Medical

Company contribution

Your company contributes separately to employees' and dependents' premiums. ● Employee: Your company covers up to 99% of the premium of Blue Shield Gold HMO 0 (Trio). Employee pays the difference in premium if they select a more expensive plan.
● Dependents: Your company covers up to 50% of the premium of Blue Shield Gold HMO 0 (Trio). Employee pays the difference in premium if they select a more expensive plan.

New hire waiting period

1st of the month after hire

Effective dates

1 year from 1st of month after hire

Dental

Company contribution

Your company contributes separately to employees' and dependents' premiums. ! Employee: Your company covers 99% of the premium.
! Dependents: Your company covers 50% of the premium.

New hire waiting period

1st of the month after hire

Effective dates

1 year from 1st of month after hire

Vision

Company contribution

Overview

Your company contributes separately to employees' and dependents' premiums. ! Employee: Your company covers 99% of the premium. ! Dependents: Your company covers 50% of the premium.

New hire waiting period

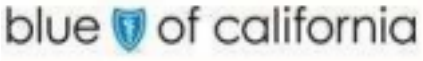
1st of the month after hire

Effective dates

1 year from 1st of month after hire

Overview

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



Coverage Period: Beginning On or After 1/1/2019 **Gold Full PPO 0/20 OffEx Coverage for: Individual + Family | Plan Type: PPO**

The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately. This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, visit bsca.com/policies/M0016492_EOC.pdf or call **1-888-319-5999**. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms see the Glossary. You can view the Glossary at healthcare.gov/sbc-glossary or call **1-866-444-3272** to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	**$0** per individual / **$0** per family for participating providers and non participating providers.	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.
Are there services covered before you meet your deductible?	Yes. Preventive care and services listed in your complete terms of coverage.	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost-sharing and before you meet your deductible. See a list of covered preventive services at healthcare.gov/coverage/preventive-care-benefits.
Are there other deductibles for specific services?	No.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	**$7,000** per individual / **$14,000** per family for participating providers; **$12,550** per individual / **$25,100** per family for non-participating providers.	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, the overall family out-of-pocket limit must be met.
What is not included in the out-of-pocket limit?	Copayments for certain services, premiums, balance-billing charges, and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out-of-pocket limit.
Will you pay less if you use a network provider?	Yes. See blueshieldca.com/fap or call **1-888-319-5999** for a list of network providers.	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware, your network provider might use an

		out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist?	No.	You can see the specialist you choose without a referral.

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PENDING REGULATORY APPROVAL

All **copayment** and **coinsurance** costs shown in this chart are after your **deductible** has been met, if a **deductible** applies.

Common Medical Event	Services You May Need	What You Will Pay	Limitations, Exceptions, & Other Important Information
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness		----------None----------
	Specialist visit		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.
	Preventive care/screening /immunization		The services listed are at a freestanding location.
If you have a test	Diagnostic test (x-ray, blood work)		
	Imaging (CT/PET scans, MRIs)		Preauthorization is required. Failure to obtain preauthorization may result in non-payment of benefits.
If you need drugs to treat your	Tier 1		Preauthorization is required for select drugs. Failure to obtain

illness or condition More information about prescription drug coverage is available at blueshieldca.com/	Tier 2 Tier 3	**Participating Provider (You will pay the least)** $20/visit $50/visit No Charge *Lab & Path*: $20/visit *X-Ray & Imaging*: $50/visit *Other Diagnostic Examination*: $50/visit *Outpatient Radiology Center*: 30% coinsurance *Outpatient Hospital*: $100/visit+ 30% coinsurance *Retail*: $15/prescription *Mail Service*: $30/prescription *Retail*: $40/prescription *Mail Service*: $80/prescription *Retail*: $60/prescription *Mail Service*: $120/prescription	**Non-Participating Provider (You will pay the most)** 40% coinsurance 40% coinsurance Not Covered *Lab & Path*: 40% coinsurance *X-Ray & Imaging*: 40% coinsurance *Other Diagnostic Examination*: 40% coinsurance *Outpatient Radiology Center*: 40% coinsurance *Outpatient Hospital*: 40% coinsurance up to $350/day plus 100% of additional charges *Retail*: Not Covered *Mail Service*: Not Covered *Retail*: Not Covered *Mail Service*: Not Covered *Retail*: Not Covered *Mail Service*: Not Covered	preauthorization may result in non payment of benefits. *Retail*: Covers up to a 30-day supply; *Mail Service*: Covers up to a 90-day supply.

Common Medical Event	Services You May	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Participating Provider (You will pay the least)	Non-Participating Provider (You will pay the most)	
formulary				Preauthorization is required. Failure to obtain preauthorization may result in non-payment of benefits. *Retail and Network Specialty Pharmacies*: Covers up to a 30-day supply; Specialty Drugs must be obtained at a Network Specialty Pharmacy. *Mail Service*: Covers up to a 90-day supply.
	Need Tier 4	*Retail and Network Specialty Pharmacies*: 30% coinsurance up to $250/prescription *Mail Service*: 30% coinsurance up to $500/prescription	*Retail*: Not Covered *Mail Service*: Not Covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	*Ambulatory Surgery Center*: 30% coinsurance *Outpatient Hospital*: $150/surgery+ 30% coinsurance	*Ambulatory Surgery Center*: 40% coinsurance up to $350/day plus 100% of additional charges *Outpatient Hospital*: 40% coinsurance up to $350/day plus 100% of additional charges	----------None----------
	Physician/surgeon fees	30% coinsurance	40% coinsurance	----------None----------
If you need immediate medical attention	Emergency room care	*Facility Fee*: $250/visit+ 30% coinsurance *Physician Fee*: 30% coinsurance	*Facility Fee*: $250/visit+ 30% coinsurance *Physician Fee*: 30% coinsurance	---
	Emergency medical transportation	30% coinsurance	30% coinsurance	----------None----------
	Urgent care	$20/visit	40% coinsurance	---
If you have a hospital stay	Facility fee (e.g., hospital room)	30% coinsurance	40% coinsurance up to $2,000/day plus 100% of additional charges	This payment is for emergency or authorized transport.
	Physician/surgeon fees	30% coinsurance	40% coinsurance	----------None---------- --- Preauthorization is required. Failure to obtain preauthorization may result in non-payment of benefits.
				----------None----------

