|  |
| --- |
| **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. |

|  |  |  |  |
| --- | --- | --- | --- |
| **Important Questions** | | **Answers** | **Why This Matters** |
| **What is the overall** [**deductible**](https://www.healthcare.gov/sbc-glossary/#deductible)**?** | | **$250**/individual; **$500**/family | Generally, you must pay all of the costs from providers up to the [deductible](https://www.healthcare.gov/sbc-glossary/#deductible) amount before this [plan](https://www.healthcare.gov/sbc-glossary/#plan) begins to pay. If you have other family members on the [plan](https://www.healthcare.gov/sbc-glossary/#plan), each family member must meet their own individual [deductible](https://www.healthcare.gov/sbc-glossary/#deductible) until the total amount of [deductible](https://www.healthcare.gov/sbc-glossary/#deductible) expenses paid by all family members meets the overall family [deductible](https://www.healthcare.gov/sbc-glossary/#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:  In-network-providers: **$2,000**/individual; **$4,000**/family.  Out-of-network providers: **$8,000**/individual; **$16,000/**family.  For prescription drug expenses: **$2,350**/individual; **$4,700**/family. | The [out-of-pocket limit](https://www.healthcare.gov/sbc-glossary/#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](https://www.healthcare.gov/sbc-glossary/#plan), they have to meet their own [out-of-pocket limits](https://www.healthcare.gov/sbc-glossary/#out-of-pocket-limit) until the overall family [out-of-pocket limit](https://www.healthcare.gov/sbc-glossary/#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](https://www.healthcare.gov/sbc-glossary/#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.  S7 |
| **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. | | |

| **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 copayment/office visit | 40% 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 copayment/office visit  Chiropractor/Acupuncture: 20% coinsurance | 40% coinsurance |
| [Preventive care](https://www.healthcare.gov/sbc-glossary/#preventive-care)/[screening](https://www.healthcare.gov/sbc-glossary/#screening)/  immunization | No charge  Deductible 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](https://www.healthcare.gov/sbc-glossary/#preventive-care). Ask your [provider](https://www.healthcare.gov/sbc-glossary/#provider) if the services you need are preventive. Then check what your [plan](https://www.healthcare.gov/sbc-glossary/#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 | 40% coinsurance | None |
| Imaging (CT/PET scans, MRIs) | 20% coinsurance | 40% 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: $10 copayment; Mail Order for 90-day supply: $20 copayment. Prescription contraceptives: No charge for generic drugs. | Not covered (unless you enrolled in the plan in 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: $25 copayment; Mail Order for 90-day supply: $50 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: $50 copayment; Mail Order for 90-day supply: $100 copayment. |
| [Specialty drugs](https://www.healthcare.gov/sbc-glossary/#specialty-drug) | Mail Order: $20 copayment generic; $50 copayment preferred brand; $100 copayment non-preferred brand. | Not covered |
| **If you have outpatient surgery** | Facility fee (e.g., ambulatory surgery center) | 20% coinsurance | 40% coinsurance | None |
| Physician/surgeon fees | 20% coinsurance | 40% 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 | 40% coinsurance | None |
| [Urgent care](https://www.healthcare.gov/sbc-glossary/#urgent-care) | No charge first $1,000,  then 20% coinsurance  (Deductible does not apply) | No charge first $1,000,  then 40% coinsurance (Deductible does not apply) | None |
| **If you have a  hospital stay** | Facility fee (e.g., hospital room) | 20% coinsurance | 40% coinsurance | Elective hospital admissions must be preauthorized. Any days not preauthorized  are not covered. |
| Physician/surgeon fees | 20% coinsurance | 40% coinsurance | None |
| **If you need mental health, behavioral health, or substance abuse services** | Outpatient services | Mental health/behavioral health: $20 copayment  Substance abuse:  20% coinsurance | 40% coinsurance | Services must be medically necessary and are subject to plan limitations.  Substance abuse: TAP review is recommended but not required. |
| Inpatient services | Mental health/behavioral health: 20% coinsurance  Substance abuse:  No charge first admission; 20% coinsurance for subsequent admissions | 40% coinsurance | Elective hospital admission requires preauthorization. Any days not preauthorized are not covered. |
| **If you are pregnant** | Office visits | No charge | 40% coinsurance | [Cost sharing](https://www.healthcare.gov/sbc-glossary/#cost-sharing) does not apply to certain [preventive services](https://www.healthcare.gov/sbc-glossary/#preventive-care). Depending on the type of services, [coinsurance](https://www.healthcare.gov/sbc-glossary/#coinsurance) may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e., ultrasound). |
| Childbirth/delivery  professional services | 20% coinsurance | 40% coinsurance |
| Childbirth/delivery  facility services | 20% coinsurance | 40% 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 | 40% coinsurance | Plan pays up to 100 visits/year. |
| [Rehabilitation services](https://www.healthcare.gov/sbc-glossary/#rehabilitation-services) | 20% coinsurance | 40% 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 | Not covered | You pay 100% for these services. |
| [Skilled nursing care](https://www.healthcare.gov/sbc-glossary/#skilled-nursing-care) | 20% coinsurance | 40% 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 | 40% coinsurance | Preauthorization is recommended. |
| [Hospice services](https://www.healthcare.gov/sbc-glossary/#hospice-services) | 20% coinsurance | 40% coinsurance | 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:**

|  |  |  |
| --- | --- | --- |
| **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) |

|  |  |  |
| --- | --- | --- |
| **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:\Users\plai\AppData\Local\Microsoft\Windows\Temporary%20Internet%20Files\Content.Outlook\AFBK9QIP\www.dol.gov\ebsa\healthreform).

**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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Exclamation

**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:**

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

**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) **$250**

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

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

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

|  |  |
| --- | --- |
| *Cost Sharing* | |
| Deductibles | $250 |
| Copayments | $10 |
| Coinsurance | $1,800 |
| *What isn’t covered* | |
| Limits or exclusions | $60 |
| **The total Peg would pay is** | **$2,060** |

◼ **The** [**plan’s**](https://www.healthcare.gov/sbc-glossary/#plan) **overall** [**deductible**](https://www.healthcare.gov/sbc-glossary/#deductible) **$250**

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

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

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

|  |  |
| --- | --- |
| *Cost Sharing* | |
| Deductibles | $250 |
| Copayments | $700 |
| Coinsurance | $100 |
| *What isn’t covered* | |
| Limits or exclusions | $20 |
| **The total Joe would pay is** | **$1,070** |

**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) **$250**

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

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

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

|  |  |
| --- | --- |
| *Cost Sharing* | |
| Deductibles | $250 |
| Copayments | $70 |
| Coinsurance | $400 |
| *What isn’t covered* | |
| Limits or exclusions | $0 |
| **The total Mia would pay is** | **$720** |