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| **The Summary of Benefits and Coverage (SBC) document will help you choose a health** [**plan**](https://www.healthcare.gov/sbc-glossary/#plan)**. The SBC shows you how you and the** [**plan**](https://www.healthcare.gov/sbc-glossary/#plan) **would share the cost for covered health care services. NOTE: Information about the cost of this** [**plan**](https://www.healthcare.gov/sbc-glossary/#plan) **(called the** [**premium**](https://www.healthcare.gov/sbc-glossary/#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](https://www.healthcare.gov/sbc-glossary/#allowed-amount), [balance billing](https://www.healthcare.gov/sbc-glossary/#balance-billing), [coinsurance](https://www.healthcare.gov/sbc-glossary/#coinsurance), [copayment](https://www.healthcare.gov/sbc-glossary/#copayment), [deductible](https://www.healthcare.gov/sbc-glossary/#deductible), [provider](https://www.healthcare.gov/sbc-glossary/#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. |

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| **Important Questions** | **Answers** | **Why This Matters** |
| **What is the overall** [**deductible**](https://www.healthcare.gov/sbc-glossary/#deductible)**?** | **$100**/individual; **$300**/family | 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**](https://www.healthcare.gov/sbc-glossary/#deductible)**?** | Yes. In-network preventive care, in-network office visits, and outpatient prescription drugs are covered before you meet your deductible. | This [plan](https://www.healthcare.gov/sbc-glossary/#plan) covers some items and services even if you haven’t yet met the [deductible](https://www.healthcare.gov/sbc-glossary/#deductible) amount. But a [copayment](https://www.healthcare.gov/sbc-glossary/#copayment) or [coinsurance](https://www.healthcare.gov/sbc-glossary/#coinsurance) may apply. For example, this [plan](https://www.healthcare.gov/sbc-glossary/#plan) covers certain [preventive services](https://www.healthcare.gov/sbc-glossary/#preventive-care) without [cost-sharing](https://www.healthcare.gov/sbc-glossary/#cost-sharing) and before you meet your [deductible](https://www.healthcare.gov/sbc-glossary/#deductible). See a list of covered [preventive services](https://www.healthcare.gov/sbc-glossary/#preventive-care) at <https://www.healthcare.gov/coverage/preventive-care-benefits/>. |
| **Are there other** [**deductibles**](https://www.healthcare.gov/sbc-glossary/#deductible) **for specific services?** | No.  | You don’t have to meet deductibles for specific services. |
| **What is the** [**out-of-pocket limit**](https://www.healthcare.gov/sbc-glossary/#out-of-pocket-limit) **for this** [**plan**](https://www.healthcare.gov/sbc-glossary/#plan)**?** | For medical expenses, **$1,000**/individual and **$3,000**/family; for prescription drug expenses, **$5,500**/person and **$9,900**/family. | 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, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met. |
| **What is not included in the** [**out-of-pocket limit**](https://www.healthcare.gov/sbc-glossary/#out-of-pocket-limit)**?** | Premiums, balance-billed charges, and services this plan does not cover do not count toward the out-of-pocket limit. | 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**](https://www.healthcare.gov/sbc-glossary/#network-provider)**?** | Yes. For a list of **in-network providers**, see[**www.bluecrossca.com**](http://www.bluecrossca.com)or call the Administrative Office at **1-800-267-3232.**For a list of **in-network substance abuse providers**, call the Administrative Office at **1-800-267-3232**. For more information on the Teamsters’ Assistance Program (“TAP”) visit [**www.tap-program.org**](http://www.tap-program.org), or call TAP at **510-562-3600** (**1-800-253-8326** if outsidethe SF Bay Area). | 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**](https://www.healthcare.gov/sbc-glossary/#referral) **to see a** [**specialist**](https://www.healthcare.gov/sbc-glossary/#specialist)**?** | No. | You can see the specialist you choose without a referral. |