Common Medical Event	Services You May	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Participating Provider (You will pay the least)	Non-Participating Provider (You will pay the most)	
	Need Outpatient services	*Office Visit*: $20/visit *Other Outpatient Services*: 30% coinsurance	*Office Visit*: 40% coinsurance *Other Outpatient Services*: 40% coinsurance	Preauthorization is required except for office visits, electroconvulsive therapy, and psychological testing. Failure to obtain preauthorization may result in non-payment of benefits.
If you need mental health, behavioral health, or substance abuse services		*Partial Hospitalization*: 30% coinsurance *Psychological Testing*: 30% coinsurance	*Partial Hospitalization*: 40% coinsurance up to $350/day plus 100% of additional charges *Psychological Testing*: 40% coinsurance	
	Inpatient services	*Physician Inpatient Services*: 30% coinsurance *Hospital Services*: 30% coinsurance *Residential Care*: 30% coinsurance	*Physician Inpatient Services:* 40% coinsurance *Hospital Services:* 40% coinsurance up to $2,000/day plus 100% of additional charges *Residential Care:* 40% coinsurance up to $2,000/day plus 100% of additional charges	Preauthorization is required. Failure to obtain preauthorization may result in non-payment of benefits.
	Office visits	No Charge	40% coinsurance	----------None----------
If you are pregnant	Childbirth/delivery professional services Childbirth/delivery facility services	30% coinsurance	40% coinsurance	----------None----------
If you need help recovering or have other	Home health care	30% coinsurance	40% coinsurance up to $2,000/day plus 100% of additional charges	Preauthorization is required. Failure to obtain preauthorization may result in non-payment of benefits. Coverage limited to 100 visits per

special health needs		30% coinsurance	Not Covered	member per calendar year.

Common Medical Event	Services You May	What You Will Pay	Limitations, Exceptions, & Other Important Information
	Need Rehabilitation services		----------None----------
	Habilitation services		Preauthorization is required. Failure to obtain preauthorization may result in non-payment of benefits. Coverage limited to 100 days per member per benefit period.
	Skilled nursing care		Preauthorization is required. Failure to obtain preauthorization may result in non-payment of benefits.
	Durable medical equipment		Preauthorization is required except for pre-hospice consultation. Failure to obtain preauthorization may result in non-payment of benefits.

		Participating Provider (You will pay the least)	**Non-Participating Provider (You will pay the most)**	
If your child needs dental or eye care	Hospice services	*Office Visit*: 30% coinsurance *Outpatient Hospital*: 30% coinsurance	*Office Visit*: 40% coinsurance *Outpatient Hospital*: 40% coinsurance up to $350/day plus 100% of additional charges	Coverage limited to one exam per member per calendar year. Coverage is limited to one eyeglass frame and eyeglass lenses or contact lenses instead of eyeglasses, up to the benefit per calendar year. The cost listed is for Single Vision.
	Children's eye exam			
	Children's glasses	*Office Visit*: 30% coinsurance *Outpatient Hospital*: 30% coinsurance	*Office Visit*: 40% coinsurance *Outpatient Hospital*: 40% coinsurance up to $350/day plus 100% of additional charges	
		Freestanding SNF: 30% coinsurance *Hospital-based SNF*: 30% coinsurance	*Freestanding SNF*: 30% coinsurance *Hospital-based SNF*: 40% coinsurance up to $2,000/day plus 100% of additional charges	
		50% coinsurance	Not Covered	
		No Charge	Not Covered	
		No Charge	Coverage up to a maximum allowance of $30	
		No Charge	Coverage up to a maximum allowance of $25	

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
	Children's dental check-up	No Charge	20% coinsurance	Coverage for prophylaxis services (cleaning) is limited to once in a six month period.

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 • Infertility Treatment • Private-duty nursing • Routine foot care • Dental care (Adult) • Long-term care • Routine eye care (Adult) • Weight loss programs • Hearing Aids • Non-emergency care when traveling outside the U.S.

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

• Acupuncture • Bariatric surgery • Chiropractic Care

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, at 1-877-267-2323 x61565 or cciio.cms.gov. Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit HealthCare.gov or call 1-800-318-2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice or assistance, contact: Blue Shield Customer Service at 1-888-319-5999 or the Department of Labor's Employee Benefits Security Administration at **1-866-444-EBSA (3272)** or dol.gov/ebsa/healthreform. Additionally, you can contact the California Department of Managed Health Care Help at 1-888-466-2219 or visit helpline@dmhc.ca.gov or visit http://www.healthhelp.ca.gov.

Does this plan provide Minimum Essential Coverage? Yes

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

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, llam
1-866-346-7198.

Tagalog (Tagalog): Kung kailanganninyo ang libreng tulongsa Tagal
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 1-866-346-7

Navajo (Dine): **Diné k'ehjí doo bąąh ílínígó shika' at'oowoł nínízingo, kwij**
1-866-346-7198.

Vietnamese (Tiếng Việt): Đểđược hỗ trợ miễn phí tiếng Việt, vui lòng gọi
1-866-346-7198.

Korean (한국어): 한국어도움이필요하시면, 1-866-346-7198 무료전화 로전

Armenian (Հայերեն): Հայերենիեզվովանվճարօգնությունստանալուհամա
ենքզանգահարել 1-866-346-7198.

Russian (Русский): если нужна бесплатная помощь на русском я
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**
無料で提供します。

Persian (فارسی): .1-866-346-7198 تماس بگیرید لطفاً با شماره تلفن ،مک رایگان زبان فارسی

Punjabi(ਪੰਜਾਬੀ): .1-866-346-7198 ਤੇ ਮੁਫ਼ਤ ਕਾਲ ਕਰੋ ਪੰਜਾਬੀ ਵਿਚ ਮਦਦ ਲਈ ਮਿਹਰਬਾਨੀ ਕਰ ਕੇ

Khmer (ភាសាខ្មែរ): 1-866-346-7198.

Arabic(العربية): .1-866-346-7198 اعدة في اللغة العربية مجانا ، تفضل باتصال على هذا الرقم:

Hmong (Hnoob): Xav tau kev pab dawb lub Hmoob, thov hu rau 1-8

Hindi (हिन्दी): हिन्दीमेंबिना खर्च केसहायताकेलिए, 1-866-346-7198 परकॉलकरें।.

Thai (ไทย): 1-866-346-7198.

