



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
<u>What is the overall deductible?</u>	\$100/individual; \$300/family	Generally, you must pay all of the costs from <u>providers</u> up to the <u>deductible</u> amount before this <u>plan</u> begins to pay. If you have other family members on the <u>plan</u> , each family member must meet their own individual <u>deductible</u> until the total amount of <u>deductible</u> expenses paid by all family members meets the overall family <u>deductible</u> .
<u>Are there services covered before you meet your <u>deductible</u>?</u>	Yes. In-network <u>preventive care</u> , in-network office visits, and outpatient <u>prescription drugs</u> are covered before you meet your <u>deductible</u> .	This <u>plan</u> covers some items and services even if you haven't yet met the <u>deductible</u> amount. But a <u>copayment</u> or <u>coinsurance</u> may apply. For example, this <u>plan</u> covers certain <u>preventive services</u> without <u>cost-sharing</u> and before you meet your <u>deductible</u> . See a list of covered <u>preventive services</u> at <a href="https://www.healthcare.gov/coverage/preventive-care-benefits/">https://www.healthcare.gov/coverage/preventive-care-benefits/</a> .
<u>Are there other <u>deductibles</u> for specific services?</u>	No.	You don't have to meet <u>deductibles</u> for specific services.
<u>What is the <u>out-of-pocket limit</u> for this <u>plan</u>?</u>	For <u>medical</u> expenses, \$1,000/individual and \$3,000/family; for <u>prescription drug</u> expenses, \$5,500/person and \$9,900/family.	The <u>out-of-pocket limit</u> is the most you could pay in a year for covered services. If you have other family members in this <u>plan</u> , they have to meet their own <u>out-of-pocket limits</u> until the overall family <u>out-of-pocket limit</u> has been met.
<u>What is not included in the <u>out-of-pocket limit</u>?</u>	Premiums, <u>balance-billed</u> charges, and services this <u>plan</u> does not cover do not count toward the <u>out-of-pocket limit</u> .	Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u> .
<u>Will you pay less if you use a <u>network provider</u>?</u>	Yes. For a list of <u>in-network providers</u> , 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 <u>in-network substance abuse providers</u> , 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 <u>plan</u> uses a <u>provider network</u> . You will pay less if you use a <u>provider</u> in the <u>plan's network</u> . You will pay the most if you use an <u>out-of-network provider</u> , and you might receive a bill from a <u>provider</u> for the difference between the <u>provider's</u> charge and what your <u>plan</u> pays ( <u>balance billing</u> ). Be aware your <u>network provider</u> might use an <u>out-of-network provider</u> for some services (such as lab work). Check with your <u>provider</u> before you get services.
<u>Do you need a <u>referral</u> to see a <u>specialist</u>?</u>	No.	You can see the <u>specialist</u> you choose without a <u>referral</u> .

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

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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 <u>provider's</u> office or clinic	Primary care visit to treat an injury or illness		20% <u>coinsurance</u>	Services must be <u>medically necessary</u> and are subject to <u>plan</u> limitations. Chiropractor/Acupuncture: this <u>plan</u> covers up to 20 visits/year without <u>preauthorization</u> . <u>Preauthorization</u> is required after 20 visits.
	<u>Specialist</u> visit		20% <u>coinsurance</u>	
	Preventive care/screening/immunization	No charge <u>Deductible</u> does not apply	Not covered	Plan covers <u>preventive services</u> and supplies required by the Health Reform law. Age and frequency guidelines apply to covered <u>preventive care</u> . You may have to pay for services that aren't preventive. Ask your <u>provider</u> if the services needed are preventive. Then check what your <u>plan</u> will pay for.
If you have a test	<u>Diagnostic test</u> (x-ray, blood work)		20% <u>coinsurance</u>	None
	Imaging (CT/PET scans, MRIs)		20% <u>coinsurance</u>	None
If you need drugs to treat your illness or condition  More information about <u>prescription drug coverage</u> 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: \$5 <u>copayment</u> ; Mail Order for 90-day supply: \$15 <u>copayment</u> . 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 <u>plan</u> (first eligible for the <u>plan</u> within the last 90 days) or are out of the country.	If the cost of the drug is less than the <u>copayment</u> , 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 ( <u>formulary</u> )	Retail Pharmacy for 34-day supply: \$10 <u>copayment</u> ; Mail Order for 90-day supply: \$30 <u>copayment</u> . 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 <u>copayment</u> ; Mail Order for 90-day supply: \$60 <u>copayment</u> .		

