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[redacted]

Summary of Coverage: What this Plan Covers & What it Costs

Policy Period: 1/1/2012 – 12/31/2012
Coverage for: <all contract types>| **Plan Type:** [redacted]

This is not a policy. You can get the policy at [redacted] or by calling 1-800-XXX-XXXX.
A policy has more detail about how to use the plan and what you and your insurer must do. It also has more detail about your coverage and costs.

Important Questions	Answers	Why this Matters:
What is the premium?	Please contact your employer for your share of the premium amount.	The premium is the amount paid for health insurance.
What is the overall deductible?	**$1,500** per member per calendar year for Basic [redacted]; **$0** per member per calendar year for Benefits from ACO Provider in [redacted]; **$1,500** per member per calendar year combined for preferred and non-preferred providers in [redacted]; **$0** per member per calendar year for [redacted]	You must pay all the costs up to the deductible amount before this health insurance plan begins to pay for covered services you use. Check your policy 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 deductibles for specific services?	Yes; **$75** for brand name prescriptions per member per calendar year for Basic [redacted] and Main [redacted]; **$500** for facility services for ACO provider tier in Main [redacted] per member per calendar year.	You must pay all of the costs for these services up to the specific deductible amount before this plan begins to pay for these services.
Is there an out-of-pocket limit on my expenses?	Yes; **$7,000** per member per calendar year for Basic [redacted] preferred providers; **$10,000** per member per calendar year for Basic [redacted] non-preferred providers; **$1,500** per member per calendar year for Main [redacted] ACO providers; ; **$7,000** per member per calendar year for Main [redacted] preferred providers; **$10,000** per member per calendar year for Main [redacted] non-preferred providers; **$1,000** per member per calendar year for [redacted]	The out-of-pocket limit is the most you could pay during a policy period for your share of the cost of covered services. This limit helps you plan for health care expenses.
What is not included in the out-of-pocket limit?	Deductibles, premium, balance-billed charges, prescription drugs, and health care this plan does not cover.	Even though you pay these expenses, they don't count toward the out-of-pocket limit. So, a longer list of expenses means you have less coverage.

Questions: Call 1-800-XXX-XXXX or visit us at [redacted].
If you aren't clear about any of the terms used in this form, see the Glossary at [redacted].

[redacted]
Summary of Coverage: What this Plan Covers & What it Costs

Policy Period: 1/1/2012 – 12/31/2012
Coverage for: <all contract types>| **Plan Type:** [redacted]

Important Questions	Answers	Why this Matters:
Is there an overall annual limit on what the insurer pays?	Yes; **$10,000** per member per calendar year combined for benefits under Main [redacted] preferred and non-preferred providers	This plan will pay for covered services only up to this limit during each policy period, even if your own need is greater. You're responsible for all expenses above this limit. The chart on page 2 describes *specific* coverage limits such as limits on the number of office visits.
Does this plan use a network of providers?	Yes, this plan uses [redacted] Providers for [redacted]; an ACO network for the first tier of coverage for Main [redacted]; as well as a Preferred Provider network for both Basic [redacted] and Main [redacted]. You may use health care providers that aren't preferred providers for both Main [redacted] and Basic [redacted], but you may pay more. For a list of participating providers, see www.[redacted]. *Exception statement about "Other Providers".* Please be aware that preferred providers will sometimes use non-preferred specialists.	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. Plans use the term in-network, preferred, or participating for providers in their network.
Do I need a referral to see a specialist?	Yes. A written referral is may be needed to see a specialist for ACO provider plan benefits with Main [redacted] and one is needed to so a specialist in [redacted]. An exception exists allowing for a woman to self-refer to an OB/GYN or family practice physician in her personal physician's medical group or IPA for OB/GYN services. You don't need a referral to see a specialist for preferred and non-preferred provider benefits in Basic [redacted] and Main [redacted].	This plan will pay some or all of the costs to see a specialist but only if you have the plan's permission before you see the specialist for covered services.
Are there services this plan doesn't cover?	Yes.	Some of the services this plan doesn't cover are listed in the "Excluded Services & Other Covered Services" section.

Questions: Call 1-800-XXX-XXXX or visit us at [redacted].
If you aren't clear about any of the terms used in this form, see the Glossary at [redacted].

