



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 at www.smw104d2fringe.org.com. 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 or call 1-925-208-9992 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible ?	\$150 / individual or \$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 ?	Yes. Preventive care and primary care services are covered before you meet your deductible .	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost sharing and before you meet your deductible . See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/ .
Are there other deductibles for specific services?	Yes. \$200 per admission for out-of-network hospitals. 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 ?	For network providers \$5,150 individual / \$5,300 family; for out-of-network providers there is no limit unless a preferred provider is not available	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 ?	Copayments for certain services, premiums , balance-billing charges, health care this plan doesn't cover, and penalties for failure to pre-authorize.	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 1-800-393-6130 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 ?	Yes.	This plan will pay some or all of the costs to see a specialist for covered services but only if you have a referral before you see the specialist .

 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 provider's office or clinic	Primary care visit to treat an injury or illness	20% coinsurance	40% coinsurance	None
	Specialist visit	20% coinsurance	40% coinsurance	Preauthorization is required.
	Preventive care/screening/immunization	No charge	40% 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	40% coinsurance	None
	Imaging (CT/PET scans, MRIs)	20% coinsurance	40% coinsurance	
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.sheet162fringe.org	Generic drugs	25% coinsurance , \$5 minimum, \$50 maximum	The In-Network Generic copay plus the difference between In-Network price and the amount you paid, if any.	Covers up to a 30-day supply (retail subscription); 31-90 day supply (mail order prescription).
	Preferred brand drugs	25% coinsurance , \$5 minimum, \$100 maximum. Difference in cost added if generic available	The In-Network Brand Copay plus the difference between In-Network price and the amount you paid, if any.	
	Non-preferred brand drugs	25% coinsurance , \$5 minimum. Difference in cost added if generic available	The In-Network Brand Copay plus the difference between In-Network price and the	

[* For more information about limitations and exceptions, see the [plan](#) or policy document at www.smw104d2fringe.org.com.]

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)	
			amount you paid, if any.	
	Specialty drugs	25% coinsurance , \$5 minimum, \$200 maximum. Difference in cost added if generic available	The In-Network Specialty Copay plus the difference between In-Network price and the amount you paid, if any.	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance	40% coinsurance	Preauthorization is required. If you don't get preauthorization , benefits could be reduced by 20% of the total cost of the service.
	Physician/surgeon fees	20% coinsurance	40% coinsurance , 20% if at an in-network facility	Anesthesia paid at 80% of UCR for out-of-network facility.
If you need immediate medical attention	Emergency room care	20% coinsurance	20% coinsurance	None
	Emergency medical transportation	20% coinsurance	20% coinsurance	
	Urgent care	20% coinsurance	40% coinsurance	
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance	40% coinsurance	Preauthorization is required. If you don't get preauthorization , benefits could be reduced by 20% of the total cost of the service. Anesthesia paid at 80% of UCR for out-of-network facility.
	Physician/surgeon fees	20% coinsurance	40% coinsurance , 20% if at an in-network facility	None
If you need mental health, behavioral health, or substance abuse services	Mental and behavioral health services	20% coinsurance for other outpatient services	40% coinsurance	Mental and behavioral health services must be preauthorized by Blue Shield at 1-800-541-6652. Substance abuse disorder services must be preauthorized by TARP at 1-800-522-8277.
	Substance abuse disorder services	10% coinsurance first treatment, 20% coinsurance for	40% coinsurance	

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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)	
		subsequent treatment		
If you are pregnant	Office visits	20% coinsurance	40% coinsurance	Cost sharing does not apply for preventive services . Depending on the type of services, a 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	20% coinsurance	40% coinsurance	Preauthorization is required.
	Rehabilitation services	20% coinsurance	40% coinsurance	Preauthorization is required. Includes physical therapy, speech therapy, and occupational therapy.
	Habilitation services	20% coinsurance	40% coinsurance	Preauthorization is required.
	Skilled nursing care	20% coinsurance	40% coinsurance	Preauthorization is required.
	Durable medical equipment	20% coinsurance	20% coinsurance	Costs over \$2,000 must be preauthorized. Excludes vehicle modifications, home modifications, and exercise equipment.
	Hospice services	20% coinsurance	20% coinsurance	Preauthorization is required. Limited to \$10,000 per patient, and six months from certification.
If your child needs dental or eye care	Children's eye exam	\$10 copay	Not covered	Coverage limited to one exam/year.
	Children's glasses	\$25 copay	Not covered	Coverage limited to one pair of glasses/24 months. \$130 frame allowance.
	Children's dental check-up	\$0 copay	Charges in excess of in-network allowance.	None

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 .)		
<ul style="list-style-type: none"> • Bariatric surgery • Cosmetic surgery • Infertility treatment to directly aid conception (such as IVF or intrauterine insemination) • Long-term care 	<ul style="list-style-type: none"> • Non-emergency care when traveling outside the U.S. • Private-duty nursing 	<ul style="list-style-type: none"> • Weight loss programs

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Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your [plan](#) document.)

- Acupuncture (if prescribed for rehabilitation purposes)
- Chiropractic care
- Dental care (Adult)
- Hearing aids
- Infertility treatment, limited to diagnosis to determine cause and surgical or hormonal treatment to correct the problem
- Routine foot care
- Routine eye care (Adult)

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](#). 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 Administrative Office at (925) 208-9992. You may also contact the 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 1-925-208-9992.

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 [plan's](#) overall [deductible](#) \$500
- [Specialist copayment](#) \$50
- Hospital (facility) [coinsurance](#) 20%
- Other [coinsurance](#) 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
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In this example, Peg would pay:

<i>Cost Sharing</i>	
Deductibles	\$500
Copayments	\$200
Coinsurance	\$1,800
<i>What isn't covered</i>	
Limits or exclusions	\$60
The total Peg would pay is	\$2,560

Managing Joe's Type 2 Diabetes

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

- The [plan's](#) overall [deductible](#) \$500
- [Specialist copayment](#) \$50
- Hospital (facility) [coinsurance](#) 20%
- Other [coinsurance](#) 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
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In this example, Joe would pay:

<i>Cost Sharing</i>	
Deductibles *	\$800
Copayments	\$900
Coinsurance	\$100
<i>What isn't covered</i>	
Limits or exclusions	\$20
The total Joe would pay is	\$1,820

Mia's Simple Fracture

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

- The [plan's](#) overall [deductible](#) \$500
- [Specialist copayment](#) \$50
- Hospital (facility) [coinsurance](#) 20%
- Other [coinsurance](#) 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
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In this example, Mia would pay:

<i>Cost Sharing</i>	
Deductibles *	\$500
Copayments	\$200
Coinsurance	\$400
<i>What isn't covered</i>	
Limits or exclusions	\$0
The total Mia would pay is	\$1,100

*Note: This [plan](#) has other [deductibles](#) for specific services included in this coverage example. See "Are there other [deductibles](#) for specific services?" row above.

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