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)	
	<a href="#">Specialty drugs</a>	Mail Order: \$15 <u>copayment</u> generic; \$30 <u>copayment</u> preferred brand; \$60 <u>copayment</u> for non-preferred brand.	Not covered.	<u>Specialty drugs</u> must be filled through BriovaRx.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% <u>coinsurance</u>		None
	Physician/surgeon fees	20% <u>coinsurance</u>		None
If you need immediate medical attention	<a href="#">Emergency room care</a>	No charge first \$1,000, then 20% <u>coinsurance</u> ( <u>deductible</u> does not apply)		Only applicable to medical emergencies
	<a href="#">Emergency medical transportation</a>	20% <u>coinsurance</u>		None
	<a href="#">Urgent care</a>	No charge first \$1,000, then 20% <u>coinsurance</u> ( <u>deductible</u> does not apply)		None
If you have a hospital stay	Facility fee (e.g., hospital room)	No charge first \$1,000, then 20% <u>coinsurance</u> ( <u>deductible</u> does not apply)		Elective hospital admissions must be <u>preauthorized</u> . Any days not <u>preauthorized</u> are not covered.
	Physician/surgeon fees	20% <u>coinsurance</u>		None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Mental health/behavioral health: 20% <u>coinsurance</u> Substance abuse: 20% <u>coinsurance</u>	20% <u>coinsurance</u>	Services must be <u>medically necessary</u> and are subject to <u>plan</u> limitations. Substance abuse: TAP limitations review is recommended but not required.
	Inpatient services	Mental health/behavioral health: No charge first \$1,000, then 20% <u>coinsurance</u> ( <u>deductible</u> does not apply) Substance abuse: No charge first admission; 20% <u>coinsurance</u> for subsequent admissions	Mental health/behavioral health: No charge first \$1,000, then 20% <u>coinsurance</u> ( <u>deductible</u> does not apply) Substance abuse: No charge first \$1,000, then 20% <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	20% <u>coinsurance</u>	Cost sharing does not apply to certain preventive services. 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>	
	Childbirth/delivery facility services		20% <u>coinsurance</u>	
If you need help recovering or have other special health needs	<u>Home health care</u>		20% <u>coinsurance</u>	Plan pays up to 100 visits/year
	<u>Rehabilitation services</u>		20% <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.
	<u>Habilitation services</u>		Not covered	You pay 100% of these expenses.
	<u>Skilled nursing care</u>		20% <u>coinsurance</u>	Skilled Nursing facility requires <u>preauthorization</u> . Any days not <u>preauthorized</u> are not covered.
	<u>Durable medical equipment</u>		20% <u>coinsurance</u>	<u>Preauthorization</u> is recommended.
	<u>Hospice services</u>		20% <u>coinsurance</u>	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	

#### Excluded Services & Other Covered Services:

#### Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other 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 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](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](http://Marketplace). For more information about the [Marketplace](http://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.]

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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 <a href="#">plan's</a> overall <a href="#">deductible</a>	\$100
■ <a href="#">Specialist</a> [ <a href="#">cost sharing</a> ]	20%
■ Hospital (facility) [ <a href="#">cost sharing</a> ]	20%
■ Other [ <a href="#">cost sharing</a> ]	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>\$12,700</b>
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#### In this example, Peg would pay:

Cost Sharing	
Deductibles	\$100
Copayments	\$10
Coinsurance	\$900
What isn't covered	
Limits or exclusions	\$60
<b>The total Peg would pay is</b>	<b>\$1,060</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>	\$100
■ <a href="#">Specialist</a> [ <a href="#">cost sharing</a> ]	20%
■ Hospital (facility) [ <a href="#">cost sharing</a> ]	20%
■ Other [ <a href="#">cost sharing</a> ]	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*)

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

Cost Sharing	
Deductibles	\$100
Copayments	\$200
Coinsurance	\$400
What isn't covered	
Limits or exclusions	\$20
<b>The total Joe would pay is</b>	<b>\$720</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>	\$100
■ <a href="#">Specialist</a> [ <a href="#">cost sharing</a> ]	20%
■ Hospital (facility) [ <a href="#">cost sharing</a> ]	20%
■ Other [ <a href="#">cost sharing</a> ]	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>\$2,800</b>
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#### In this example, Mia would pay:

Cost Sharing	
Deductibles	\$100
Copayments	\$10
Coinsurance	\$500
What isn't covered	
Limits or exclusions	\$0
<b>The total Mia would pay is</b>	<b>\$610</b>

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