[redacted]

Summary of Coverage: What this Plan Covers & What it Costs

Policy Period: 1/1/2012 – 12/31/2012

Coverage for: <all contract types>| **Plan Type:** [redacted]

- Co-payments are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.
- Co-insurance is *your* share of the costs of a covered service, calculated as a percent of the allowed amount for the service. You pay this plus any deductible amounts you owe under this health insurance plan. For example, if the health plan's allowed amount for an overnight hospital stay is $1,000 and you've met your deductible, your co-insurance payment of 20% would be $200. If you haven't met any of the deductible and it's at least $1,000, you would pay the full cost of the hospital stay.
- The plan's payment 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 ACO, Patient-centered medical home or preferred providers by charging you lower deductibles, co-payments and co-insurance amounts.

Common Medical Event	Services You May Need [redacted]	Your cost if you use a							Limitations & Exceptions
		Basic [redacted]		Main [redacted]			Care+ [redacted]		
		Preferred Provider	Non-Preferred Provider	ACO Provider	Preferred Provider	Non-Preferred Provider	Patient - Centered Medical Home	Non-Preferred Provider	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$45 co-pay/ visit	50% co-insurance	$20 co-pay/ visit	$45 co-pay/ visit	50% coinsurance	$0	Not covered	Preferred provider co-pay is not subject to the calendar year deductible
	Specialist visit	$45 co-pay/ visit	50% co-insurance	$20 copay/ visit with referral; $30 co-pay/ visit with Access+ Specialist	$45 co-pay/ visit	50% coinsurance	$0	Not covered	Preferred provider co-pay is not subject to the calendar year deductible
	Other practitioner office visit	$0	Not covered	Not covered	$0	Not covered	Not covered	Not covered	----------none----------
	Preventive care/screening/immunization	$0	Not Covered	$0	Not covered	Not covered	$0	Not covered	----------none----------
If you have a test	Diagnostic test (x-ray, blood work)	$45 co-pay/ visit	50% coinsurance	$0	30% co-insurance	50% coinsurance	$0	Not covered	----------none----------
	Imaging (CT/PET scans, MRIs)	$100 co-pay/ visit plus 30%	50% co-insurance	$0	30% co-insurance	50% coinsurance	$0	Not covered	Prior authorization required

Questions: Call 1-800-XXX-XXXX or visit us at [redacted]

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[redacted]

Summary of Coverage: What this Plan Covers & What it Costs

Policy Period: 1/1/2012 – 12/31/2012

Coverage for: <all contract types>| **Plan Type:** [redacted]

Common Medical Event	Services You May Need	Your cost if you use a							Limitations & Exceptions
		Basic [redacted]		Main [redacted]			Care+ [redacted]		
		Preferred Provider	Non-Preferred Provider	ACO Provider	Preferred Provider	Non-Preferred Provider	Patient-Centered Medical Home	Non-Preferred Provider	
If you need drugs to treat your illness or condition More information about drug coverage is at www.insurancecompany.com/prescriptions.	Generic drugs	$10 co-pay (retail); $15co-pay (mail order)	Not covered	$10 co-pay (retail); $15co-pay (mail order)		Not covered	$10 co-pay (retail); $15 co-pay (mail order) for non-selected chronic conditions; $5 co-pay (retail); $7.50 co-pay (mail order) for selected chronic conditions	Not covered	Covers up to a 30-day supply (retail prescriptions); up to a 90-day supply (mail order prescriptions)
	Preferred brand drugs	$40 co-pay (retail); $100 co-pay (mail order)	Not covered	$40 co-pay (retail); $100 co-pay (mail order)		Not covered	$40 co-pay (retail); $100 co-pay (mail order) for non-selected chronic conditions; $20 co-pay (retail); $50 co-pay (mail order)	Not covered	Covers up to a 30-day supply (retail prescriptions); up to a 90-day supply (mail order prescriptions) Selected formulary and non-formulary drugs require prior authorization. If generic drug equivalent is available, member

Questions: Call 1-800-XXX-XXXX or visit us at [redacted].

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						for selected chronic conditions		pays the generic copay plus the difference in cost to [redacted] between the generic and brand.
	Non-preferred brand drugs	$50 co-pay or 30% co-insurance up to $100 co-pay maximum / prescription (retail); $125 co-pay or 30% co-insurance up to $250 co-pay maximum / prescription (mail order);	Not covered	$30 co-pay or 30% co-insurance up to $100 co-pay maximum / prescription (retail); $75 co-pay or 30% co-insurance up to $250 co-pay maximum / prescription (mail order);	Not covered	$50 co-pay or 30% co-insurance up to $100 co-pay maximum / prescription (retail); $125 co-pay or 30% co-insurance up to $250 co-pay maximum / prescription (mail order) for non-selected chronic conditions; $45 co-pay or 25% co-insurance up to $80 co-pay maximum / prescription (retail); $100 co-pay	Not covered	Covers up to a 30-day supply (retail prescriptions); up to a 90-day supply (mail order prescriptions) Selected formulary and non-formulary drugs require prior authorization.

