



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 1-855-256-9404.

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>?	\$500 per individual / \$1,000 per family Does not apply to preventive care and generic drugs.	You must pay all the costs up to the deductible amount before this <u>plan</u> begins to pay for covered services you use. Check your policy or <u>plan</u> document to see when the deductible starts over (usually, but not always, January 1st). See the chart starting on page 2 for how much you pay for covered services after you meet the deductible .
Are there other <u>deductibles</u> 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 <u>plan</u> covers.
Is there an <u>out-of-pocket limit</u> on my expenses?	Medical: Yes. For preferred : \$2,000 per individual / \$4,000 per family For non-preferred : \$2,000 per individual / \$4,000 per family Prescription: Yes. \$4,600 per individual / \$9,200 per family	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 medical and prescription services. This limit helps you plan 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), Premiums , Balance-billed charges and Health care this <u>plan</u> doesn't cover.	Even though you pay these expenses, they don't count toward the out-of-pocket limit .

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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.cciio.cms.gov or call 1-866-444-3272 to request a copy.

Important Questions	Answers	Why this Matters:
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. For a list of preferred providers , see www.blueshieldca.com/csacea or call 1-855-256-9404	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 .
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 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	\$20 / visit	50% coinsurance	-----None-----
	Specialist visit	\$20 / visit	50% coinsurance	-----None-----

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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
	Other practitioner office visit	20% <u>coinsurance</u> for chiropractic	50% <u>coinsurance</u> for chiropractic	Covers up to 26 visits per calendar year combined with acupuncture services. Plan payment maximum of \$50 for <u>preferred providers</u> and \$25 per visit for <u>non-preferred providers</u> .
		20% <u>coinsurance</u> for acupuncture	20% <u>coinsurance</u> for acupuncture	Covers up to 26 visits per calendar year combined with chiropractic services.
	Preventive care/screening /immunization	No Charge	Not Covered	-----None-----
If you have a test	Diagnostic test (x-ray, blood work)	No Charge at freestanding lab/x-ray center	50% <u>coinsurance</u> at freestanding lab/x-ray center	-----None-----
	Imaging (CT/PET scans, MRIs)	20% <u>coinsurance</u> at freestanding diagnostic center	50% <u>coinsurance</u> at freestanding diagnostic center	Prior authorization is required. Failure to prior authorize may result in nonpayment of benefits.

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Common Medical Event	Services You May Need	Your Cost If You Use a <u>Preferred Provider</u>	Your Cost If You Use a <u>Non-Preferred Provider</u>	Limitations & Exceptions
<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>\$5 Co-pay (retail)</p> <p>\$10 Co-pay (mail order)</p>	<p>\$5 Co-pay (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 prepackaged drugs that have more than a 30 day supply, members will be charged up to 3 co-pays at a retail pharmacy per fill.</p> <p>Prior Authorization / Coverage Management programs may apply to some drugs</p> <p>Retail fill allowance: The first three times that you purchase a long-term drug at a participating retail pharmacy, you'll pay your retail co-payment. After the third purchase, you'll pay a higher cost if you continue to purchase it at retail.</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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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
	<p><u>Preferred</u> brand drugs</p>	<p>\$30 Co-pay (retail) \$75 Co-pay (mail order)</p>	<p>\$30 Co-pay (retail) 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>For prepackaged drugs that have more than a 30 day supply, members will be charged up to 3 co-pays at a retail pharmacy per fill.</p> <p>Prior Authorization / Coverage Management programs may apply to some drugs</p> <p>Retail fill allowance: The first three times that you purchase a long-term drug at a participating retail pharmacy, you'll pay your retail co-payment. After the third purchase, you'll pay a higher cost if you continue to purchase it at retail.</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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Common Medical Event	Services You May Need	Your Cost If You Use a <u>Preferred Provider</u>	Your Cost If You Use a <u>Non-Preferred Provider</u>	Limitations & Exceptions
	<p><u>Non-preferred</u> brand drugs</p>	<p>\$45 Co-pay (retail) \$112.5 Co-pay (mail order)</p>	<p>\$45 Co-pay (retail) 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>For prepackaged drugs that have more than a 30 day supply, members will be charged up to 3 co-pays at a retail pharmacy per fill.</p> <p>Prior Authorization / Coverage Management programs may apply to some drugs</p> <p>Retail fill allowance: The first three times that you purchase a long-term drug at a participating retail pharmacy, you'll pay your retail co-payment. After the third purchase, you'll pay a higher cost if you continue to purchase it at retail.</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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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
	Specialty drugs	30%	Not Covered	<p>Most specialty drugs must be obtained through Accredo Specialty Pharmacy.</p> <p>Specialty meds have a co-pay maximum of \$150 per script filled at retail and a \$300 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)	20% <u>coinsurance</u>	50% <u>coinsurance</u>	If service provided by a non-preferred provider , you pay the <u>coinsurance</u> percentage of up to \$350 per day, plus charges over \$350 per day.
	Physician/surgeon fees	20% <u>coinsurance</u>	50% <u>coinsurance</u>	-----None-----
If you need immediate medical attention	Emergency room services	\$100 / admission + 20% <u>coinsurance</u>	\$100 / admission + 20% <u>coinsurance</u>	-----None-----
	Emergency medical transportation	20% <u>coinsurance</u>	20% <u>coinsurance</u>	-----None-----
	<u>Urgent care</u>	\$20 / visit at freestanding <u>urgent care</u> center	50% <u>coinsurance</u> at freestanding <u>urgent care</u> center	-----None-----