To see example of how this s plan might cover costs for a sample medical situation .section nextthe , see

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.

is $3,880

■ **The plan's overall deductible $0 ■ Specialist copayment $50 ■ Hospital (facility) coinsurance 30% ■ Other copayment $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
In this example, Peg would pay:
Cost Sharing
Deductibles $0 Copayments $350 Coinsurance $3,470 *What isn't covered*
Limits or exclusions $60 **The total Peg would pay**

■ **The plan's overall deductible $0 ■ Specialist copayment $50 ■ Hospital (facility) coinsurance 30% ■ Other copayment $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
In this example, Joe would pay:
Cost Sharing
Deductibles $0 Copayments $1,510 Coinsurance $940 *What isn't covered*
Limits or exclusions $60 **The total Joe would pay is $2,510**

■ **The plan's overall deductible $0 ■ Specialist copayment $50 ■ Hospital (facility) coinsurance 30% ■ Other copayment $50**

This EXAMPLE event includes services like:
Emergency room care *(including medical supplies)*
Diagnostic test *(x-ray)*
Durable medical equipment *(crutches)*
Rehabilitation services *(physical therapy)*

Total Example Cost $2,500
In this example, Mia would pay:
Cost Sharing
Deductibles $0 Copayments $70 Coinsurance $560
What isn't covered
Limits or exclusions $0 **The total Mia would pay is $630**

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PENDING REGULATORY APPROVAL

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

Notice Informing Individuals about Nondiscrimination and Accessibility Requirements

Discrimination is against the law

Blue Shield of California complies with applicable state laws and federal civil rights laws, and does not discriminate on the basis of race, color, national origin, ancestry, religion, sex, marital status, gender, gender identity, sexual orientation, age or disability. Blue Shield of California does not exclude people or treat them differently because of race, color, national origin, ancestry, religion, sex, marital status, gender, gender identity, sexual orientation, age, or disability.

Blue Shield of California:

- Provides aids and services at no cost to people with disabilities to communicate effectively with us such as:
  - Qualified sign language interpreters
  - Written information in other formats (including large print, audio, accessible electronic formats and other formats)
- Provides language services at no cost to people whose primary language is not English such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, contact the Blue Shield of California Civil Rights Coordinator.

If you believe that Blue Shield of California has failed to provide these services or discriminated in another way on the basis of race, color, national origin, ancestry, religion, sex, marital status, gender, gender identity, sexual orientation, age, or disability, you can file a grievance with:

Blue Shield of California
Civil Rights Coordinator
P.O. Box 629007
El Dorado Hills, CA 95762-9007
Phone: (844) 831-4133 (TTY: 711)
Fax: (844) 696-6070

Email: BlueShieldCivilRightsCoordinator@blueshieldca.com

You can file a grievance in person or by mail, fax or email. If you need help filing a grievance, our Civil Rights Coordinator is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at **https://ocrportal.hhs.gov/ocr/portal/lobby.jsf** or by mail or phone at:

U.S. Department of Health and Human Services

200 Independence Avenue SW.

Room 509F, HHH Building

Washington, DC 20201

(800) 368-1019; TTY: (800) 537-7697

Complaint forms are available at **www.hhs.gov/ocr/office/file/index.html.**

Blue Shield of California
50 Beale Street, San Francisco, CA 94105 blueshieldca.com

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

blue of california **Coverage Period: Beginning On or After 1/1/2019** **Gold Access+ HMO® 0/30 OffEx Coverage for: Individual + Family** | **Plan Type: HMO**

The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately. This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, visit bsca.com/policies/M0016470_EOC.pdf or call **1-888-319-5999**. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms see the Glossary. You can view the Glossary at healthcare.gov/sbc-glossary or call **1-866-444-3272** to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	**$0.**	See the Common Medical Events chart below for your costs for services this plan covers.
Are there services covered before you meet your deductible?	Yes. Preventive care and services listed in your complete terms of coverage.	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost-sharing and before you meet your deductible. See a list of covered preventive services at healthcare.gov/coverage/preventive-care-benefits.

Are there other deductibles for specific services?	No.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	**$5,750** per individual / **$11,500** per family for participating providers.	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, the overall family out-of-pocket limit must be met.
What is not included in the out-of-pocket limit?	Copayments for certain services, premiums, and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out-of-pocket limit.
Will you pay less if you use a network provider?	Yes. See blueshieldca.com/fap or call **1-888-319-5999** for a list of network providers.	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware, your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist?	Yes.	This plan will pay some or all of the costs to see a specialist for covered services but only if you have a referral before you see the specialist.

All **copayment** and **coinsurance** costs shown in this chart are after your **deductible** has been met, if a **deductible** applies.

Common Medical Event	Services You May Need	What You Will Pay	Limitations, Exceptions, & Other Important Information
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness		Self-referral is available for Access+ Specialist visits.
	Specialist visit		You may have to pay for services that

If you have a test **If you need drugs to treat your illness or condition** More information about prescription drug coverage is available at blueshieldca.com/	Preventive care/screening /immunization Diagnostic test (x-ray, blood work) Imaging (CT/PET scans, MRIs) Tier 1 Tier 2 Tier 3	**Participating Provider (You will pay the least)** $30/visit *Access+ Specialist*: $55/visit *Other Specialist*: $55/visit No Charge *Lab & Path*: $30/visit *X-Ray & Imaging*: $50/visit *Other Diagnostic Examination*: $50/visit *Outpatient Radiology Center*: $50/visit *Outpatient Hospital*: $250/visit *Retail*: $15/prescription *Mail Service*: $30/prescription *Retail*: $30/prescription *Mail Service*: $60/prescription *Retail*: $50/prescription *Mail Service*: $100/prescription	**Non-Participating Provider (You will pay the most)** Not Covered Not Covered Not Covered *Lab & Path*: Not Covered *X-Ray & Imaging*: Not Covered *Other Diagnostic Examination*: Not Covered *Outpatient Radiology Center*: Not Covered *Outpatient Hospital*: Not Covered *Retail*: Not Covered *Mail Service*: Not Covered *Retail*: Not Covered *Mail Service*: Not Covered *Retail*: Not Covered *Mail Service*: Not Covered	aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for. Preauthorization is required. Failure to obtain preauthorization may result in non-payment of benefits. The services listed are at a freestanding location. Preauthorization is required. Failure to obtain preauthorization may result in non-payment of benefits. 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; *Mail Service*: Covers up to a 90-day supply.

