



**Cover Letter for Summary of Benefits and Coverage**

**Mental Health Services:**

**University of California Custom Health Savings Plan 1300/2600**

**Coverage Period: 01/01/2015-12/31/2015**

The enclosed Summary of Benefits and Coverage (SBC) document is provided to you as required by the Department of Managed Health Care as part of the Patient Protection and Affordable Care Act (PPACA). We are including this cover letter to explain benefits not provided by Blue Shield of California.

Mental Health and Substance Abuse services for this plan, effective January 1, 2015, are not covered by Blue Shield of California. Blue Shield of California holds no responsibility for benefits indicated herein, and cannot be held liable for the accuracy of benefits listed as they are provided by another carrier. Benefits noted in the SBC are listed as a courtesy to provide a complete picture of the benefit package provided to Members who are enrolled in the Health Savings Account (HSA) Plan.

Mental Health and Substance Abuse benefits are covered by a third party administrator, **Optum Behavioral Health**. All questions regarding Mental Health and Substance Abuse benefits, or appeals about claims processing should be directed to **Optum Behavioral Health by calling, 1-888-440-8225**.

For members who contact Blue Shield of California's customer service and appeals departments related to Mental Health and Substance Abuse benefits, they will be advised that services are not covered, and direct all inquiries to **Optum Behavioral Health**.

It is important to understand that Benefits are subject to change at Optum Behavioral Health's discretion, without notification to Blue Shield of California as these carriers are separate entities.

Please distribute this cover letter and the SBC to all employees.

**Attachment:**

**SBC for:** Individual + Family | **Plan Type:** PSP



**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/UC](http://www.blueshieldca.com/UC) or by calling 1-855-201-8375.

Important Questions	Answers	Why this Matters:
<p><b>What is the overall <u>deductible</u>?</b></p>	<p>For participating providers:  <b>\$1,300</b> per individual / <b>\$2,600</b> per family.                      For non-participating providers:  <b>\$2,500</b> per individual / <b>\$5,000</b> per family.                      Does not apply to breast pump, and preventive health services at participating providers.                      For family coverage, the full family deductible must be met before the enrollee or covered dependents can receive benefits for covered services. Deductibles accrue separately for participating and non-participating providers. Non-participating provider deductible includes participating provider deductible.</p>	<p>You must pay all the costs up to the <b>deductible</b> amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the <b>deductible</b> 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 <b>deductible</b>.</p>
<p><b>Are there other <u>deductibles</u> for specific services?</b></p>	<p>No.</p>	<p>You don't have to meet <b>deductibles</b> for specific services, but see the chart starting on page 2 for other costs for services this plan covers.</p>
<p><b>Is there an <u>out-of-pocket limit</u> on my expenses?</b></p>	<p>Yes. For participating providers:  <b>\$4,000</b> per individual / <b>\$6,400</b> per family.                      For non-participating providers:  <b>\$8,000</b> per individual / <b>\$16,000</b> per family.                      For family coverage, the full family out-of-pocket maximum must be</p>	<p>The <b>out-of-pocket limit</b> 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.</p>

**Questions:** Call 1-855-201-8375 or visit us at [www.blueshieldca.com/UC](http://www.blueshieldca.com/UC).

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](http://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:
	met before the enrollee or covered dependents can receive 100% benefits for covered services. Out-of-pocket maximum accumulates separately for participating and non-participating providers. Non-participating provider out-of-pocket maximum includes participating provider out-of-pocket maximum.	
<b>What is not included in the <u>out-of-pocket limit</u>?</b>	Premiums, balance-billed charges, some copayments, and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the <b><u>out-of-pocket limit</u></b> .
<b>Is there an overall annual limit on what the plan pays?</b>	No.	The chart starting on page 2 describes any limits on what the plan will pay for <i>specific</i> covered services, such as office visits.
<b>Does this plan use a <u>network of providers</u>?</b>	Yes. See <a href="http://www.blueshieldca.com/UC">www.blueshieldca.com/UC</a> or call 1-855-201-8375 for a list of participating providers.	If you use an in-network doctor or other health care <b><u>provider</u></b> , 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 <b><u>provider</u></b> for some services. Plans use the term in-network, <b><u>preferred</u></b> , or participating for <b><u>providers</u></b> in their <b><u>network</u></b> . See the chart starting on page 2 for how this plan pays different kinds of <b><u>providers</u></b> .
<b>Do I need a referral to see a <u>specialist</u>?</b>	No.	You can see the <b><u>specialist</u></b> you choose without permission from this plan.
<b>Are there services this plan doesn't cover?</b>	Yes.	Some of the services this plan doesn't cover are listed on page 9. See your policy or plan document for additional information about <b><u>excluded services</u></b> .



