



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 ? | \$225 / individual or \$900 / 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 \$5,225 individual / \$250 for each additional family member up to \$5,900 family maximum; 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. |

| Important Questions | Answers | Why This Matters: |
|--|---------|--|
| 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. | |

| 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) | |
| | 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 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 | |

| 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 | 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 subsequent treatment | 40% coinsurance | |
| 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, exercise, and bathroom 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. | Limited to 2 exams and 2 cleanings per calendar year. |

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.) | | |
| • Bariatric surgery | • Long-term care | • Weight loss programs |

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
- Infertility treatment to directly aid conception (such as IVF or intrauterine insemination)
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing

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 eye care (Adult)
- 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: 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.

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](#) \$225
- [Specialist coinsurance](#) 20%
- 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 |
|---------------------------|-----------------|

In this example, Peg would pay:

| <i>Cost Sharing</i> | |
|-----------------------------------|----------------|
| Deductibles | \$225 |
| Copayments | \$0 |
| Coinsurance | \$2,483 |
| <i>What isn't covered</i> | |
| Limits or exclusions | \$60 |
| The total Peg would pay is | \$2,543 |

Managing Joe's Type 2 Diabetes

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

- The [plan's](#) overall [deductible](#) \$225
- [Specialist coinsurance](#) 20%
- 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 |
|---------------------------|----------------|

In this example, Joe would pay:

| <i>Cost Sharing</i> | |
|-----------------------------------|----------------|
| Deductibles * | \$225 |
| Copayments | \$0 |
| Coinsurance | \$1,071 |
| <i>What isn't covered</i> | |
| Limits or exclusions | \$20 |
| The total Joe would pay is | \$1,091 |

Mia's Simple Fracture

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

- The [plan's](#) overall [deductible](#) \$225
- [Specialist coinsurance](#) 20%
- 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 |
|---------------------------|----------------|

In this example, Mia would pay:

| <i>Cost Sharing</i> | |
|-----------------------------------|--------------|
| Deductibles * | \$225 |
| Copayments | \$0 |
| Coinsurance | \$515 |
| <i>What isn't covered</i> | |
| Limits or exclusions | \$0 |
| The total Mia would pay is | \$515 |

*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.