Common Medical Event	Services You May	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Participating Provider (You will pay the least)	Non-Participating Provider (You will pay the most)	
formulary				Preauthorization is required. Failure to obtain preauthorization may result in non-payment of benefits.
	Need Tier 4	*Retail and Network Specialty Pharmacies*: 20% coinsurance up to $250/prescription *Mail Service*: 20% coinsurance up to $500/prescription	*Retail*: Not Covered *Mail Service*: Not Covered	*Retail and Network Specialty Pharmacies*: Covers up to a 30-day supply; Specialty Drugs must be obtained at a Network Specialty Pharmacy. *Mail Service*: Covers up to a 90-day supply.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	*Ambulatory Surgery Center*: $150/surgery	*Ambulatory Surgery Center*: Not Covered	----------None----------
	Physician/surgeon fees	*Outpatient Hospital*: $300/surgery	*Outpatient Hospital*: Not Covered	---
	Emergency room care	No Charge	Not Covered	----------None----------
If you need immediate medical attention	Emergency medical transportation	*Facility Fee*: $250/visit *Physician Fee*: No Charge	*Facility Fee*: $250/visit *Physician Fee*: No Charge	---
		$100/transport	$100/transport	----------None----------
	Urgent care	*Within Plan Service Area:* $30/visit *Outside Plan Service Area:* $30/visit	*Within Plan Service Area*: Not Covered *Outside Plan Service Area*: $30/visit	---
If you have a hospital stay	Facility fee (e.g., hospital room) Physician/surgeon fees	$600/day up to 5 days/admission No Charge	Not Covered Not Covered	This payment is for emergency or authorized transport. ----------None---------- Preauthorization is required. Failure to obtain preauthorization may result in non-payment of benefits.

				----------None----------

Common Medical Event	Services You May	What You Will Pay	Limitations, Exceptions, & Other Important Information
If you need mental health, behavioral health, or substance abuse services	Need Outpatient services		Preauthorization is required except for office visits, electroconvulsive therapy, and psychological testing. Failure to obtain preauthorization may result in non-payment of benefits.
	Inpatient services		Preauthorization is required. Failure to obtain preauthorization may result in non-payment of benefits.
If you are pregnant	Office visits Childbirth/delivery professional services Childbirth/delivery facility services		----------None---------- ----------None----------
	Home health care		Preauthorization is required. Failure to obtain preauthorization may result in non-payment of benefits. Coverage limited to 100 visits per member per calendar year.
If you need help recovering or	Rehabilitation services		

have other special health needs	Habilitation services	**Participating Provider (You will pay the least)** *Office Visit*: $30/visit *Other Outpatient Services*: No Charge *Partial Hospitalization*: No Charge *Psychological Testing*: No Charge *Physician Inpatient Services*: No Charge *Hospital Services*: $600/day up to 5 days/admission *Residential Care*: $600/day up to 5 days/admission No Charge No Charge $600/day up to 5 days/admission $30/visit *Office Visit*: $30/visit *Outpatient Hospital*: $30/visit *Office Visit*: $30/visit *Outpatient Hospital*: $30/visit	**Non-Participating Provider (You will pay the most)** *Office Visit*: Not Covered *Other Outpatient Services*: Not Covered *Partial Hospitalization*: Not Covered *Psychological Testing*: Not Covered *Physician Inpatient Services:* Not Covered *Hospital Services:* Not Covered *Residential Care:* Not Covered Not Covered Not Covered Not Covered Not Covered *Office Visit*: Not Covered *Outpatient Hospital*: Not Covered *Office Visit*: Not Covered *Outpatient Hospital*: Not Covered	----------None----------

Common Medical Event	Services You May	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Participating Provider (You will pay the least)	Non-Participating Provider (You will pay the most)	
If your child needs dental or eye care	Need Skilled nursing care	*Freestanding SNF*: $300/day *Hospital-based SNF*: $300/day	*Freestanding SNF*: Not Covered *Hospital-based SNF*: Not Covered	Preauthorization is required. Failure to obtain preauthorization may result in non-payment of benefits. Coverage limited to 100 days per member per benefit period.
	Durable medical equipment	50% coinsurance	Not Covered	Preauthorization is required. Failure to obtain preauthorization may result in non-payment of benefits.
	Hospice services	No Charge	Not Covered	Preauthorization is required except for pre-hospice consultation. Failure to obtain preauthorization may result in non-payment of benefits.
	Children's eye exam	No Charge	Not Covered	Coverage limited to one exam per member per calendar year.
	Children's glasses	No Charge	Not Covered	Coverage is limited to one eyeglass frame and eyeglass lenses or contact lenses instead of eyeglasses, up to the benefit per calendar year. The cost listed is for Single Vision.
	Children's dental check-up	No Charge	Not Covered	Coverage for prophylaxis services (cleaning) is limited to once in a six month period.

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 • Long-term care • Private-duty nursing • Routine foot care • Dental care (Adult) • Non-emergency care when traveling outside the U.S. • Routine eye care (Adult) • Weight loss programs • Hearing Aids

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 • Infertility Treatment

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.

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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

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PENDING REGULATORY APPROVAL

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, llam
1-866-346-7198.

Tagalog (Tagalog): Kung kailanganninyo ang libreng tulongsa Tagal
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 1-866-346-7

Navajo (Dine): **Diné k'ehjí doo bąąh ílínígó shika' at'oowoł nínízingo, kwij**
1-866-346-7198.

Vietnamese (Tiếng Việt): Đểđược hỗ trợ miễn phí tiếng Việt, vui lòng gọi
1-866-346-7198.

Korean (한국어): 한국어도움이필요하시면, 1-866-346-7198 무료전화 로전

Armenian (Հայերեն): Հայերենիեզվովանվճարօգնությունստանալուհամա
ենքզանգահարել 1-866-346-7198.

Russian (Русский): если нужна бесплатная помощь на русском я
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**
無料で提供します。

Persian (فارسی): .1-866-346-7198 تماس بگیرید لطفاً با شماره تلفن ،مک رایگان زبان فارسی

Punjabi(ਪੰਜਾਬੀ): 1-866-346-7198 ਤੇ ਮੁਫ਼ਤ ਕਾਲ ਕਰੋ. ਪੰਜਾਬੀ ਵਿਚ ਮਦਦ ਲਈ ਮਿਹਰਬਾਨੀ ਕਰ ਕੇ

Khmer (ភាសាខ្មែរ): 1-866-346-7198.