- **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

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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
<b>If you visit a health care provider's office or clinic</b>	Primary care visit to treat an injury or illness	20% coinsurance	40% coinsurance	For other services received during the office visit, additional member cost-share may apply.
	Specialist visit	20% coinsurance	40% coinsurance	For other services received during the office visit, additional member cost-share may apply.
	Other practitioner office visit	<u>Chiropractic:</u> 20% coinsurance  <u>Acupuncture:</u> 20% coinsurance	<u>Chiropractic:</u> 40% coinsurance  <u>Acupuncture:</u> 20% coinsurance	Coverage for chiropractic and acupuncture services is limited to 24 combined visits per calendar year. Additional member cost-share applies for covered X-ray services received in conjunction with the office visit.
	Preventive care/screening /immunization	No Charge	40% coinsurance	Coverage for services consistent with ACA requirements and California laws. Please refer to your plan contract for details. Not subject to the calendar-year medical deductible at participating providers.

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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
<b>If you have a test</b>	Diagnostic test (x-ray, blood work)	<u>Lab &amp; Path at Free Standing Location:</u> 20% coinsurance  <u>X-Ray &amp; Imaging at Free Standing Radiology Center:</u> 20% coinsurance  <u>Other Diagnostic Examination at Free Standing Location:</u> 20% coinsurance  <u>X-Ray, Lab &amp; Other Examination at Outpatient Hospital:</u> 20% coinsurance	<u>Lab &amp; Path at Free Standing Location:</u> 40% coinsurance  <u>X-Ray &amp; Imaging at Free Standing Radiology Center:</u> 40% coinsurance  <u>Other Diagnostic Examination at Free Standing Location:</u> 40% coinsurance  <u>X-Ray, Lab &amp; Other Examination at Outpatient Hospital:</u> 40% coinsurance	Benefits in this section are for diagnostic, non-preventive health services.  <u>X-Ray, Lab &amp; Other Examination at Outpatient Hospital:</u> The maximum allowed amount for non-participating providers is \$350 per day. Members are responsible for 40% of this \$350 per day, plus all charges in excess of \$350.
	Imaging (CT/PET scans, MRIs)	<u>Radiological &amp; Nuclear Imaging at Free Standing Radiology Center:</u> 20% coinsurance  <u>Radiological &amp; Nuclear Imaging at Outpatient Hospital:</u> 20% coinsurance	<u>Radiological &amp; Nuclear Imaging at Free Standing Radiology Center:</u> 40% coinsurance  <u>Radiological &amp; Nuclear Imaging at Outpatient Hospital:</u> 40% coinsurance	Benefits in this section are for diagnostic, non-preventive health services. Pre-authorization is required. <u>Radiological &amp; Nuclear Imaging at Outpatient Hospital:</u> The maximum allowed amount for non-participating providers is \$350 per day. Members are responsible for 40% of this \$350 per day, plus all charges in excess of \$350.