						or 25% co-insurance up to $200 co-pay maximum / prescription (mail order) for selected chronic conditions;		
	Specialty drugs (e.g., chemotherapy)	20% co-insurance up to $150 max	Not covered	20% co-insurance up to $150 max	Not covered	20% co-insurance up to $150 max	Not covered	Specialty-drugs are covered only when dispensed by select pharmacies in the Specialty Pharmacy Network unless Medically Necessary for a covered emergency

[redacted] Blue Shield of California's Blue Groove

Summary of Coverage: What this Plan Covers & What it Costs

Policy Period: 1/1/2012 – 12/31/2012

Coverage for: <all contract types>| **Plan Type:** [redacted] Blue Groove

Common Medical Event	Services You May Need	Your cost if you use a							Limitations & Exceptions
		Basic [redacted]		Main [redacted]			Care+ [redacted]		
		Preferred Provider	Non-Preferred Provider	ACO Provider	Preferred Provider	Non-Preferred Provider	Patient-Centered Medical Home	Non-Preferred Provider	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	30% co-insurance	50% co-insurance	$75 co-pay/ surgery at ambulatory surgery center; $150 co-pay/ surgery at hospital	30% co-insurance	50% co-insurance	$75 co-pay/ surgery at ambulatory surgery center; $150 co-pay/ surgery at hospital	Not covered	ACO Main [redacted] benefit subject to facility deductible
	Physician/surgeon fees	30% co-insurance	50% co-insurance	$0	30% co-insurance	50% co-insurance	$0	Not covered	----none-----
If you need immediate medical attention	Emergency room services	$100 co-pay/ visit + 30% co-insurance	$100 co-pay/ visit + 30% co-insurance	$100 co-pay/ visit	$100 co-pay/ visit	$100 co-pay/ visit	$100 co-pay/ visit	$100 co-pay/ visit	----none-----
	Emergency medical transportation	30% co-insurance	30% co-insurance	$50 co-pay	$50 co-pay	$50 co-pay	$0	$0	----none-----
	Urgent care	$45 co-pay/ visit	50% co-insurance	$20 co-pay/ visit	$45 co-pay/ visit	50% co-insurance	$0	Not covered	Not covered for ACO or patient-centered medical home benefits if care is not provided by or referred by your personal physician
If you have a hospital stay	Facility fee (e.g., hospital room)	30% co-insurance	50% co-insurance	$250 co-pay /admission	30% co-insurance	50% co-insurance	$250 co-pay /admission	Not covered	ACO Main [redacted] benefit subject to facility deductible
	Physician/surgeon fee	30% co-insurance	50% co-insurance	$0	30% co-insurance	50% co-insurance	$0	Not covered	----none-----

Questions: Call 1-800-XXX-XXXX or visit us at [redacted].

If you aren't clear about any of the terms used in this form, see the Glossary at [redacted]

[redacted]

Summary of Coverage: What this Plan Covers & What it Costs

Policy Period: 1/1/2012 – 12/31/2012

Coverage for: <all contract types>| **Plan Type:** [redacted]

Common Medical Event	Services You May Need	Your cost if you use a							Limitations & Exceptions
		Basic [redacted]		Main [redacted]			Care+ [redacted]		
		Preferred Provider	Non-Preferred Provider	ACO Provider	Preferred Provider	Non-Preferred Provider	Patient - Centered Medical Home	Non-Preferred Provider	
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	$45 co-pay/ visit	50% co-insurance	$20 co-pay/ visit for MHSA provider		50% coinsurance	$0	Not covered	Preferred provider co-pay is not subject to the calendar year deductible
	Mental/Behavioral health inpatient services	30% co-insurance	50% co-insurance	$250 co-pay /admission		50% coinsurance	$250 co-pay /admission	Not covered	ACO Main [redacted] benefit subject to facility deductible
	Substance use disorder outpatient services	Not covered	Not covered	Not covered	Not covered	Not covered	Not covered	Not covered	----none-----
	Substance use disorder inpatient services	Not covered	Not covered	Not covered	Not covered	Not covered	Not covered	Not covered	----none-----
If you become pregnant	Prenatal and postnatal care	30% co-insurance	50% co-insurance	$0	30% co-insurance	50% co-insurance	$0	Not covered	----none-----
	Delivery and all inpatient services	30% co-insurance	50% co-insurance	$250 co-pay /admission	30% co-insurance	50% co-insurance	$250 co-pay /admission	Not covered	ACO Main [redacted] benefit subject to facility deductible

Questions: Call 1-800-XXX-XXXX or visit us at [redacted]

