



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, call 1-800-267-3232. 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 [www.dol.gov/ebsa/healthreform](http://www.dol.gov/ebsa/healthreform) or call 1-800-267-3232 to request a copy.

Important Questions	Answers	Why This Matters
<b>What is the overall <a href="#">deductible</a>?</b>	\$250/individual; \$500/family	Generally, you must pay all of the costs from <a href="#">providers</a> up to the <a href="#">deductible</a> amount before this <a href="#">plan</a> begins to pay. If you have other family members on the <a href="#">plan</a> , each family member must meet their own individual <a href="#">deductible</a> until the total amount of <a href="#">deductible</a> expenses paid by all family members meets the overall family <a href="#">deductible</a> .
<b>Are there services covered before you meet your <a href="#">deductible</a>?</b>	Yes. In-network <a href="#">preventive care</a> , in-network office visits, and outpatient <a href="#">prescription drugs</a> are covered before you meet your <a href="#">deductible</a> .	This <a href="#">plan</a> covers some items and services even if you haven't yet met the <a href="#">deductible</a> amount. But a <a href="#">copayment</a> or <a href="#">coinsurance</a> may apply. For example, this <a href="#">plan</a> covers certain <a href="#">preventive services</a> without <a href="#">cost-sharing</a> and before you meet your <a href="#">deductible</a> . See a list of covered <a href="#">preventive services</a> at <a href="https://www.healthcare.gov/coverage/preventive-care-benefits/">https://www.healthcare.gov/coverage/preventive-care-benefits/</a> .
<b>Are there other <a href="#">deductibles</a> for specific services?</b>	No.	You don't have to meet <a href="#">deductibles</a> for specific services.
<b>What is the <a href="#">out-of-pocket limit</a> for this <a href="#">plan</a>?</b>	For <a href="#">medical</a> expenses: <a href="#">In-network-providers</a> : \$4,000/individual; \$8,000/family. <a href="#">Out-of-network providers</a> : \$8,000/individual; \$16,000/family. For <a href="#">prescription drug</a> expenses: \$2,350/individual; \$4,700/family.	The <a href="#">out-of-pocket limit</a> is the most you could pay in a year for covered services. If you have other family members in this <a href="#">plan</a> , they have to meet their own <a href="#">out-of-pocket limits</a> until the overall family <a href="#">out-of-pocket limit</a> has been met.
<b>What is not included in the <a href="#">out-of-pocket limit</a>?</b>	<a href="#">Premiums</a> , <a href="#">balance-billed</a> charges, and services this <a href="#">plan</a> does not cover do not count toward the <a href="#">out-of-pocket limit</a> .	Even though you pay these expenses, they don't count toward the <a href="#">out-of-pocket limit</a> .
<b>Will you pay less if you use a <a href="#">network provider</a>?</b>	Yes. For a list of <a href="#">in-network providers</a> , see <a href="http://www.bluecrossca.com">www.bluecrossca.com</a> or call the Administrative Office at 1-800-267-3232. For a list of in-network substance abuse <a href="#">providers</a> , call the Administrative Office at 1-800-267-3232. For more information on the Teamsters' Assistance Program ("TAP") visit <a href="http://www.tap-program.org">www.tap-program.org</a> , or call TAP at 510-562-3600 (1-800-253-8326 if outside the SF Bay Area).	This <a href="#">plan</a> uses a <a href="#">provider network</a> . You will pay less if you use a <a href="#">provider</a> in the <a href="#">plan's</a> network. You will pay the most if you use an <a href="#">out-of-network provider</a> , and you might receive a bill from a <a href="#">provider</a> for the difference between the <a href="#">provider's</a> charge and what your <a href="#">plan</a> pays ( <a href="#">balance billing</a> ). Be aware your <a href="#">network provider</a> might use an <a href="#">out-of-network provider</a> for some services (such as lab work). Check with your <a href="#">provider</a> before you get services.
<b>Do you need a <a href="#">referral</a> to see a <a href="#">specialist</a>?</b>	No.	You can see the <a href="#">specialist</a> you choose without a <a href="#">referral</a> .