Arabic(العربية): .1-866-346-7198 اعدة في اللغة العربية مجانا ، تفضل باتصال على هذا الرقم:

Hmong (Hnoob): Xav tau kev pab dawb lub Hmoob, thov hu rau 1-8

Hindi (हिन्दी): हिन्दीमेंबिना खर्च केसहायताकेलिए, 1-866-346-7198 परकॉलकरें।.

Thai (ไทย): 1-866-346-7198.

To see example s 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.

is $1,730

■ **The plan's overall deductible $0 ■ Specialist copayment $55 ■ Hospital (facility) copayment $600 ■ Other copayment $30**

This EXAMPLE event includes services like:
Specialist office visits (*prenatal care)*
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic tests (*ultrasounds and blood work)*
Specialist visit *(anesthesia)*

Total Example Cost $12,800
In this example, Peg would pay:
Cost Sharing
Deductibles $0 Copayments $1,670 Coinsurance $0 *What isn't covered*
Limits or exclusions $60 **The total Peg would pay**

■ **The plan's overall deductible $0 ■ Specialist copayment $55 ■ Hospital (facility) copayment $600 ■ Other copayment $30**

This EXAMPLE event includes services like:
Primary care physician office visits (*including disease education)*
Diagnostic tests *(blood work)*
Prescription drugs
Durable medical equipment *(glucose meter)*

Total Example Cost $7,400
In this example, Joe would pay:
Cost Sharing
Deductibles $0 Copayments $1,580 Coinsurance $860 *What isn't covered*
Limits or exclusions $60 **The total Joe would pay is $2,500**

■ **The plan's overall deductible $0 ■ Specialist copayment $55 ■ Hospital (facility) copayment $600 ■ Other copayment $50**

This EXAMPLE event includes services like:
Emergency room care *(including medical supplies)*
Diagnostic test *(x-ray)*
Durable medical equipment *(crutches)*
Rehabilitation services *(physical therapy)*

Total Example Cost $2,500
In this example, Mia would pay:
Cost Sharing
Deductibles $0 Copayments $400 Coinsurance $40
What isn't covered
Limits or exclusions $0 **The total Mia would pay is $440**

Discrimination is against the law

Blue Shield of California complies with applicable state laws and federal civil rights laws, and does not discriminate on the basis of race, color, national origin, ancestry, religion, sex, marital status, gender, gender identity, sexual orientation, age or disability. Blue Shield of California does not exclude people or treat them differently because of race, color, national origin, ancestry, religion, sex, marital status, gender, gender identity, sexual orientation, age, or disability.

Blue Shield of California:

- Provides aids and services at no cost to people with disabilities to communicate effectively with us such as:
  - Qualified sign language interpreters
  - Written information in other formats (including large print, audio, accessible electronic formats and other formats)
- Provides language services at no cost to people whose primary language is not English such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, contact the Blue Shield of California Civil Rights Coordinator.

If you believe that Blue Shield of California has failed to provide these services or discriminated in another way on the basis of race, color, national origin, ancestry, religion, sex, marital status, gender, gender identity, sexual orientation, age, or disability, you can file a grievance with:

Blue Shield of California
Civil Rights Coordinator
P.O. Box 629007
El Dorado Hills, CA 95762-9007
Phone: (844) 831-4133 (TTY: 711)
Fax: (844) 696-6070

Email: BlueShieldCivilRightsCoordinator@blueshieldca.com

You can file a grievance in person or by mail, fax or email. If you need help filing a grievance, our Civil Rights Coordinator is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at **https://ocrportal.hhs.gov/ocr/portal/lobby.jsf** or by mail or phone at:

U.S. Department of Health and Human Services

200 Independence Avenue SW.

Room 509F, HHH Building

Washington, DC 20201

(800) 368-1019; TTY: (800) 537-7697

Complaint forms are available at **www.hhs.gov/ocr/office/file/index.html.**

Blue Shield of California
50 Beale Street, San Francisco, CA 94105 blueshieldca.com

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

blue of california **Coverage Period: Beginning On or After 1/1/2019** **Gold Trio HMO 0/30 OffEx Coverage for: Individual + Family | Plan Type: HMO**

The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately. This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, visit bsca.com/policies/M0016484_EOC.pdf or call **1-888-319-5999**. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms see the Glossary. You can view the Glossary at healthcare.gov/sbc-glossary or call **1-866-444-3272** to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	**$0.**	See the Common Medical Events chart below for your costs for services this plan covers.
Are there services covered before you meet your deductible?	Yes. Preventive care and services listed in your complete terms of coverage.	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost-sharing and before you meet your deductible. See a list of covered preventive services at healthcare.gov/coverage/preventive-care-benefits.

Are there other deductibles for specific services?	No.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	**$5,750** per individual / **$11,500** per family for participating providers.	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, the overall family out-of-pocket limit must be met.
What is not included in the out-of-pocket limit?	Copayments for certain services, premiums, and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out-of-pocket limit.
Will you pay less if you use a network provider?	Yes. See blueshieldca.com/fap or call **1-888-319-5999** for a list of network providers.	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware, your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist?	Yes.	This plan will pay some or all of the costs to see a specialist for covered services but only if you have a referral before you see the specialist.

All **copayment** and **coinsurance** costs shown in this chart are after your **deductible** has been met, if a **deductible** applies.

Common Medical Event	Services You May Need	What You Will Pay	Limitations, Exceptions, & Other Important Information
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness		Self-referral is available for Trio+ Specialist visits.
	Specialist visit		You may have to pay for services that

		Participating Provider (You will pay the least)	Non-Participating Provider (You will pay the most)	
	Preventive care/screening /immunization	$30/visit	Not Covered	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)	*Trio+ Specialist*: $55/visit *Other Specialist*: $55/visit	Not Covered	Preauthorization is required. Failure to obtain preauthorization may result in non-payment of benefits. The services listed are at a freestanding location.
	Imaging (CT/PET scans, MRIs)	No Charge	Not Covered	Preauthorization is required. Failure to obtain preauthorization may result in non-payment of benefits.
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at blueshieldca.com/formulary	Tier 1	*Lab & Path*: $30/visit *X-Ray & Imaging*: $50/visit *Other Diagnostic Examination*: $50/visit	*Lab & Path*: Not Covered *X-Ray & Imaging*: Not Covered *Other Diagnostic Examination*: Not Covered	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; *Mail Service*: Covers up to a 90-day supply.
	Tier 2	*Outpatient Radiology Center*: $50/visit *Outpatient Hospital*: $250/visit	*Outpatient Radiology Center*: Not Covered *Outpatient Hospital*: Not Covered	
		Retail: Level A: $15/prescription Level B: $20/prescription *Mail Service*: $30/prescription	*Retail*: Not Covered *Mail Service*: Not Covered	
		Retail: Level A: $30/prescription Level B: $50/prescription *Mail Service*: $60/prescription	*Retail*: Not Covered *Mail Service*: Not Covered	