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| **Exclamation** | All [**copayment**](https://www.healthcare.gov/sbc-glossary/#copayment) and [**coinsurance**](https://www.healthcare.gov/sbc-glossary/#coinsurance) costs shown in this chart are after your [**deductible**](https://www.healthcare.gov/sbc-glossary/#deductible) has been met, if a [**deductible**](https://www.healthcare.gov/sbc-glossary/#deductible) applies. |
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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)**  |
| **If you visit a health care** [**provider’s**](https://www.healthcare.gov/sbc-glossary/#provider) **office or clinic** | Primary care visit to treat an injury or illness | 20% coinsurance | Services must be medically necessary and are subject to plan limitations.Chiropractor/Acupuncture: this plan covers up to 20 visits/year without preauthorization. Preauthorization is required after 20 visits. |
| [Specialist](https://www.healthcare.gov/sbc-glossary/#specialist) visit | 20% coinsurance |
| [Preventive care](https://www.healthcare.gov/sbc-glossary/#preventive-care)/[screening](https://www.healthcare.gov/sbc-glossary/#screening)/immunization | No chargeDeductible does not apply | Not covered | Plan covers preventive services and supplies required by the Health Reform law. Age and frequency guidelines apply to covered preventive care.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. |
| **If you have a test** | [Diagnostic test](https://www.healthcare.gov/sbc-glossary/#diagnostic-test) (x-ray, blood work) | 20% coinsurance | None |
| Imaging (CT/PET scans, MRIs)  | 20% coinsurance | None |
| **If you need drugs to treat your illness or condition**More information about [**prescription drug coverage**](https://www.healthcare.gov/sbc-glossary/#prescription-drug-coverage) is available at [www.optum.com](http://www.optum.com) or 1-800-788-7871. | Generic drugs | Retail Pharmacy for 34-day supply: $5 copayment; Mail Order for 90-day supply: $15 copayment. Prescription contraceptives: No charge for generic drugs. | You pay 100% for prescriptions filled at a non-participating retail pharmacy unless you are new to the plan (first eligible for the plan within the last 90 days) or are out of the country.  | If the cost of the drug is less than the copayment, 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.Specialty drugs must be filled through BriovaRx. |
| Preferred brand drugs (formulary) | Retail Pharmacy for 34-day supply: $10 copayment; Mail Order for 90-day supply: $30 copayment. Prescription contraceptives: No charge for brand drug if generic drug is medically inappropriate. |
| Non-preferred brand drugs(non-formulary) | Retail Pharmacy for 34-day supply: $20 copayment; Mail Order for 90-day supply: $60 copayment. |
| [Specialty drugs](https://www.healthcare.gov/sbc-glossary/#specialty-drug) | Mail Order: $15 copayment generic; $30 copayment preferred brand; $60 copayment for non-preferred brand. | Not covered. |
| **If you have outpatient surgery** | Facility fee (e.g., ambulatory surgery center) | 20% coinsurance | None |
| Physician/surgeon fees | 20% coinsurance | None |
| **If you need immediate medical attention** | [Emergency room care](https://www.healthcare.gov/sbc-glossary/#emergency-room-care-emergency-services) | No charge first $1,000, then 20% coinsurance (deductible does not apply) | Only applicable to medical emergencies |
| [Emergency medical transportation](https://www.healthcare.gov/sbc-glossary/#emergency-medical-transportation) | 20% coinsurance | None |
| [Urgent care](https://www.healthcare.gov/sbc-glossary/#urgent-care) | No charge first $1,000, then 20% coinsurance (deductible does not apply) | None |
| **If you have a hospital stay** | Facility fee (e.g., hospital room) | No charge first $1,000, then 20% coinsurance (deductible does not apply) | Elective hospital admissions must be preauthorized. Any days not preauthorized are not covered.  |
| Physician/surgeon fees | 20% coinsurance | None |
| **If you need mental health, behavioral health, or substance abuse services** | Outpatient services | Mental health/behavioral health: 20% coinsuranceSubstance abuse: 20% coinsurance | 20% coinsurance | Services must be medically necessary and are subject to plan limitations.Substance abuse: TAP limitations review is recommended but not required. |
| Inpatient services | Mental health/behavioral health: No charge first $1,000, then 20% coinsurance (deductible does not apply)Substance abuse:No charge first admission; 20% coinsurance for subsequent admissions | Mental health/behavioral health: No charge first $1,000, then 20% coinsurance (deductible does not apply)Substance abuse:No charge first $1,000, then 20% coinsurance | Elective hospital admission requires preauthorization. Any days not preauthorized are not covered. |
| **If you are pregnant** | Office visits | No charge | 20% coinsurance | Cost sharing does not apply to certain preventive services. Depending on the type of services, coinsurance may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e., ultrasound). |
| Childbirth/delivery professional services | 20% coinsurance |
| Childbirth/delivery facility services | 20% coinsurance |
| **If you need help recovering or have other special health needs** | [Home health care](https://www.healthcare.gov/sbc-glossary/#home-health-care) | 20% coinsurance | Plan pays up to 100 visits/year |
| [Rehabilitation services](https://www.healthcare.gov/sbc-glossary/#rehabilitation-services) | 20% coinsurance | Any care over 20 visits/year for Outpatient physical, occupational & speech therapy must be preauthorized. Any inpatient rehab days not preauthorized are not covered.  |
| [Habilitation services](https://www.healthcare.gov/sbc-glossary/#habilitation-services) | Not covered | You pay 100% of these expenses. |
| [Skilled nursing care](https://www.healthcare.gov/sbc-glossary/#skilled-nursing-care) | 20% coinsurance | Skilled Nursing facility requires preauthorization. Any days not preauthorized are not covered.  |
| [Durable medical equipment](https://www.healthcare.gov/sbc-glossary/#durable-medical-equipment) | 20% coinsurance | Preauthorization is recommended. |
| [Hospice services](https://www.healthcare.gov/sbc-glossary/#hospice-services) | 20% coinsurance | Covered if 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:**

