**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, visit www.sheet104fringe.org or call 1-800-548-1771. 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 or call 1-800-548-1771 to request a copy.

| Important Questions | Answers | Why this Matters: |
|---|---|---|
| **What is the overall deductible?** | **$300** per person or **$600** per 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?** | **Yes. Preventive care** is covered before you meet your **deductible.** | This **plan** covers some items and services even if you haven't yet met the deducible amount. For example, this **plan** covers certain **preventive services** without **cost sharing** and before you meet your **deducible**. See a list of covered **preventive services** at https://www.healthcare.gov/coverage/preventive-care-beenfits/. |
| **Are there other deductibles for specific services?** | **Yes. $200** for each elective non-contract hospital admission. There are no other specific **deductibles**. | You must pay all of the costs for these services up to the specific **deductible** amount before this **plan** begins to pay for these services. |
| **What is the out–of–pocket limit for this plan?** | **$2,500** per individual/ **$5,000** per 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?** | Premiums, balance-billed charges, health care this **plan** doesn't cover, expenses relating to the use of non-PPO providers, and certain prescription drug expenses | 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?** | **Yes.** See www.blueshieldca.com, or call the Trust Fund Office at 1-800-548-1771 for a list of **network providers**. | 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 to see a specialist?** | No. | You can see the **specialist** you choose without a **referral**. |

- All **copayment** and **coinsurance** costs shown in this chart are after your **deductible** has been met, if a **deductible** applies.

  * Means that the percentages are based on **Usual, Customary and Reasonable (UCR)** charges.

| 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 office or clinic** | Primary care visit to treat an injury or illness | 20% **coinsurance** | 35 % **coinsurance*** | Non-emergency services provided by an Out-of-Network Provider at a Network facility is limited to 20% **coinsurance**, unless you consented to the Out-of-Network billing rates. |
| | **Specialist** visit | 20% **coinsurance** | 35 % **coinsurance*** | Non-emergency services provided by an Out-of-Network Provider at a Network facility is limited to 20% **coinsurance**, unless you consented to the Out-of-Network billing rates |
| | Other practitioner office visit | Acupuncture: 20% coinsurance* Chiropractic: plan pays $60/visit | Acupuncture: 20% coinsurance* Chiropractic: plan pays $60/visit | Acupuncture: maximum of $60/visit and $600/calendar year. Chiropractic: maximum of 26 visits and $1,560/calendar year. Does not apply to **out-of-pocket limit**. |
| | **Preventive care**/**screening**/immunization | No charge | 35 % coinsurance* | 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** (x-ray, blood work) | 20% coinsurance | 35 % coinsurance* | ——————none—————— |
| | Imaging (CT/PET scans, MRIs) | 20% coinsurance | 35 % coinsurance* | ——————none—————— |

| 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 drugs to treat your illness or condition**<br><br>More information about **prescription drug coverage** is available at www.optumrx.com. | Generic drugs | Retail: $15/Rx<br>Mail: $30/Rx | Reimbursement available | Retail is for a 30-day supply; Mail is for a 90-day supply |
| | Preferred brand drugs | Retail: 25% per Rx<br>Mail: 50% per Rx | Reimbursement available | Retail: minimum $15 copay and a maximum $50 copay; Mail: minimum $30 copay and a maximum $100 copay |
| | Non-preferred brand drugs | Retail: 25% per Rx<br>Mail: 50% per Rx | Reimbursement available | Retail: minimum $15 copay, but no maximum; Mail: minimum $30 copay, but no maximum.<br>Does not count toward the **out-of-pocket limit.** |
| | **Specialty drugs** | Retail: 20% per Rx<br>Mail: 20% per Rx | Reimbursement available | Retail: minimum $15 copay; Mail: minimum $15 copay<br>Retail & Mail: If Formulary, $50 copay maximum. If Non-Formulary, no copay maximum and your copayment does not apply to your **out-of-pocket limit.** |
| | Brand drugs (if Generic available) | Retail: $15 plus cost difference between the Brand price and Generic price<br>Mail: $30 plus cost difference between the Brand price and Generic Price | Reimbursement available | Does not count toward the **out-of-pocket limit** |
| **If you have outpatient surgery** | Facility fee (e.g., ambulatory surgery center) | 20% coinsurance | 35 % coinsurance* | Non-emergency services provided by an Out-of-Network Provider at a Network facility is limited to 20% **coinsurance**, unless you consented to the Out-of-Network billing rates. |

| 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) | |
| | Physician/surgeon fees | 20% coinsurance | 35 % coinsurance* | Non-emergency services provided by an Out-of-Network Provider at a Network facility is limited to 20% **coinsurance**, unless you consented to the Out-of-Network billing rates. |
| **If you need immediate medical attention** | **Emergency room care** | 20% coinsurance | 35% coinsurance* | 20% coinsurance* if the services were rendered in an emergency, regardless of whether the provider or hospital is an out-of-network provider. |
| | **Emergency medical transportation** | 20% coinsurance | 20% coinsurance* | ——————none—————— |
| | **Urgent care** | 20% coinsurance | 35% coinsurance* | ——————none—————— |
| **If you have a hospital stay** | Facility fee (e.g., hospital room) | 20% coinsurance | 35% coinsurance* | If you use an out-of-network hospital there is also a $200/person hospital deductible for each non-emergency admission.<br>Non-emergency services provided by an Out-of-Network Provider at a Network facility is limited to 20% **coinsurance**, unless you consented to the Out-of-Network billing rates. |
| | Physician/surgeon fee | 20% coinsurance | 35% coinsurance* | Non-emergency services provided by an Out-of-Network Provider at a Network facility is limited to 20% **coinsurance**, unless you consented to the Out-of-Network billing rates. |