If you aren't clear about any of the terms used in this form, see the Glossary at [redacted]

[redacted]

Summary of Coverage: What this Plan Covers & What it Costs

Policy Period: 1/1/2012 – 12/31/2012

Coverage for: <all contract types>| **Plan Type:** [redacted]

Common Medical Event	Services You May Need	Your cost if you use a							Limitations & Exceptions
		Basic [redacted]		Main [redacted]			Care+ [redacted]		
		Preferred Provider	Non-Preferred Provider	ACO Provider	Preferred Provider	Non-Preferred Provider	Patient-Centered Medical Home	Non-Preferred Provider	
If you have a recovery or other special health need	Home health care	30% co-insurance	Not covered	$20 co-pay/ visit	30% co-insurance	Not covered	$0	Not covered	Limited to 100 visits per calendar year
	Rehabilitation services	$45 co-pay/ visit	50% co-insurance	$20 co-pay/ visit	$45 co-pay/ visit	50% co-insurance	$0	Not covered	----none-----
	Habilitation services	$45 co-pay/ visit	50% co-insurance	$20 co-pay/ visit	$45 co-pay/ visit	50% co-insurance	$0	Not covered	Up to 30 visits per year combined for Main [redacted] preferred and non-preferred provider
	Skilled nursing care	30% co-insurance	30% co-insurance at free-standing skilled nursing facility; 50% co-insurance at skilled nursing unit of a hospital	$100 co-pay / day	30% co-insurance	30% co-insurance at free-standing skilled nursing facility; 50% co-insurance at skilled nursing unit of a hospital	$100 co-pay / day	Not covered	Requires prior-authorization; limited to 100 days per calendar year
	Durable medical equipment	50% co-insurance	50% co-insurance	50% co-insurance	50% co-insurance	50% co-insurance	$0 for osteo-arthritis devices; 20% for other DME	Not covered	----none-----
	Hospital service	30% co-insurance	50% co-insurance	$250 co-pay /admission	30% co-insurance	50% co-insurance	$250 co-pay /admission	Not covered	ACO Main [redacted] benefit subject to

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[redacted]

Policy Period: 1/1/2012 – 12/31/2012

Summary of Coverage: What this Plan Covers & What it Costs

Coverage for: <all contract types>| **Plan Type:** [redacted]

Common Medical Event	Services You May Need	Your cost if you use a							Limitations & Exceptions
		Basic [redacted]		Main [redacted]			Care+ [redacted]		
		Preferred Provider	Non-Preferred Provider	ACO Provider	Preferred Provider	Non-Preferred Provider	Patient - Centered Medical Home	Non-Preferred Provider	
If your child needs dental or eye care	Eye exam	Not covered	Not covered	Not covered	Not covered	Not covered	Not covered	Not covered	----none-----
	Glasses	Not covered	Not covered	Not covered	Not covered	Not covered	Not covered	Not covered	----none-----
	Dental check-up	Not covered	Not covered	Not covered	Not covered	Not covered	Not covered	Not covered	----none-----

Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy for others.)

- Non-emergency care when traveling outside the U.S.
- Cosmetic surgery
- Dental care
- Eye glasses
- Long-term care
- Private-duty nursing
- Routine eye care
- Acupuncture
- Substance abuse treatment
- Routine foot care
- Routine hearing test
- Weight loss programs
- Hearing aids

Other Covered Services (This isn't a complete list. Check your policy for other covered services and your costs for these services.)

- Bariatric surgery
- Infertility treatments (diagnosis and treatment of causes)

Your Rights to Continue Coverage:

You can keep this insurance as long as you pay your premium unless one or more of the following happens:

- you commit fraud
- the insurer stops offering services in the state
- you move outside the coverage area

Questions: Call 1-800-XXX-XXXX or visit us at [redacted]

If you aren't clear about any of the terms used in this form, see the Glossary at [redacted]

Your Grievance and Appeals Rights:

- A grievance is a complaint you have about your health insurer or plan. You have the right to file a written complaint to express your
- dissatisfaction or denial of coverage for claims under this health insurance. Call 1-800-XXX-XXXX or visit www. Xxxxxxxxxxxxx.com.
- An appeal is a request for your health insurer or plan to review a decision or a grievance again. For more information on the appeals process, call

your state office of health insurance customer assistance at: 1-800-XXX-XXXX or visit www. Xxxxxxxxxxxxxx.gov.

To see examples of how this plan might cover costs for a sample medical situation, see the next page.

PAGE RESERVED FOR COVERAGE EXAMPLES

PAGE RESERVED FOR COVERAGE EXAMPLES INFORMATION