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| **Services Your** [**Plan**](https://www.healthcare.gov/sbc-glossary/#plan) **Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other** [**excluded services**](https://www.healthcare.gov/sbc-glossary/#excluded-services)**.)** |
| * Cosmetic surgery
* Dental care (adult and child) (covered under a separate dental plan)
* Habilitation services
 | * Hearing aids
* Infertility treatment
* Long-term care
* Private-duty nursing
 | * Routine eye care (adult and child) (covered under a separate vision plan)
* Routine foot care
* Weight loss programs (except as required by law)
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| **Other Covered Services (Limitations may apply to these services. This isn’t a complete list. Please see your** [**plan**](https://www.healthcare.gov/sbc-glossary/#plan) **document.)** |
| * Acupuncture (see limitations above)
* Bariatric surgery
 | * Chiropractic care (see limitations above)
 | * Non-emergency care when traveling outside the U.S.
 |

**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. Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance [Marketplace](https://www.healthcare.gov/sbc-glossary/#marketplace). For more information about the [Marketplace](https://www.healthcare.gov/sbc-glossary/#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](https://www.healthcare.gov/sbc-glossary/#plan) for a denial of a [claim](https://www.healthcare.gov/sbc-glossary/#claim). This complaint is called a [grievance](https://www.healthcare.gov/sbc-glossary/#grievance) or [appeal](https://www.healthcare.gov/sbc-glossary/#appeal). For more information about your rights, look at the explanation of benefits you will receive for that medical [claim](https://www.healthcare.gov/sbc-glossary/#claim). Your [plan](https://www.healthcare.gov/sbc-glossary/#plan) documents also provide complete information to submit a [claim](https://www.healthcare.gov/sbc-glossary/#claim), [appeal](https://www.healthcare.gov/sbc-glossary/#appeal), or a [grievance](https://www.healthcare.gov/sbc-glossary/#grievance) for any reason to your [plan](https://www.healthcare.gov/sbc-glossary/#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](file:///C%3A%5CUsers%5Cplai%5CAppData%5CLocal%5CMicrosoft%5CWindows%5CTemporary%20Internet%20Files%5CContent.Outlook%5CAFBK9QIP%5Cwww.dol.gov%5Cebsa%5Chealthreform).

**Does this plan provide Minimum Essential Coverage? Yes.**

[Minimum Essential Coverage](https://www.healthcare.gov/sbc-glossary/#minimum-essential-coverage) generally includes [plans](https://www.healthcare.gov/sbc-glossary/#plan), [health insurance](https://www.healthcare.gov/sbc-glossary/#health-insurance) available through the [Marketplace](https://www.healthcare.gov/sbc-glossary/#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,](https://www.healthcare.gov/sbc-glossary/#minimum-essential-coverage) you may not be eligible for the [premium tax credit](https://www.healthcare.gov/sbc-glossary/#premium-tax-credits).

