### Important Questions

<table>
<thead>
<tr>
<th>Question</th>
<th>Answer</th>
<th>Why This Matters:</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>What is the overall deductible?</strong></td>
<td>$250 per individual / $750 per family for participating providers; $250 per individual / $750 per family for non-participating providers.</td>
<td>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.</td>
</tr>
<tr>
<td><strong>Are there services covered before you meet your deductible?</strong></td>
<td>Yes. Preventive care and services listed in your complete terms of coverage.</td>
<td>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.</td>
</tr>
<tr>
<td><strong>Are there other deductibles for specific services?</strong></td>
<td>No.</td>
<td>You don’t have to meet deductibles for specific services.</td>
</tr>
<tr>
<td><strong>What is the out-of-pocket limit for this plan?</strong></td>
<td>$3,750 per individual / $7,500 per family for participating providers; $3,750 per individual for non-participating providers.</td>
<td>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.</td>
</tr>
<tr>
<td><strong>What is not included in the out-of-pocket limit?</strong></td>
<td>Copayments for certain services, premiums, balance-billing charges, and health care this plan doesn’t cover.</td>
<td>Even though you pay these expenses, they don’t count toward the out-of-pocket limit.</td>
</tr>
<tr>
<td><strong>Will you pay less if you use a network provider?</strong></td>
<td>Yes. See bcbsglobalcore.com or call 1-804-673-1177 for 24-hour access to care for a list of network providers.</td>
<td>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.</td>
</tr>
<tr>
<td><strong>Do you need a referral to see a specialist?</strong></td>
<td>No.</td>
<td>You can see the specialist you choose without a referral.</td>
</tr>
</tbody>
</table>
All copayment and coinsurance costs shown in this chart are after your deductible has been met, if a deductible applies.

<table>
<thead>
<tr>
<th>Common Medical Event</th>
<th>Services You May Need</th>
<th>Participating Provider (You will pay the least)</th>
<th>Non-Participating Provider (You will pay the most)</th>
<th>Limitations, Exceptions, &amp; Other Important Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>If you visit a health care provider’s office or clinic</td>
<td>Primary care visit to treat an injury or illness</td>
<td>15% coinsurance</td>
<td>15% coinsurance</td>
<td>None</td>
</tr>
<tr>
<td>If you visit a health care provider’s office or clinic</td>
<td>Specialist visit</td>
<td>15% coinsurance</td>
<td>15% coinsurance</td>
<td>None</td>
</tr>
<tr>
<td>If you visit a health care provider’s office or clinic</td>
<td>Preventive care/screening /immunization</td>
<td>No Charge; deductible does not apply</td>
<td>No Charge; deductible does not apply</td>
<td>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.</td>
</tr>
<tr>
<td>If you have a test</td>
<td>Diagnostic test (x-ray, blood work)</td>
<td>Lab &amp; Path: 15% coinsurance X-Ray &amp; Imaging: 15% coinsurance Other Diagnostic Examination: 15% coinsurance</td>
<td>Lab &amp; Path: 15% coinsurance X-Ray &amp; Imaging: 15% coinsurance Other Diagnostic Examination: 15% coinsurance</td>
<td>None</td>
</tr>
<tr>
<td>If you have a test</td>
<td>Imaging (CT/PET scans, MRIs)</td>
<td>Outpatient Radiology Center: 15% coinsurance Outpatient Hospital: 15% coinsurance</td>
<td>Outpatient Radiology Center: 15% coinsurance Outpatient Hospital: 15% coinsurance</td>
<td>None</td>
</tr>
<tr>
<td>If you need drugs to treat your illness or condition</td>
<td>Contraceptive Drugs and devices</td>
<td>Retail: No Charge Mail Service: No Charge</td>
<td>Retail: Applicable to Tier 1, Tier 2 or Tier 3 copayment Mail Service: Not Covered</td>
<td>Preauthorization is required. Failure to obtain preauthorization may result in non-payment of benefits.</td>
</tr>
<tr>
<td>More information about prescription drug coverage is available at blueshieldca.com/formulary</td>
<td>Tier 1 (Mostly Preferred Generic Drugs and some Brand Drugs)</td>
<td>Retail: $10/prescription Mail Service: $20/prescription</td>
<td>Retail: 50% coinsurance + $10/prescription Mail Service: Not Covered</td>
<td>Preauthorization is required for select drugs. Failure to obtain preauthorization may result in non-payment of benefits. Retail: Covers up to a 30-day supply; up to 90-days may be covered with a copayment for each 30-day supply. Mail Service: Covers up to a 90-day supply.</td>
</tr>
</tbody>
</table>

* For more information about limitations and exceptions, see the plan or policy document at bcbglobalcore.com for 24-hour access to care; bscacom/policies for benefits and claims.

