



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
What is the overall <a href="#">deductible</a> ?	\$0	See the Common Medical Events chart below for your costs for services this <a href="#">plan</a> covers.
Are there services covered before you meet your <a href="#">deductible</a> ?	This <a href="#">plan</a> does not have a <a href="#">deductible</a> .	This <a href="#">plan</a> covers all covered items and services with no <a href="#">deductible</a> but a <a href="#">copayment</a> or <a href="#">coinsurance</a> may apply. This <a href="#">plan</a> covers certain <a href="#">preventive services</a> without <a href="#">cost-sharing</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> .
Are there other <a href="#">deductibles</a> for specific services?	No.	You don't have to meet <a href="#">deductibles</a> for specific services.
What is the <a href="#">out-of-pocket limit</a> for this <a href="#">plan</a> ?	For <a href="#">medical</a> and <a href="#">prescription drug</a> expenses, \$6,600/individual; \$13,200/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.
What is not included in the <a href="#">out-of-pocket limit</a> ?	<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> .
Will you pay less if you use a <a href="#">network provider</a> ?	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 network</a> . 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.
Do you need a <a href="#">referral</a> to see a <a href="#">specialist</a> ?	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)	
If you visit a health care <a href="#">provider's</a> office or clinic	<a href="#">Primary care</a> visit to treat an injury or illness	No charge	100% of <a href="#">Allowed Amount</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 preventive. Ask your <a href="#">provider</a> if the services needed are preventive. Then check what your <a href="#">plan</a> will pay for.
	<a href="#">Specialist</a> visit	No charge	100% of <a href="#">Allowed Amount</a>	
	<a href="#">Preventive care/screening/immunization</a>	No charge	Not covered	
If you have a test	<a href="#">Diagnostic test</a> (x-ray, blood work)	No charge	100% of <a href="#">Allowed Amount</a>	None
	Imaging (CT/PET scans, MRIs)	No charge	100% of <a href="#">Allowed Amount</a>	None
If you need drugs to treat your illness or condition  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	No charge	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.  <a href="#">Specialty drugs</a> must be filled through BriovaRx.
	Preferred brand drugs ( <a href="#">formulary</a> )	No charge		
	Non-preferred brand drugs (non- <a href="#">formulary</a> )	No charge		
	<a href="#">Specialty drugs</a>	No charge	Not covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	No charge	100% of <a href="#">Allowed Amount</a>	None
	Physician/surgeon fees	No charge	100% of <a href="#">Allowed Amount</a>	None

[\* For more information about limitations and exceptions, see the [plan](#) or policy document at [www.baag.org](http://www.baag.org).

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 need immediate medical attention	<a href="#">Emergency room care</a>	No charge	100% of <u>Allowed Amount</u>	None
	<a href="#">Emergency medical transportation</a>	No charge	100% of <u>Allowed Amount</u>	None
	<a href="#">Urgent care</a>	No charge	100% of <u>Allowed Amount</u>	None
If you have a hospital stay	Facility fee (e.g., hospital room)	No charge	100% of <u>Allowed Amount</u>	Elective hospital admissions must be <u>preauthorized</u> . Any days not <u>preauthorized</u> are not covered.
	Physician/surgeon fees	No charge	100% of <u>Allowed Amount</u>	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Mental health/behavioral health: No charge Substance abuse: No charge	100% of <u>Allowed Amount</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: No charge Substance abuse: No charge	100% of <u>Allowed Amount</u>	Elective hospital admission requires <u>preauthorization</u> . Any days not <u>preauthorized</u> are not covered.
If you are pregnant	Office visits	No charge	100% of <u>Allowed Amount</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	No charge	100% of <u>Allowed Amount</u>	
	Childbirth/delivery facility services	No charge	100% of <u>Allowed Amount</u>	
If you need help recovering or have other special health needs	<a href="#">Home health care</a>	No charge	100% of <u>Allowed Amount</u>	None
	<a href="#">Rehabilitation services</a>	No charge	100% of <u>Allowed Amount</u>	Any inpatient rehab days not <u>preauthorized</u> are not covered.
	<a href="#">Habilitation services</a>	No charge	100% of <u>Allowed Amount</u>	You pay 100% of these expenses.
	<a href="#">Skilled nursing care</a>	No charge	100% of <u>Allowed Amount</u>	Skilled Nursing facility requires <u>preauthorization</u> . Any days not <u>preauthorized</u> are not covered.
	<a href="#">Durable medical equipment</a>	No charge	100% of <u>Allowed Amount</u>	<u>Preauthorization</u> is recommended.
	<a href="#">Hospice services</a>	No charge	100% of <u>Allowed Amount</u>	Covered if terminally ill.
If your child needs dental or eye care	Children's eye exam	Not covered		Coverage under a separate vision plan.
	Children's glasses	Not covered		
	Children's dental check-up	Not covered		Coverage under a separate dental plan.

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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)	

**Excluded Services & Other Covered Services:**

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> .)		
<ul style="list-style-type: none"> <li>• Cosmetic surgery</li> <li>• Dental care (adult and child) (covered under a separate dental plan)</li> <li>• <u>Habilitation services</u></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>

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your <a href="#">plan</a> document.)		
<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.**

[Minimum Essential Coverage](#) generally includes [plans](#), [health insurance](#) available through the [Marketplace](#) or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of [Minimum Essential Coverage](#), you may not be eligible for the [premium tax credit](#).

**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.]

————— *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 <a href="#">plan's</a> overall <a href="#">deductible</a>	\$0
■ <a href="#">Specialist [cost sharing]</a>	\$0
■ Hospital (facility) <a href="#">[cost sharing]</a>	0%
■ Other <a href="#">[cost sharing]</a>	0%

#### 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>\$12,700</b>
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#### In this example, Peg would pay:

Cost Sharing	
Deductibles	\$0
Copayments	\$0
Coinsurance	\$0
What isn't covered	
Limits or exclusions	\$60
<b>The total Peg would pay is</b>	<b>\$60</b>

### Managing Joe's Type 2 Diabetes

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

■ The <a href="#">plan's</a> overall <a href="#">deductible</a>	\$0
■ <a href="#">Specialist [cost sharing]</a>	\$0
■ Hospital (facility) <a href="#">[cost sharing]</a>	0%
■ Other <a href="#">[cost sharing]</a>	0%

#### 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>\$5,600</b>
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#### In this example, Joe would pay:

Cost Sharing	
Deductibles	\$0
Copayments	\$0
Coinsurance	\$0
What isn't covered	
Limits or exclusions	\$20
<b>The total Joe would pay is</b>	<b>\$20</b>

### Mia's Simple Fracture

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

■ The <a href="#">plan's</a> overall <a href="#">deductible</a>	\$0
■ <a href="#">Specialist [cost sharing]</a>	\$0
■ Hospital (facility) <a href="#">[cost sharing]</a>	0%
■ Other <a href="#">[cost sharing]</a>	0%

#### 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>\$2,800</b>
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#### In this example, Mia would pay:

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

The [plan](#) would be responsible for the other costs of these EXAMPLE covered services.

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