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<p><b>If you need drugs to treat your illness or condition</b></p> <p>More information about <b>prescription drug coverage</b> is available at <a href="http://www.blueshieldca.com/UC">www.blueshieldca.com/UC</a></p>	Generic drugs	<u>Retail</u> : 20% coinsurance / prescription <u>UC Maintenance Drug Program</u> : 20% coinsurance / prescription <u>Mail Order</u> : 20% coinsurance / prescription	<u>Retail</u> : 40% coinsurance / prescription <u>UC Maintenance Drug Program</u> : Not Covered <u>Mail Order</u> : Not Covered	<u>Retail</u> : Covers up to a 30-day supply;
	Brand Formulary Drugs	<u>Retail</u> : 20% coinsurance / prescription <u>UC Maintenance Drug Program</u> : 20% coinsurance / prescription <u>Mail Order</u> : 20% coinsurance / prescription	<u>Retail</u> : 40% coinsurance / prescription <u>UC Maintenance Drug Program</u> : Not Covered <u>Mail Order</u> : Not Covered	<u>UC Maintenance Drug Program at select UC or specified pharmacies</u> : Covers up to a 90-day supply.  <u>Mail Order</u> : Covers up to a 90-day supply.
	Brand Non-Formulary Drugs	<u>Retail</u> : 20% coinsurance / prescription <u>UC Maintenance Drug Program</u> : 20% coinsurance / prescription <u>Mail Order</u> : 20% coinsurance / prescription	<u>Retail</u> : 40% coinsurance / prescription <u>UC Maintenance Drug Program</u> : Not Covered <u>Mail Order</u> : Not Covered	Select formulary and non-formulary drugs require pre-authorization.
	Specialty drugs	20% coinsurance / prescription	Not Covered	Covers up to a 30-day supply. Coverage limited to drugs dispensed by select pharmacies in the Specialty Pharmacy Network unless medically necessary for a covered emergency. Pre-authorization is required.
<p><b>If you have outpatient surgery</b></p>	Facility fee (e.g., ambulatory surgery center)	20% coinsurance	40% coinsurance	The maximum allowed amount for non-participating providers is \$350 per day. Members are responsible for 40% of this \$350 per day, plus all charges in excess of \$350.

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	Physician/surgeon fees	20% coinsurance	40% coinsurance	-----None-----
<b>If you need immediate medical attention</b>	Emergency room services	20% coinsurance	20% coinsurance	This is for the hospital/facility charge only. The ER physician charge is separate. Coverage outside of California under BlueCard.
	Emergency medical transportation	20% coinsurance	20% coinsurance	-----None-----
	Urgent care	20% coinsurance at freestanding urgent care center	40% coinsurance at freestanding urgent care center	-----None-----
<b>If you have a hospital stay</b>	Facility fee (e.g., hospital room)	20% coinsurance	40% coinsurance	The maximum allowed amount for non-participating providers is \$600 per day. Members are responsible for 40% of this \$600 per day, plus all charges in excess of \$600. Pre-authorization is required for all services. Failure to obtain pre-authorization may result in additional \$250 payment per hospital admission or non-payment of benefits.
	Physician/surgeon fee	20% coinsurance	40% 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
<b>If you have mental health, behavioral health, or substance abuse needs</b> These services are carved out to and administered by <b>Optum Behavioral Health</b> . For more information, please call 1-888-440-8225.	Mental/Behavioral health outpatient services	20% <u>coinsurance</u>	40% <u>coinsurance</u>	Non-routine and non-office visit services require preauthorization.
	Mental/Behavioral health inpatient services	20% <u>coinsurance</u>	40% <u>coinsurance</u>	\$250 penalty for failure to preauthorize treatment. Applies to out-of-network admissions.
	Substance use disorder outpatient services	20% <u>coinsurance</u>	40% <u>coinsurance</u>	Non-routine and non-office visit services require preauthorization.
	Substance use disorder inpatient services	20% <u>coinsurance</u>	40% <u>coinsurance</u>	\$250 penalty for failure to preauthorize treatment. Applies to out-of-network admissions.
<b>If you are pregnant</b>	Prenatal and postnatal care	<u>Prenatal:</u> 20% coinsurance <u>Postnatal:</u> 20% coinsurance	40% coinsurance	-----None-----
	Delivery and all inpatient services	20% coinsurance	40% coinsurance	The maximum allowed amount for non-participating providers is \$600 per day. Members are responsible for 40% of this \$600 per day, plus all charges in excess of \$600. Pre-authorization is required for all services. Failure to obtain pre-authorization may result in additional \$250 payment per hospital admission 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
<b>If you need help recovering or have other special health needs</b>	Home health care	20% 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	<u>Office visit:</u> 20% coinsurance	<u>Office visit:</u> 40% coinsurance	Coverage for physical, occupational and respiratory therapy services.  <u>Outpatient hospital:</u> The maximum allowed amount for non-participating providers is \$350 per day. Members are responsible for 40% of this \$350 per day, plus all charges in excess of \$350.
		<u>Outpatient hospital:</u> 20% coinsurance	<u>Outpatient hospital:</u> 40% coinsurance	
	Habilitation services	<u>Office visit:</u> 20% coinsurance	<u>Office visit:</u> 40% coinsurance	Coverage for physical, occupational and respiratory therapy services.  <u>Outpatient hospital:</u> The maximum allowed amount for non-participating providers is \$350 per day. Members are responsible for 40% of this \$350 per day, plus all charges in excess of \$350.
		<u>Outpatient hospital:</u> 20% coinsurance	<u>Outpatient hospital:</u> 40% coinsurance	
Skilled nursing care	20% coinsurance at freestanding skilled nursing facility	20% coinsurance at freestanding skilled nursing facility	Coverage limited to 100 days per member per calendar year combined with hospital/free-standing skilled nursing facility. Pre-authorization is required for all services. Failure to obtain pre-authorization may result in additional \$250 payment per hospital admission or non-payment of benefits.	
Durable medical equipment	20% coinsurance	40% coinsurance	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
	Hospice service	No Charge	Not Covered	20% coinsurance applies for 24-hour continuous home care and general inpatient care hospice services. 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 non-payment of benefits.
<b>If your child needs dental or eye care</b>	Eye exam	Not Covered	Not Covered	-----None-----
	Glasses	Not Covered	Not Covered	-----None-----
	Dental check-up	Not Covered	Not Covered	-----None-----