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
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
<b>If you visit a health care <a href="#">provider's</a> office or clinic</b>	<a href="#">Primary care</a> visit to treat an injury or illness	\$20 <a href="#">copayment</a> /office visit	40% <a href="#">coinsurance</a>	Services must be <a href="#">medically necessary</a> and are subject to <a href="#">plan</a> limitations. Chiropractor/Acupuncture: this <a href="#">plan</a> covers up to 20 visits/year without <a href="#">preauthorization</a> . <a href="#">Preauthorization</a> is required after 20 visits.  <a href="#">Plan</a> covers <a href="#">preventive services</a> and supplies required by the Health Reform law. Age and frequency guidelines apply to covered <a href="#">preventive care</a> . You may have to pay for services that aren't <a href="#">preventive</a> . Ask your <a href="#">provider</a> if the services you need are <a href="#">preventive</a> . Then check what your <a href="#">plan</a> will pay for.
	<a href="#">Specialist</a> visit	\$20 <a href="#">copayment</a> /office visit Chiropractor/Acupuncture: 20% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	
	<a href="#">Preventive care/screening/immunization</a>	No charge <a href="#">Deductible</a> does not apply	Not covered	
<b>If you have a test</b>	<a href="#">Diagnostic test</a> (x-ray, blood work)	20% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	None
	Imaging (CT/PET scans, MRIs)	20% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	None
<b>If you need drugs to treat your illness or condition</b>  More information about <a href="#">prescription drug coverage</a> is available at <a href="http://www.optum.com">www.optum.com</a> or 1-800-788-7871.	Generic drugs	Retail Pharmacy for 34-day supply: \$10 <a href="#">copayment</a> ; Mail Order for 90-day supply: \$20 <a href="#">copayment</a> . Prescription contraceptives: No charge for generic drugs.	Not covered (unless you enrolled in the <a href="#">plan</a> in the last 90 days or are out of the country)	If the cost of the drug is less than the <a href="#">copayment</a> , you pay just the drug cost.  Certain drugs may be subject to: OptumRx vigilant drug lists; OptumRx comprehensive utilization management; OptumRx compound management; Exclusive Specialty with BriovaRx; OptumRx home delivery; OptumRx clinical safety programs; Gaps in care Rx monitor.
	Preferred brand drugs ( <a href="#">formulary</a> )	Retail Pharmacy for 34-day supply: \$25 <a href="#">copayment</a> ; Mail Order for 90-day supply: \$50 <a href="#">copayment</a> . Prescription contraceptives: No charge for brand drug if generic drug is medically inappropriate.		

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
	Non-preferred brand drugs (non-formulary)	Retail Pharmacy for 34-day supply: \$50 <u>copayment</u> ; Mail Order for 90-day supply: \$100 <u>copayment</u> .		<u>Specialty drugs</u> must be filled through BriovaRx.
	<u>Specialty drugs</u>	Mail Order: \$20 <u>copayment</u> generic; \$50 <u>copayment</u> preferred brand; \$100 <u>copayment</u> non-preferred brand.	Not covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% <u>coinsurance</u>	40% <u>coinsurance</u>	None
	Physician/surgeon fees	20% <u>coinsurance</u>	40% <u>coinsurance</u>	None
If you need immediate medical attention	<u>Emergency room care</u>	No charge first \$1,000, then 20% <u>coinsurance</u> ( <u>Deductible</u> does not apply)		Only applicable to medical emergencies
	<u>Emergency medical transportation</u>	20% <u>coinsurance</u>	40% <u>coinsurance</u>	None
	<u>Urgent care</u>	No charge first \$1,000, then 20% <u>coinsurance</u> ( <u>Deductible</u> does not apply)	No charge first \$1,000, then 40% <u>coinsurance</u> ( <u>Deductible</u> does not apply)	None
If you have a hospital stay	Facility fee (e.g., hospital room)	20% <u>coinsurance</u>	40% <u>coinsurance</u>	Elective hospital admissions must be <u>preauthorized</u> . Any days not <u>preauthorized</u> are not covered.
	Physician/surgeon fees	20% <u>coinsurance</u>	40% <u>coinsurance</u>	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Mental health/behavioral health: \$20 <u>copayment</u> Substance abuse: 20% <u>coinsurance</u>	40% <u>coinsurance</u>	Services must be <u>medically necessary</u> and are subject to <u>plan</u> limitations. Substance abuse: TAP review is recommended but not required.
	Inpatient services	Mental health/behavioral health: 20% <u>coinsurance</u> Substance abuse: No charge first admission; 20% <u>coinsurance</u> for subsequent admissions	40% <u>coinsurance</u>	Elective hospital admission requires <u>preauthorization</u> . Any days not <u>preauthorized</u> are not covered.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you are pregnant	Office visits	No charge	40% <u>coinsurance</u>	<u>Cost sharing</u> does not apply to certain <u>preventive services</u> . Depending on the type of services, <u>coinsurance</u> may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e., ultrasound).
	Childbirth/delivery professional services	20% <u>coinsurance</u>	40% <u>coinsurance</u>	
	Childbirth/delivery facility services	20% <u>coinsurance</u>	40% <u>coinsurance</u>	
If you need help recovering or have other special health needs	<a href="#">Home health care</a>	20% <u>coinsurance</u>	40% <u>coinsurance</u>	Plan pays up to 100 visits/year.
	<a href="#">Rehabilitation services</a>	20% <u>coinsurance</u>	40% <u>coinsurance</u>	Any care over 20 visits/year for outpatient physical, occupational & speech therapy must be <u>preauthorized</u> . Any inpatient rehab days not <u>preauthorized</u> are not covered.
	<a href="#">Habilitation services</a>	Not covered	Not covered	You pay 100% for these services.
	<a href="#">Skilled nursing care</a>	20% <u>coinsurance</u>	40% <u>coinsurance</u>	Skilled Nursing facility requires <u>preauthorization</u> . Any days not <u>preauthorized</u> are not covered.
	<a href="#">Durable medical equipment</a>	20% <u>coinsurance</u>	40% <u>coinsurance</u>	<u>Preauthorization</u> is recommended.
	<a href="#">Hospice services</a>	20% <u>coinsurance</u>	40% <u>coinsurance</u>	Covered if patient is terminally ill.
If your child needs dental or eye care	Children's eye exam	Not covered		Covered under a separate vision plan.
	Children's glasses	Not covered		
	Children's dental check-up	Not covered		Covered under a separate dental plan.