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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 have a hospital stay	Facility fee (e.g., hospital room)	20% <u>coinsurance</u>	50% <u>coinsurance</u>	If service provided by a <u>non-preferred provider</u> , you pay the <u>coinsurance</u> percentage of up to \$600 per day, plus charges over \$600 per day. Prior authorization is required. Failure to prior authorize may result in nonpayment of benefits.
	Physician/surgeon fee	20% <u>coinsurance</u>	50% <u>coinsurance</u>	-----None-----

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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 have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	\$20 / visit	50% <u>coinsurance</u>	-----None-----
	Mental/Behavioral health inpatient services	20% <u>coinsurance</u>	50% <u>coinsurance</u>	If service provided by a non-preferred provider , you pay the <u>coinsurance</u> percentage of up to \$600 per day, plus charges over \$600 per day. Prior authorization is required. Failure to prior authorize may result in nonpayment of benefits.
	Substance use disorder outpatient services	\$20 / visit	50% <u>coinsurance</u>	-----None-----
	Substance use disorder inpatient services	20% <u>coinsurance</u>	50% <u>coinsurance</u>	If service provided by a non-preferred provider , you pay the <u>coinsurance</u> percentage of up to \$600 per day, plus charges over \$600 per day. Prior authorization is required. Failure to prior authorize may result in nonpayment of benefits.
If you are pregnant	Prenatal and postnatal care	20% <u>coinsurance</u>	50% <u>coinsurance</u>	-----None-----
	Delivery and all inpatient services	20% <u>coinsurance</u>	50% <u>coinsurance</u>	If service provided by a non-preferred provider , you pay the <u>coinsurance</u> percentage of up to \$600 per day, plus charges over \$600 per day.

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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 need help recovering or have other special health needs	<u>Home health care</u>	20% <u>coinsurance</u>	Not Covered	Covers up to 100 visits per calendar year. <u>Non-preferred home health care</u> and home infusion are not covered unless pre-authorized. When these services are pre-authorized, you pay the <u>preferred provider copayment</u> . Prior authorization is required. Failure to prior authorize may result in nonpayment of benefits.
	<u>Rehabilitation services</u>	20% <u>coinsurance</u>	50% <u>coinsurance</u>	-----None-----
	<u>Habilitation services</u>	20% <u>coinsurance</u>	50% <u>coinsurance</u>	-----None-----
	<u>Skilled nursing care</u>	20% <u>coinsurance</u> at freestanding SNF	20% <u>coinsurance</u> at freestanding SNF	Covers up to 100 days per calendar year combined with Hospital Skilled Nursing Facility Unit. Prior authorization is required. Failure to prior authorize may result in nonpayment of benefits.
	<u>Durable medical equipment</u>	20% <u>coinsurance</u>	50% <u>coinsurance</u>	Prior authorization is required. Failure to prior authorize may result in nonpayment of benefits.
	<u>Hospice service</u>	20% <u>coinsurance</u>	Not Covered	Prior authorization is required. Failure to prior authorize may result in nonpayment of benefits. <u>Coinsurance</u> may apply for other <u>hospice services</u> .
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-----

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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"> • Cosmetic surgery • Dental care (Adult/Child) • Hearing aids • Infertility treatment 	<ul style="list-style-type: none"> • Long-term care • Non-emergency care when traveling outside the U.S. • Private -duty nursing • Routine eye care (Adult) 	<ul style="list-style-type: none"> • Services not deemed <u>medically necessary</u> • Routine foot care • 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 • ACA Preventive Meds Iron (OTC)- Exception: Covered through 12 months of age 	<ul style="list-style-type: none"> • ACA Preventive Meds Smoking Cessation- excluded under age 18 • ACA Preventive Meds Fluoride- excluded for age 6 and older • ACA Preventive Meds - Vitamin D and Calcium/Vitamin D, all other situations • ACA Preventive Meds - Bowel Prep Agents, all other situations • ACA Preventive Meds - Breast Cancer Prevention, all other situations • ACA Preventive Meds – Aspirin for Preeclampsia, all other situations 	<ul style="list-style-type: none"> • Drugs labeled “Caution-limited by Federal law to investigational use” or experimental drugs, even though a charge is made to the individual • 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.)

- Acupuncture
- Bariatric surgery
- Chiropractic care

Other Pharmacy Benefit Inclusions

- | | | |
|--|--|---|
| <ul style="list-style-type: none"> • 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 • ACA Preventive Meds - Vitamin D and Calcium/Vitamin D (HSA241) age 65 and over | <ul style="list-style-type: none"> • ACA Preventive Meds Single Source Brand and Generic Bowel Prep Agents - OTC Only from age 50 through age 70 • ACA Preventive Meds - Breast Cancer Prevention - Tamoxifen tablets or Single Source Brand liquid Soltamox: Women; ≥ 35 years of age who meet criteria. Raloxifene tablets: Postmenopausal women ≥ 35 years of age who meet criteria. • ACA Preventive Meds – Aspirin for Preeclampsia – Generic OTC Products ≤ 81mg • Federal Legend Drugs • Insulin | <ul style="list-style-type: none"> • 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.

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For more information on your rights to continue coverage, contact the plan at 1-855-256-9404. 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.

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: 1-855-256-9404 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, kwijjigo 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 \$5,870
- Patient pays \$1,670

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>	\$500
<u>Copays</u>	\$0
<u>Coinsurance</u>	\$1,000
Limits or exclusions	\$170
Total	\$1,670

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

- Amount owed to providers: \$5,400
- Plan pays \$1,580
- Patient pays \$3,820

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>	\$500
<u>Copays</u>	\$170
<u>Coinsurance</u>	\$220
Limits or exclusions	\$2,930
Total	\$3,820

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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.

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