### Excluded Services & Other Covered Services:

<b>Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy or plan document for other <u>excluded services</u>.)</b>		
<ul style="list-style-type: none"> <li>• Cosmetic surgery</li> </ul>	<ul style="list-style-type: none"> <li>• Non-emergency care when traveling outside the U.S.</li> </ul>	<ul style="list-style-type: none"> <li>• Routine foot care (unless for treatment of diabetes)</li> </ul>
<ul style="list-style-type: none"> <li>• Dental care (Adult/Child)</li> </ul>	<ul style="list-style-type: none"> <li>• Private -duty nursing (unless enrolled in a participating hospice program)</li> </ul>	<ul style="list-style-type: none"> <li>• Weight loss programs</li> </ul>
<ul style="list-style-type: none"> <li>• Long-term care</li> </ul>	<ul style="list-style-type: none"> <li>• Routine eye care (Adult)</li> </ul>	

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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.)

- |   |  |  |
|---|--|--|
| <ul style="list-style-type: none"><li>• Acupuncture (coverage limited to 24 combined visits with chiropractic per calendar year.)</li></ul>                                     | <ul style="list-style-type: none"><li>• Chiropractic care (coverage limited to 24 combined visits with acupuncture per calendar year.)</li></ul> | <ul style="list-style-type: none"><li>• Infertility treatment (coverage limited to studies and tests of cause of infertility.)</li></ul> |
| <ul style="list-style-type: none"><li>• Bariatric surgery (pre-authorization is required. Failure to obtain pre-authorization may result in non-payment of benefits.)</li></ul> | <ul style="list-style-type: none"><li>• Hearing aids (coverage limited to \$2,000 maximum allowance per member per 36 months.)</li></ul>         |  |

### 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.

For more information on your rights to continue coverage, contact the plan at **1-855-201-8375**. 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](http://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](http://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: **1-855-201-8375** or the Department of Labor's Employee Benefits Security Administration at **1-866-444-EBSA (3272)** or [www.dol.gov/ebsa/healthreform](http://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.**

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## 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, kwijigo holne' 1-866-346-7198.

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*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 \$4,890
- Patient pays \$2,650

#### 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
<b>Total</b>	<b>\$7,540</b>

#### Patient pays:

Deductibles	\$1,300
Copays	\$0
Coinsurance	\$1,200
Limits or exclusions	\$150
<b>Total</b>	<b>\$2,650</b>

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

- Amount owed to providers: \$5,400
- Plan pays \$3,230
- Patient pays \$2,170

#### 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
<b>Total</b>	<b>\$5,400</b>

#### Patient pays:

Deductibles	\$1,300
Copays	\$0
Coinsurance	\$790
Limits or exclusions	\$80
<b>Total</b>	<b>\$2,170</b>

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You can view the Glossary at [www.dol.gov/ebsa/healthreform](http://www.dol.gov/ebsa/healthreform) or call 1-866-444-3272 to request a copy.

Blue Shield of California is an independent member of the Blue Shield Association.

## 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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