Common Medical Event	Services You May	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Participating Provider (You will pay the least)	Non-Participating Provider (You will pay the most)	
	Need Tier 3	*Retail*: Level A: $50/prescription Level B: $80/prescription *Mail Service*: $100/prescription	*Retail*: Not Covered *Mail Service*: Not Covered	Preauthorization is required. Failure to obtain preauthorization may result in non-payment of benefits. *Retail and Network Specialty Pharmacies*: Covers up to a 30-day supply; Specialty Drugs must be obtained at a Network Specialty Pharmacy. *Mail Service*: Covers up to a 90-day supply.
	Tier 4	*Retail and Network Specialty Pharmacies*: Level A: 20% coinsurance up to $250/prescription Level B: 20% coinsurance up to $250/prescription *Mail Service*: 20% coinsurance up to $500/prescription	*Retail*: Not Covered *Mail Service*: Not Covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	*Ambulatory Surgery Center*: $150/surgery	*Ambulatory Surgery Center*: Not Covered	----------None----------
	Physician/surgeon fees	*Outpatient Hospital*: $300/surgery	*Outpatient Hospital*: Not Covered	---
If you need immediate medical attention	Emergency room care	No Charge	Not Covered	----------None----------
	Emergency medical transportation	*Facility Fee*: $250/visit *Physician Fee*: No Charge	*Facility Fee*: $250/visit *Physician Fee*: No Charge	---
	Urgent care	$100/transport	$100/transport	----------None----------
		Within Plan Service Area: $30/visit *Outside Plan Service Area:* $30/visit	*Within Plan Service Area*: Not Covered *Outside Plan Service Area*: $30/visit	---
If you have a hospital stay	Facility fee (e.g., hospital	$600/day up to 5 days/admission	Not Covered	This payment is for emergency or authorized transport.
	room) Physician/surgeon		Not Covered	----------None----------

	fees	No Charge		Preauthorization is required. Failure to obtain preauthorization may result in non-payment of benefits. ----------None----------

Common Medical Event	Services You May	What You Will Pay	Limitations, Exceptions, & Other Important Information
If you need mental health, behavioral health, or substance abuse services	Need Outpatient services		Preauthorization is required except for office visits, electroconvulsive therapy, and psychological testing. Failure to obtain preauthorization may result in non-payment of benefits.
	Inpatient services		Preauthorization is required. Failure to obtain preauthorization may result in non-payment of benefits.
If you are pregnant	Office visits		----------None----------
	Childbirth/delivery professional services		----------None----------
	Childbirth/delivery facility services		Preauthorization is required. Failure to obtain preauthorization may
	Home health care		

If you need help recovering or have other special health needs	Rehabilitation services Habilitation services	**Participating Provider (You will pay the least)** *Office Visit*: $30/visit *Other Outpatient Services*: No Charge *Partial Hospitalization*: No Charge *Psychological Testing*: No Charge *Physician Inpatient Services*: No Charge *Hospital Services*: $600/day up to 5 days/admission *Residential Care*: $600/day up to 5 days/admission No Charge No Charge $600/day up to 5 days/admission $30/visit *Office Visit*: $30/visit *Outpatient Hospital*: $30/visit *Office Visit*: $30/visit *Outpatient Hospital*: $30/visit	**Non-Participating Provider (You will pay the most)** *Office Visit*: Not Covered *Other Outpatient Services*: Not Covered *Partial Hospitalization*: Not Covered *Psychological Testing*: Not Covered *Physician Inpatient Services:* Not Covered *Hospital Services:* Not Covered *Residential Care:* Not Covered Not Covered Not Covered Not Covered Not Covered *Office Visit*: Not Covered *Outpatient Hospital*: Not Covered *Office Visit*: Not Covered *Outpatient Hospital*: Not Covered	result in non-payment of benefits. Coverage limited to 100 visits per member per calendar year. ----------None----------

