatient Services:</i> 40% <u>coinsurance</u> <i>Partial Hospitalization:</i> 40% <u>coinsurance</u> up to \$350 per day plus 100% of additional charges <i>Psychological Testing:</i> 40% <u>coinsurance</u>	<u>Preauthorization</u> is required except for office visits. Failure to obtain <u>preauthorization</u> may result in reduction or non-payment of benefits. Substance abuse not covered.
	Inpatient services	<i>Physician Inpatient Services:</i> No Charge <i>Hospital Services:</i> \$100/admission + 20% <u>coinsurance</u> <i>Residential Care:</i> \$100/admission + 20% <u>coinsurance</u>	<i>Physician Inpatient Services:</i> 40% <u>coinsurance</u> <i>Hospital Services:</i> 40% <u>coinsurance</u> up to \$600 per day plus 100% of additional charges <i>Residential Care:</i> 40% <u>coinsurance</u> up to \$600 per day plus 100% of additional charges	<u>Preauthorization</u> is required. Failure to obtain <u>preauthorization</u> may result in reduction or non-payment of benefits. Substance abuse not covered.
If you are pregnant	Office visits	20% <u>coinsurance</u>	40% <u>coinsurance</u>	
	Childbirth/delivery professional services	20% <u>coinsurance</u>	40% <u>coinsurance</u>	-----None-----
	Childbirth/delivery facility services	\$100/admission + 20% <u>coinsurance</u>	40% <u>coinsurance</u> up to \$600 per day plus 100% of additional charges	

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Common Medical Event	Services You May Need	What You Will Pay Participating Provider (You will pay the least)	What You Will Pay Non-Participating Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information
If you need help recovering or have other special health needs	<u>Home health care</u>	20% <u>coinsurance</u>	Not Covered	<u>Preauthorization</u> is required. Failure to obtain <u>preauthorization</u> may result in reduction or non-payment of benefits. Coverage limited to 100 visits per member per calendar year.
	<u>Rehabilitation services</u>	<i>Office Visit:</i> \$25/visit <i>Outpatient Hospital:</i> \$25/visit	<i>Office Visit:</i> 40% <u>coinsurance</u> <i>Outpatient Hospital:</i> 40% <u>coinsurance</u> up to \$350 per day plus 100% of additional charges	-----None-----
	<u>Habilitation services</u>	<i>Office Visit:</i> \$25/visit <i>Outpatient Hospital:</i> \$25/visit	<i>Office Visit:</i> 40% <u>coinsurance</u> <i>Outpatient Hospital:</i> 40% <u>coinsurance</u> up to \$350 per day plus 100% of additional charges	-----None-----
	<u>Skilled nursing care</u>	<i>Freestanding SNF:</i> 20% <u>coinsurance</u> <i>Hospital-based SNF:</i> 20% <u>coinsurance</u>	<i>Freestanding SNF:</i> 20% <u>coinsurance</u> <i>Hospital-based SNF:</i> 40% <u>coinsurance</u> up to \$600 per day plus 100% of additional charges	<u>Preauthorization</u> is required. Failure to obtain <u>preauthorization</u> may result in reduction or non-payment of benefits. Coverage limited to 100 days per member per benefit period.
	<u>Durable medical equipment</u>	20% <u>coinsurance</u>	40% <u>coinsurance</u>	<u>Preauthorization</u> is required. Failure to obtain <u>preauthorization</u> may result in reduction or non-payment of benefits.
	<u>Hospice services</u>	No Charge; calendar year <u>deductible</u> does not apply	Not Covered	
If your child needs dental or eye care	Children's eye exam	Not Covered	Not Covered	-----None-----
	Children's glasses	Not Covered	Not Covered	
	Children's dental check-up	Not Covered	Not Covered	

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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)
- Infertility treatment
- Hearing aids
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing
- Routine eye care (Adult)
- Routine foot care
- Substance Abuse Services
- 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 1-855-836-9705 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

If you don't have Minimum Essential Coverage for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

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.

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 tulong sa 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, kwijí' 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): 한국어도움이 필요하시면, 1-866-346-7198 무료전화 로전화하십시오.

Armenian (Հայերեն): Հայերենի եզրնվանված արժույթը յոն 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 ਓ ਜ ਮਦਦ ਲੈਂ ਮੇਰੀ ਕਰ ਕੇ 1-866-346-7198 ਤੇ ਮਫਤ ਕਾਲ ਕਰੋ.

Khmer (ភាសាខ្មែរ): សូមទំនួលយកពាក្យអង្គការសុខភាពសាធារណៈ ខ្មែរ 1-866-346-7198.

Arabic (العربية): للحصول على المساعدة في اللغة العربية مجاناً ، 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): हिन्दीमें बिना खर्च के सहायताके लिए, 1-866-346-7198 पर कॉल करें।

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

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

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 \$1,100
- Specialist copayment \$25
- Hospital (facility) copay+coins \$100+20%
- 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	\$12,800
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In this example, Peg would pay:

<i>Cost Sharing</i>	
Deductibles	\$1,100
Copayments	\$660
Coinsurance	\$2,271
<i>What isn't covered</i>	
Limits or exclusions	\$60
The total Peg would pay is	\$4,091

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

- The plan's overall deductible \$1,100
- Specialist copayment \$25
- Hospital (facility) copay+coins \$100+20%
- 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	\$7,400
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In this example, Joe would pay:

<i>Cost Sharing</i>	
Deductibles	\$0
Copayments	\$1,505
Coinsurance	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$1,783
The total Joe would pay is	\$3,288

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

- The plan's overall deductible \$1,100
- Specialist copayment \$25
- Hospital (facility) copay+coins \$100+20%
- Other copayment \$25

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	\$2,500
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In this example, Mia would pay:

<i>Cost Sharing</i>	
Deductibles	\$1,100
Copayments	\$200
Coinsurance	\$270
<i>What isn't covered</i>	
Limits or exclusions	\$37
The total Mia would pay is	\$1,607

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

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