**Does this plan meet the Minimum Value Standards? Yes.**

If your [plan](https://www.healthcare.gov/sbc-glossary/#plan) doesn’t meet the [Minimum Value Standards](https://www.healthcare.gov/sbc-glossary/#minimum-value-standard), you may be eligible for a [premium tax credit](https://www.healthcare.gov/sbc-glossary/#premium-tax-credits) to help you pay for a [plan](https://www.healthcare.gov/sbc-glossary/#plan) through the [Marketplace](https://www.healthcare.gov/sbc-glossary/#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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**This is not a cost estimator.** Treatments shown are just examples of how this [plan](https://www.healthcare.gov/sbc-glossary/#plan) might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your [providers](https://www.healthcare.gov/sbc-glossary/#provider) charge, and many other factors. Focus on the [cost sharing](https://www.healthcare.gov/sbc-glossary/#cost-sharing) amounts ([deductibles](https://www.healthcare.gov/sbc-glossary/#deductible), [copayments](https://www.healthcare.gov/sbc-glossary/#copayment) and [coinsurance](https://www.healthcare.gov/sbc-glossary/#coinsurance)) and [excluded services](https://www.healthcare.gov/sbc-glossary/#excluded-services) under the [plan](https://www.healthcare.gov/sbc-glossary/#plan). Use this information to compare the portion of costs you might pay under different health [plans](https://www.healthcare.gov/sbc-glossary/#plan). Please note these coverage examples are based on self-only coverage.

**About these Coverage Examples:**

**Peg is Having a Baby**(9 months of in-network pre-natal care
and a hospital delivery)

◼ **The** [**plan’s**](https://www.healthcare.gov/sbc-glossary/#plan) **overall** [**deductible**](https://www.healthcare.gov/sbc-glossary/#deductible) **$100**

◼ [**Specialist**](https://www.healthcare.gov/sbc-glossary/#specialist) ***[cost sharing]* 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)*

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| --- | --- |
| **Total Example Cost** | **$12,700** |

**In this example, Peg would pay:**

|  |
| --- |
| *Cost Sharing* |
| Deductibles | $100 |
| Copayments | $10 |
| Coinsurance | $900 |
| *What isn’t covered* |
| Limits or exclusions | $60 |
| **The total Peg would pay is** | **$1,060** |

**Managing Joe’s Type 2 Diabetes**(a year of routine in-network care
of a well-controlled condition)

◼ **The** [**plan’s**](https://www.healthcare.gov/sbc-glossary/#plan) **overall** [**deductible**](https://www.healthcare.gov/sbc-glossary/#deductible) **$100**

◼ [**Specialist**](https://www.healthcare.gov/sbc-glossary/#specialist) ***[cost sharing]* 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 tests *(blood work)*

Prescription drugs

Durable medical equipment *(glucose meter)*

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| --- | --- |
| **Total Example Cost** | **$5,600** |

**In this example, Joe would pay:**

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| --- |
| *Cost Sharing* |
| Deductibles | $100 |
| Copayments | $200 |
| Coinsurance | $400 |
| *What isn’t covered* |
| Limits or exclusions | $20 |
| **The total Joe would pay is** | **$720** |

**Mia’s Simple Fracture**(in-network emergency room visit
and follow up care)

◼ **The** [**plan’s**](https://www.healthcare.gov/sbc-glossary/#plan) **overall** [**deductible**](https://www.healthcare.gov/sbc-glossary/#deductible) **$100**

◼ [**Specialist**](https://www.healthcare.gov/sbc-glossary/#specialist) ***[cost sharing]* 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)*

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| **Total Example Cost** | **$2,800** |

**In this example, Mia would pay:**

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| --- |
| *Cost Sharing* |
| Deductibles | $100 |
| Copayments | $10 |
| Coinsurance | $500 |
| *What isn’t covered* |
| Limits or exclusions | $0 |
| **The total Mia would pay is** | **$610** |