Common Medical Event	Services You May	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Participating Provider (You will pay the least)	Non-Participating Provider (You will pay the most)	
If your child needs dental or eye care	Need Skilled nursing care	*Freestanding SNF*: $300/day *Hospital-based SNF*: $300/day	*Freestanding SNF*: Not Covered *Hospital-based SNF*: Not Covered	Preauthorization is required. Failure to obtain preauthorization may result in non-payment of benefits. Coverage limited to 100 days per member per benefit period.
	Durable medical equipment	50% coinsurance	Not Covered	Preauthorization is required. Failure to obtain preauthorization may result in non-payment of benefits.
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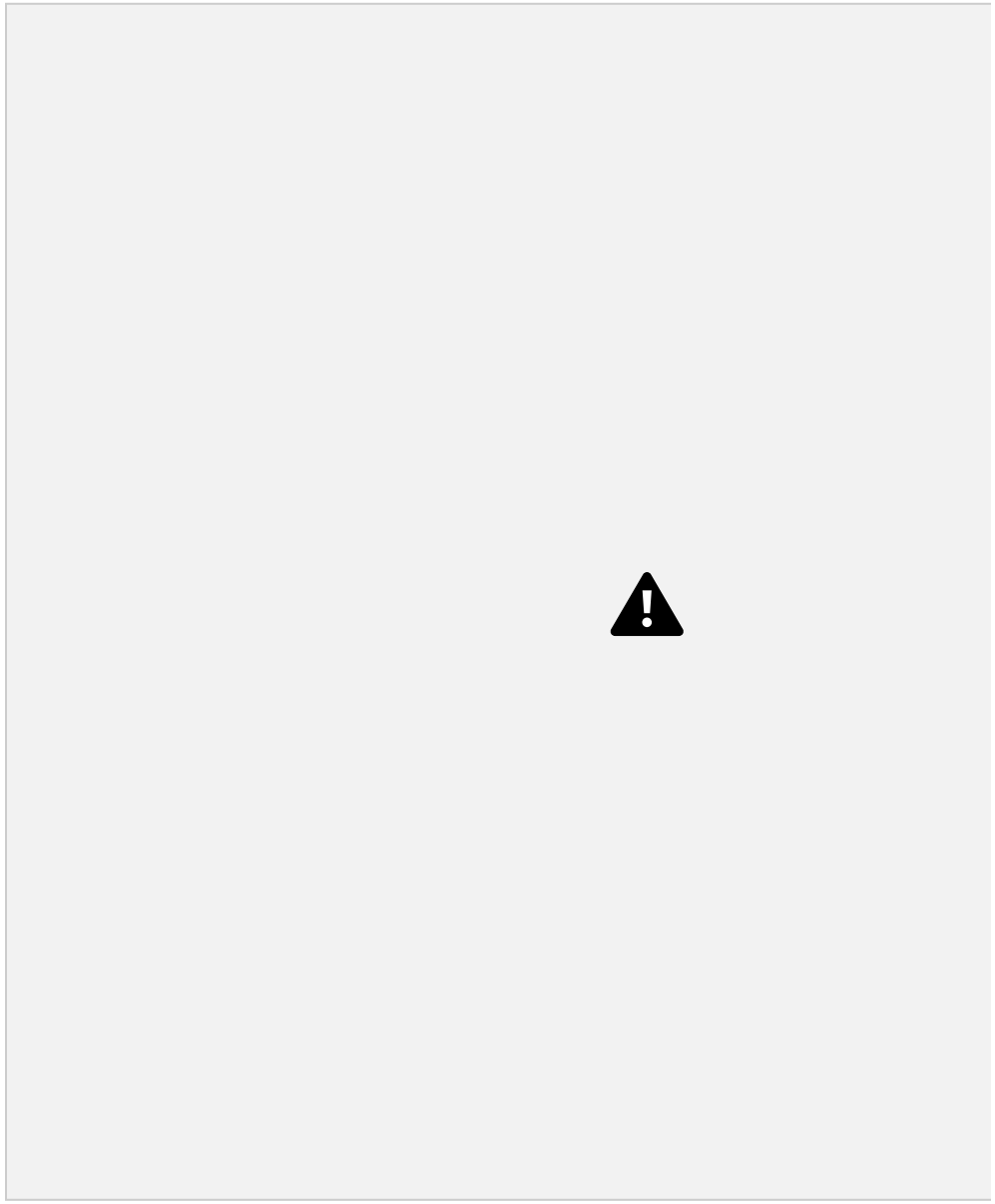
PENDING REGULATORY APPROVAL

Language Access Services:



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

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

PENDING REGULATORY APPROVAL

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is $1,730

■ **The plan's overall deductible $0 ■ Specialist copayment $55 ■ Hospital (facility) copayment $600 ■ Other copayment $30**

This EXAMPLE event includes services like:
Specialist office visits (*prenatal care)*
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Childbirth/Delivery Facility Services
Diagnostic tests (*ultrasounds and blood work)*
Specialist visit *(anesthesia)*

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In this example, Peg would pay:
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Deductibles $0 Copayments $1,670 Coinsurance $0 *What isn't covered*
Limits or exclusions $60 **The total Peg would pay**

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Primary care physician office visits (*including disease education)*
Diagnostic tests *(blood work)*
Prescription drugs
Durable medical equipment *(glucose meter)*

Total Example Cost $7,400
In this example, Joe would pay:
Cost Sharing
Deductibles $0 Copayments $1,580 Coinsurance $860 *What isn't covered*
Limits or exclusions $60 **The total Joe would pay is $2,500**

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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
In this example, Mia would pay:
Cost Sharing
Deductibles $0 Copayments $400 Coinsurance $40
What isn't covered
Limits or exclusions $0 **The total Mia would pay is $440**

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

PENDING REGULATORY APPROVAL

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

Notice Informing Individuals about Nondiscrimination and Accessibility Requirements

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  - Written information in other formats (including large print, audio, accessible electronic formats and other formats)
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  - Information written in other languages

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Blue Shield of California
Civil Rights Coordinator
P.O. Box 629007
El Dorado Hills, CA 95762-9007
Phone: (844) 831-4133 (TTY: 711)
Fax: (844) 696-6070

Email: BlueShieldCivilRightsCoordinator@blueshieldca.com

You can file a grievance in person or by mail, fax or email. If you need help filing a grievance, our Civil Rights Coordinator is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at **https://ocrportal.hhs.gov/ocr/portal/lobby.jsf** or by mail or phone at:

U.S. Department of Health and Human Services

200 Independence Avenue SW.

Room 509F, HHH Building

Washington, DC 20201

(800) 368-1019; TTY: (800) 537-7697

Complaint forms are available at **www.hhs.gov/ocr/office/file/index.html.**

Blue Shield of California
50 Beale Street, San Francisco, CA 94105 blueshieldca.com

BENEFITS SUMMARY

VSP Choice Plan #2

EXAM EVERY LENSES EVERY FRAMES EVERY

Choice Network: 31,000 preferred providers | 57,000 access points

12 months

12 months

12 months

CONTACTS (IN LIEU OF GLASSES) 12 months

COPAYMENTS

EXAM

$10

MATERIALS

$10

CONTACT LENS FITTING & EVALUATION

15% discount
(not to exceed $60)

IN NETWORK ALLOWANCES

RETAIL FRAM VALUE 1,2,3

$150 / 20% off overage $150

ELECTIVE CONTACT LENSES

Low Vision & Polycarbonate for Children

COVERED LENS OPTIONS

VALUE ADDED PROGRAMS

DIABETIC EYECARE PLUS PROGRAM

HEARING AID DISCOUNTS

EYE HEALTH MANAGEMENT

DIABETIC EXAM REMINDER LETTERS

OUT-OF-NETWORK ALLOWANCES

EXAMINATION, up to

SINGLE VISION LENSES, up to

BIFOCAL LENSES, up to

TRIFOCAL LENSES, up to

Included Included Included Included

$45

$30

$50

$65

LENTICULAR LENSES, up to $100

FRAMES, up to $70

ELECTIVE CONTACT LENSES, up to

$105

NECESSARY CONTACT LENSES, up to $210

EXTRA DISCOUNTS & SAVINGS

LENS ENHANCEMENTS	Most popular are covered with a copay, saving an average 20-25%
ADDITIONAL PAIR OF GLASSES	20% off
SUNGLASSES	20% off
LASER VISION CORRECTION (LVC)	15% discount avg.