| 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 mental health, behavioral health, or substance abuse services** | outpatient services | 20% **coinsurance** | 35% **coinsurance*** | ——————none—————— |
| | inpatient services | 20% **coinsurance** | 35% **coinsurance*** | Non-emergency services provided by an Out-of-Network Provider at a Network facility is limited to 20% **coinsurance**, unless you consented to the Out-of-Network billing rates. |
| | Substance use disorder outpatient services | No charge | 35% **coinsurance*** | Network Providers include Blue Shield and Beat It! |
| | Substance use disorder inpatient services | 20% **coinsurance** | 35% **coinsurance*** | Network Providers include Blue Shield and Beat It! Detoxification requires prior authorization from Blue Shield. 1st occurrence is covered at no charge. Subsequent occurrences, you pay 20% **coinsurance.** Non-emergency services provided by an Out-of-Network Provider at a Network facility is limited to 20% **coinsurance**, unless you consented to the Out-of-Network billing rates. |
| **If you are pregnant** | Prenatal and postnatal care | No charge | 35% coinsurance* | ——————none—————— |
| | Delivery and all inpatient services | 20% coinsurance | 35% coinsurance* | ——————none—————— |

| 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 help recovering or have other special health needs** | **Home health care** | 20% coinsurance* | 20% coinsurance* | Requires preauthorization. The **plan** pays for up to 30 days per calendar year. |
| | **Rehabilitation services** | Physical/Occupational Therapy: 20% coinsurance Speech Therapy: 20% coinsurance* | Physical/Occupational Therapy: 20% coinsurance* Speech Therapy: 20% coinsurance* | Physical/Occupational Therapy: Maximum 20 visits/calendar year. **Out-of-network** charges will not count toward the **out-of-pocket limit**. Speech Therapy: Maximum 30 visits/calendar year. |
| | **Habilitation services** | See Rehabilitation Services | See Rehabilitation Services | See Rehabilitation Services |
| | **Skilled nursing care** | 20% coinsurance | 35% coinsurance* | Requires preauthorization. The **plan** pays for up to 100 days/calendar year. |
| | **Durable medical equipment** | 20% coinsurance* | 20% coinsurance* | Expenses do not count toward the **out-of-pocket limit**. |
| | **Hospice service** | 20% coinsurance* | 20% coinsurance* | Requires certification from a physician that the life expectancy is less than six months. Continuation after six months requires preauthorization. |
| **If you need dental or eye care** | Eye exam | No charge | Not covered | Provided by VSP. |
| | Glasses | Not covered | Not covered | ——————none—————— |
| | Dental check-up | Plan covers 2 cleanings per year at 100% | Not covered | Provided by Delta Dental. Maximum calendar year benefit is $3,500/individual and $7,000/family |

## Excluded Services & Other Covered Services:

**Services Your Plan Does NOT Cover (This isn't a complete list. Check your plan document for a list of any other excluded services.)**

- Cosmetic surgery
- Infertility treatment
- Long term care
- Non-emergency care when traveling outside the U.S.
- Private duty nursing
- Weight loss programs

| Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.) | | | |
|---|---|---|---|
| • Acupuncture<br>• Bariatric surgery | • Chiropractic care<br>• Dental Care | • Hearing aids<br>• Routine eye care | • Routine foot care |

**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: your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa. 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 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 on how 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 plan at 1-800-548-1771 or www.sheet104fringe.org. You may also contact the U.S. Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or 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 1-800-548-1771.
Chinese (中文): 如果需要中文的帮助，请拨打这个号码 1-800-548-1771.

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

## 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 $300**
- **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)

| **Total Example Cost** | **$12,700** |
|---|---|
| **In this example, Peg would pay:** | |
| *Cost Sharing* | |
| Deductibles | $300 |
| Copayments | $0 |
| Coinsurance | $2,480 |
| *What isn't covered* | |
| Limits or exclusions | $0 |
| **The total Peg would pay is** | **$2,780** |

### Managing Joe's type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

- **The plan's overall deductible $300**
- **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)

| **Total Example Cost** | **$5,600** |
|---|---|
| **In this example, Joe would pay:** | |
| *Cost Sharing* | |
| Deductibles | $300 |
| Copayments | $0 |
| Coinsurance | $1,060 |
| *What isn't covered* | |
| Limits or exclusions | $0 |
| **The total Joe would pay is** | **$1,360** |

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

- **The plan's overall deductible $300**
- **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)

| **Total Example Cost** | **$2,800** |
|---|---|
| **In this example, Mia would pay:** | |
| *Cost Sharing* | |
| Deductibles | $300 |
| Copayments | $0 |
| Coinsurance | $500 |
| *What isn't covered* | |
| Limits or exclusions | $0 |
| **The total Mia would pay is** | **$800** |

**The plan would be responsible for the other costs of these EXAMPLE covered services.**