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<table>
<thead>
<tr>
<th>Common Medical Event</th>
<th>Services You May Need</th>
<th>Participating Provider (You will pay the least)</th>
<th>Non-Participating Provider (You will pay the most)</th>
<th>Limitations, Exceptions, &amp; Other Important Information</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>If you need drugs to treat your illness or condition</strong>&lt;br&gt;More information about prescription drug coverage is available at blueshieldca.com/formulary</td>
<td>Tier 2 (Mostly Preferred Brand Drugs and some Generic Drugs)</td>
<td>Retail: $25/prescription&lt;br&gt;Mail Service: $50/prescription</td>
<td>Retail: 50% coinsurance + $25/prescription&lt;br&gt;Mail Service: Not Covered</td>
<td>Preauthorization is required for select drugs. Failure to obtain preauthorization may result in non-payment of benefits.&lt;br&gt; Retail: Covers up to a 30-day supply; 90-days may be covered with a copayment for each 30-day supply; Mail Service: Covers up to a 90-day supply.</td>
</tr>
<tr>
<td><strong>If you need drugs to treat your illness or condition</strong>&lt;br&gt;More information about prescription drug coverage is available at blueshieldca.com/formulary</td>
<td>Tier 3 (Non-Preferred Generic and Non-Preferred Brand Drugs)</td>
<td>Retail: $50/prescription&lt;br&gt;Mail Service: $100/prescription</td>
<td>Retail: 50% coinsurance + $50/prescription&lt;br&gt;Mail Service: Not Covered</td>
<td>Preauthorization is required for select drugs. Failure to obtain preauthorization may result in non-payment of benefits.&lt;br&gt; Retail: Covers up to a 30-day supply; 90-days may be covered with a copayment for each 30-day supply; Mail Service: Covers up to a 90-day supply.</td>
</tr>
<tr>
<td><strong>If you need drugs to treat your illness or condition</strong>&lt;br&gt;More information about prescription drug coverage is available at blueshieldca.com/formulary</td>
<td>Tier 4 ( Specialty and high-cost Drugs)</td>
<td>Retail and Network Specialty Pharmacies: $50/prescription&lt;br&gt;Mail Service: $100/prescription</td>
<td>Retail: 50% coinsurance + $50/prescription&lt;br&gt;Mail Service: Not Covered</td>
<td>Preauthorization is required. Failure to obtain preauthorization may result in non-payment of benefits.&lt;br&gt; 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.</td>
</tr>
<tr>
<td><strong>If you have outpatient surgery</strong></td>
<td>Facility fee (e.g., ambulatory surgery center)</td>
<td>Ambulatory Surgery Center: 15% coinsurance&lt;br&gt;Outpatient Hospital: 15% coinsurance</td>
<td>Ambulatory Surgery Center: 15% coinsurance&lt;br&gt;Outpatient Hospital: 15% coinsurance</td>
<td>----------------------None-----------------------</td>
</tr>
<tr>
<td><strong>If you have outpatient surgery</strong></td>
<td>Physician/surgeon fees</td>
<td>15% coinsurance</td>
<td>15% coinsurance</td>
<td>----------------------None-----------------------</td>
</tr>
</tbody>
</table>