WHY BEAM

DENTAL BENEFITS SUMMARY

SmartPremium Plus **PLAN:** 100/80/50/50-1500/1500a

Beam is the future of group dental insurance for employers large and small. We're pairing innovative

tech with personal service to deliver an insurance experience unlike any other.

No waiting periods

90th Percentile UCR OON

Digital implementation and admin

BEAM PERKS INCLUDED

Everything needed for great dental care delivered right to member's doors every 6 months.

Beam Brush
Sonic powered, smart, electric toothbrush.

Replacement heads
Soft bristle brush heads made specifically for your brush.

Beam Paste
High-quality, custom formulated toothpaste.

Beam Floss
50 yards of high quality ribbon floss.

QUESTIONS?

We'd love to help! Or visit app.beam.dental and login to view more info.

No downgrades on composites

Nationwide network

Beam Perks included

3 colors available!

Please check your Certificate of Insurance for a description of coverage, limitations, and exclusions under the plan.

Some Services require prior authorization.

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PLAN COVERAGE PREVENTIVE & DIAGNOSTIC

IN-NETWORK OUT-OF-NETWORK (PPO FEE) (90TH PERCENTILE UCR)

maintainers, x-rays, and sealants 100% 100% **Diagnostic and preventive:** exams, cleanings, fluoride, space

BASIC
Minor restorative: fillings
Prosthetic maintenance: relines and repairs to bridges, implants, and dentures
Emergency palliative treatment: to temporarily relieve pain
Endodontics: root canals
Periodontics: to treat gum disease
Oral surgery: extractions and dental surgery

ORTHODONTIA

80% 80% 50% 50%

MAJOR
Major restorative: crowns, inlays, and onlays
Prosthodontics: dentures
Prosthetics: bridges
Implants:

Child Orthodontics: braces with age limit of 19 50% 50% **Adult Orthodontics:** braces over the age of 19

PLAN MAXES

Annual maximum applies to diagnostic & preventive, basic services, and major services. Lifetime maximum applies to orthodontic services.
Annual Max based on Calendar Year.

Benefit Period: Calendar Year $1,500 /yr **ANNUAL MAX**

ORTHO LIFETIME MAX $1,500 /lifetime

PLAN DEDUCTIBLE

The deductible is waived for diagnostic & preventive services.

INDIVIDUAL $50.00 /yr **FAMILY** $150.00 /yr

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FREQUENCIES & LIMITATIONS COVERAGE RULES

CODE
D1110
D0120
D0140
D0150
D0210
D0220, 0230 D0270 - 0277 D0330
D1206, 1208 D1351, 1352 D2390 - 2394 D3330
D4341, 4346 D4355
D4381
D4910
D5110, 5120… D6010, 6056… D2740, 2950… D7140
D7953
D9110
D9223, 9243 D9310
D9940
D0431

PROCEDURE
Prophylaxis
Periodic oral exam
Limited oral exam
Comprehensive oral exam Radiographs – FMX
Radiographs – periapical
Radiographs – bitewings
Radiographs – panoramic Fluoride
Sealants
Fillings

Root canal *(N, X2)*

Periodontal root planing *(N, P, X)* Full mouth debridement *(N)* Localized antimicrobial delivery *(P, H)* Periodontal maintenance *(H)* Dentures *(N, X, A)*

Implants *(N, X)*

Crowns *(N, X, A)*

Simple extractions

Bone replacement graft *(N, X)* Emergency palliative treatment *(N)* General anesthesia *(N)*

Consultation

Occlusal mouthguards *(N)* Cancer screening

COVERED UNDER Preventive

Preventive

Preventive

Preventive

Preventive

Preventive

Preventive

Preventive

Preventive

Preventive

Minor Restorative Endodontics

Periodontics

Preventive

Periodontics

Periodontics

Major

Major

Major

Minor Restorative Oral surgery

Emergency Palliative Emergency Palliative Preventive

Periodontics

Preventive

FREQUENCY

Two per benefit period

Two per benefit period

Two per 12 months

One per 60 months per location One per 60 months

One per 6 months per location Every 6 months, to the date One per 60 months

One per 12 months

One per 48 months

One per 24 months, per surface One per lifetime, same tooth One per 24 months, per quadrant Once per lifetime

One per 24 months, per tooth One per 90 days

One per 60 months

One per 60 months

One per 60 months

No frequency restrictions One per 60 months

Three per 12 months

No frequency restrictions Two per 12 months per location One per 60 months

One per benefit period

NOTES

Shared frequency with D4910

No shared frequency with D0140

Can do treatment on same day

Shared frequency with D0160

Shared frequency with D0330, D0274

Can perform 6 months after D0210

Shared frequency with D0210

Covered through age 16

Covered through age 16, 1st & 2nd permanent molar s No downgrades on posterior composite

Can perform all 4 quads in one day, shared freq with D111 0 No exams within 5 days

Can perform 6 weeks after D4341

Shared frequency with D1110, covered 90 days after D434 1 Paid on seat date, not prep date

Paid on seat date, not prep date

No downgrades; build-up is covered separately

Only covered in conjunction with an implant Only medically necessary x-rays same day No tooth-specific guidelines

Can do treatment same day

For bruxism only

No age limit

Not covered: D0350, D0364, D0470, D1330, D1525, D2962, D3110, D3120, D8093, D9230, D9248

FREQUENTLY ASKED QUESTIONS

Continuation of service?

Coordination of benefits?

Wisdom tooth coverage?

Frequency of ortho payments?

Are prior extractions covered?

Timely filling limit?

REQUIRED DOCUMENTATION

Is pre-authorization mandatory?

CLAIMS

INFORMATION

Covered starting on patient's effective date

Standard – earlier effective date is primary

Send to medical first, then covered by Beam

Monthly – need claims for on-going treatment Yes – no missing tooth clause

Yes – 12 months from date of service No – but recommended for $300+ claims

N = Narrative of medical necessity

P = Perio charting

X = Dated, pre-op x-rays

X2 = Dated, pre-op and post-op x-rays

H = Periodontal history

A = Age of existing prosthetics, if applicable

Beam Insurance

Administrators PO Box 75372 form 2006 or later
Cincinnati, OH 45275
Electronic payer ID BEAM1
Fax number 844 688 4821
Phone number (800) 648-1179
Claim form accepted ADA

Beam Dental PPO Standard coverages, as of August 1, 2018