### Excluded Services & Other Covered Services:

<b>Services Your <a href="#">Plan</a> Generally Does NOT Cover (Check your policy or <a href="#">plan</a> document for more information and a list of any other <a href="#">excluded services</a>.)</b>		
<ul style="list-style-type: none"> <li>• Cosmetic surgery</li> <li>• Dental care (adult and child) (covered under a separate dental plan)</li> <li>• <a href="#">Habilitation services</a></li> </ul>	<ul style="list-style-type: none"> <li>• Hearing aids</li> <li>• Infertility treatment</li> <li>• Long-term care</li> <li>• Private-duty nursing</li> </ul>	<ul style="list-style-type: none"> <li>• Routine eye care (adult and child) (covered under a separate vision plan)</li> <li>• Routine foot care</li> <li>• Weight loss programs (except as required by law)</li> </ul>
<b>Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your <a href="#">plan</a> document.)</b>		
<ul style="list-style-type: none"> <li>• Acupuncture (see limitations above)</li> <li>• Bariatric surgery</li> </ul>	<ul style="list-style-type: none"> <li>• Chiropractic care (see limitations above)</li> </ul>	<ul style="list-style-type: none"> <li>• Non-emergency care when traveling outside the U.S.</li> </ul>

**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: 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). 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 [www.HealthCare.gov](http://www.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 the Administration Office at 1-800-267-3232 or the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA or [www.dol.gov/ebsa/healthreform](http://www.dol.gov/ebsa/healthreform).

**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](#).

**Language Access Services:**

[Spanish (Español): Para obtener asistencia en Español, llame al 1-800-267-3232.]

[Chinese (中文): 如果需要中文的帮助, 请拨打这个号码 1-800-267-3232.]

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

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About these Coverage Examples:



**This is not a cost estimator.** Treatments shown are just examples of how this [plan](#) might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your [providers](#) charge, and many other factors. Focus on the [cost sharing](#) amounts ([deductibles](#), [copayments](#) and [coinsurance](#)) and [excluded services](#) under the [plan](#). Use this information to compare the portion of costs you might pay under different health [plans](#). Please note these coverage examples are based on self-only coverage.

**Peg is Having a Baby**

(9 months of in-network pre-natal care and a hospital delivery)

- The [plan's](#) overall [deductible](#) \$250
- [Specialist \[copayment\]](#) \$20
- Hospital (facility) [\[cost sharing\]](#) 20%
- Other [\[cost sharing\]](#) 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*)

<b>Total Example Cost</b>	<b>\$12,800</b>
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**In this example, Peg would pay:**

<i>Cost Sharing</i>	
Deductibles	\$250
Copayments	\$40
Coinsurance	\$2,470
<i>What isn't covered</i>	
Limits or exclusions	\$60
<b>The total Peg would pay is</b>	<b>\$2,820</b>

**Managing Joe's Type 2 Diabetes**

(a year of routine in-network care of a well-controlled condition)

- The [plan's](#) overall [deductible](#) \$250
- [Specialist \[copayment\]](#) \$20
- Hospital (facility) [\[cost sharing\]](#) 20%
- Other [\[cost sharing\]](#) 20%

**This EXAMPLE event includes services like:**

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

<b>Total Example Cost</b>	<b>\$7,500</b>
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**In this example, Joe would pay:**

<i>Cost Sharing</i>	
Deductibles	\$250
Copayments	\$840
Coinsurance	\$330
<i>What isn't covered</i>	
Limits or exclusions	\$60
<b>The total Joe would pay is</b>	<b>\$1,480</b>

**Mia's Simple Fracture**

(in-network emergency room visit and follow up care)

- The [plan's](#) overall [deductible](#) \$250
- [Specialist \[copayment\]](#) \$20
- Hospital (facility) [\[cost sharing\]](#) 20%
- Other [\[cost sharing\]](#) 20%

**This EXAMPLE event includes services like:**

Emergency room care (*including medical supplies*)  
 Diagnostic test (*x-ray*)  
 Durable medical equipment (*crutches*)  
 Rehabilitation services (*physical therapy*)

<b>Total Example Cost</b>	<b>\$2,000</b>
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**In this example, Mia would pay:**

<i>Cost Sharing</i>	
Deductibles	\$250
Copayments	\$40
Coinsurance	\$190
<i>What isn't covered</i>	
Limits or exclusions	\$0
<b>The total Mia would pay is</b>	<b>\$480</b>