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<table>
<thead>
<tr>
<th>Common Medical Event</th>
<th>Services You May Need</th>
<th>What You Will Pay Participating Provider (You will pay the least)</th>
<th>Non-Participating Provider (You will pay the most)</th>
<th>Limitations, Exceptions, &amp; Other Important Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>If you need immediate medical attention</td>
<td>Emergency room care</td>
<td>Facility Fee: 15% coinsurance Physician Fee: 15% coinsurance</td>
<td>Facility Fee: 15% coinsurance Physician Fee: 15% coinsurance</td>
<td>None</td>
</tr>
<tr>
<td>If you need immediate medical attention</td>
<td>Emergency medical transportation</td>
<td>15% coinsurance</td>
<td>15% coinsurance</td>
<td>Coverage is available for emergency or authorized transport.</td>
</tr>
<tr>
<td>If you need immediate medical attention</td>
<td>Urgent care</td>
<td>15% coinsurance</td>
<td>15% coinsurance</td>
<td>None</td>
</tr>
<tr>
<td>If you have a hospital stay</td>
<td>Facility fee (e.g., hospital room)</td>
<td>15% coinsurance</td>
<td>15% coinsurance</td>
<td>Preauthorization is required. Failure to obtain preauthorization may result in non-payment of benefits.</td>
</tr>
<tr>
<td>If you have a hospital stay</td>
<td>Physician/surgeon fees</td>
<td>15% coinsurance</td>
<td>15% coinsurance</td>
<td>None</td>
</tr>
<tr>
<td>If you need mental health, behavioral health, or substance abuse services</td>
<td>Outpatient services</td>
<td>Office Visit: 15% coinsurance Other Outpatient Services: 15% coinsurance Partial Hospitalization: 15% coinsurance Psychological Testing: 15% coinsurance</td>
<td>Office Visit: 15% coinsurance Other Outpatient Services: 15% coinsurance Partial Hospitalization: 15% coinsurance Psychological Testing: 15% coinsurance</td>
<td>Preauthorization is required except for office visits and office-based opioid treatment. Failure to obtain preauthorization may result in non-payment of benefits.</td>
</tr>
<tr>
<td>If you need mental health, behavioral health, or substance abuse services</td>
<td>Inpatient services</td>
<td>Physician Inpatient Services: 15% coinsurance Hospital Services: 15% coinsurance Residential Care: 15% coinsurance</td>
<td>Physician Inpatient Services: 15% coinsurance Hospital Services: 15% coinsurance Residential Care: 15% coinsurance</td>
<td>Preauthorization is required. Failure to obtain preauthorization may result in non-payment of benefits.</td>
</tr>
<tr>
<td>Common Medical Event</td>
<td>Services You May Need</td>
<td>What You Will Pay</td>
<td>Limitations, Exceptions, &amp; Other Important Information</td>
<td></td>
</tr>
<tr>
<td>----------------------</td>
<td>-----------------------</td>
<td>-------------------</td>
<td>-------------------------------------------------------</td>
<td></td>
</tr>
<tr>
<td>If you are pregnant</td>
<td>Office visits</td>
<td>15% coinsurance</td>
<td>15% coinsurance</td>
<td></td>
</tr>
<tr>
<td>If you are pregnant</td>
<td>Childbirth/delivery professional services</td>
<td>15% coinsurance</td>
<td>15% coinsurance</td>
<td></td>
</tr>
<tr>
<td>If you are pregnant</td>
<td>Childbirth/delivery facility services</td>
<td>15% coinsurance</td>
<td>15% coinsurance</td>
<td></td>
</tr>
<tr>
<td>If you need help recovering or have other special health needs</td>
<td>Home health care</td>
<td>15% coinsurance</td>
<td>15% coinsurance</td>
<td></td>
</tr>
<tr>
<td>If you need help recovering or have other special health needs</td>
<td>Rehabilitation services</td>
<td>Office Visit: 15% coinsurance</td>
<td>Office Visit: 15% coinsurance</td>
<td></td>
</tr>
<tr>
<td>If you need help recovering or have other special health needs</td>
<td>Habilitation services</td>
<td>Office Visit: 15% coinsurance</td>
<td>Office Visit: 15% coinsurance</td>
<td></td>
</tr>
<tr>
<td>If you need help recovering or have other special health needs</td>
<td>Skilled nursing care</td>
<td>Freestanding SNF: 15% coinsurance</td>
<td>Freestanding SNF: 15% coinsurance</td>
<td></td>
</tr>
<tr>
<td>If you need help recovering or have other special health needs</td>
<td>Durable medical equipment</td>
<td>15% coinsurance</td>
<td>15% coinsurance</td>
<td></td>
</tr>
</tbody>
</table>

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<th>Services You May Need</th>
<th>What You Will Pay</th>
<th>Limitations, Exceptions, &amp; Other Important Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>If you need help recovering or have other special health needs</td>
<td>Hospice services</td>
<td>Participating Provider (You will pay the least)</td>
<td>15% coinsurance</td>
</tr>
<tr>
<td>If your child needs dental or eye care</td>
<td>Children's eye exam</td>
<td>Participating Provider (You will pay the least)</td>
<td>No Charge; deductible does not apply</td>
</tr>
<tr>
<td>If your child needs dental or eye care</td>
<td>Children's glasses</td>
<td>Non-Participating Provider (You will pay the most)</td>
<td>Not Covered</td>
</tr>
<tr>
<td>If your child needs dental or eye care</td>
<td>Children's dental check-up</td>
<td>Non-Participating Provider (You will pay the most)</td>
<td>Not Covered</td>
</tr>
</tbody>
</table>

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Excluded Services & Other Covered Services:

<table>
<thead>
<tr>
<th>Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Cosmetic surgery</td>
</tr>
<tr>
<td>• Dental care (Adult)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Other Covered Services (Limitations may apply to these services. This isn’t a complete list. Please see your plan document.)</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Acupuncture</td>
</tr>
<tr>
<td>• Bariatric surgery</td>
</tr>
</tbody>
</table>

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 1-800-60004141 for International or 1-916-738-8280 for direct dial for benefits and claims or the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or dol.gov/ebsa/healthreform.

Does this plan provide Minimum Essential Coverage? Yes
Minimum Essential Coverage generally includes plans, health insurance available through the Marketplace or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of Minimum Essential Coverage, you may not be eligible for the premium tax credit.

Does this plan meet the Minimum Value Standards? Yes
If your plan doesn’t meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.
Language Access Services:
English: For assistance in English at no cost, call 1-866-346-7198.
Navajo (Dine): Diné kellíí doo bágh ilínígó shíka' ar'ooowít niiñí:go, kwįį' hodííłníi 1-866-346-7198.
Vietnamese (Tiếng Việt): Để được hỗ trợ miễn phí tiếng Việt, vui lòng gọi điện số 1-866-346-7198.
Armenian (Հայերեն): Հայերեն լեզվով օգնություն ստանելու համար կատարի հազար համար 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: برای دریافت کمک رایگان زبان فارسی، لطفاً با شماره ۱-۸۶۶-۳۴۶-۷۱۹۸ تماس بگیرید (فارسی).
Punjabi (ਪੰਜਾਬੀ): ਪੰਜਾਬੀ ਵਿਚ ਸੰਬੰਧ ਦੇ ਸੰਸਕਰਣ ਲਈ ਸੰਬੰਧ ਕਰੋ 1-866-346-7198 ਦੇ ਲਾਭ ਲੈ।
Khmer (ខ្មែរ): បានសម្រួលលំនាំបំផុតជាការអនុញ្ជាដូចជាការឡើងក្នុងកិច្ចសកម្មបច្ចេកទិសតេស្រាប់ 1-866-346-7198
Arabic: لتصبح مساعدة في اللغة العربية مجانا، تفضل بالاتصال على هذا الرقم: 1-866-346-7198
Hmong (Hmong): Xav tau kev pab dawnb 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): สำหรับความช่วยเหลือภาษาไทยโดยไม่ต้องใช้เงินโปรดโทร 1-866-346-7198
Laotian (ລາວ): ເຊິ່ງມີບໍ່ເສົສເຫຼືອຈາກພາສາລາວແບ່ງປາງ, โปรดโทร 1-866-346-7198.

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: $250
- Specialist coinsurance: 15%
- Hospital (facility) coinsurance: 15%
- Other coinsurance: 15%

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:

<table>
<thead>
<tr>
<th>Cost Sharing</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Deductibles</td>
<td>$300</td>
</tr>
<tr>
<td>Copayments</td>
<td>$10</td>
</tr>
<tr>
<td>Coinsurance</td>
<td>$1,800</td>
</tr>
</tbody>
</table>

**What isn’t covered**
- Limits or exclusions: $60
- The total Peg would pay is: $2,170

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

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

- The plan’s overall deductible: $250
- Specialist coinsurance: 15%
- Hospital (facility) coinsurance: 15%
- Other coinsurance: 15%

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:

<table>
<thead>
<tr>
<th>Cost Sharing</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Deductibles</td>
<td>$300</td>
</tr>
<tr>
<td>Copayments</td>
<td>$500</td>
</tr>
<tr>
<td>Coinsurance</td>
<td>$300</td>
</tr>
</tbody>
</table>

**What isn’t covered**
- Limits or exclusions: $20
- The total Joe would pay is: $1,120

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

- The plan’s overall deductible: $250
- Specialist coinsurance: 15%
- Hospital (facility) coinsurance: 15%
- Other coinsurance: 15%

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:

<table>
<thead>
<tr>
<th>Cost Sharing</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Deductibles</td>
<td>$300</td>
</tr>
<tr>
<td>Copayments</td>
<td>$10</td>
</tr>
<tr>
<td>Coinsurance</td>
<td>$400</td>
</tr>
</tbody>
</table>

**What isn’t covered**
- Limits or exclusions: $20
- The total Mia would pay is: $710

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