This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at **www.eisb.org** or by calling **415-263-3670**

Important Questions	Answers	Why this Matters:
What is the overall deductible?	**$150** per person **$300** per family Does not apply to: preventive care; first $5,000 of out-patient Hospital charges (see plan for requirements); early screenings; and prescription drugs. Copayments do not count toward the deductible.	You must pay all the costs up to the **deductible** amount before this Plan begins to pay for covered services you use. Check your Plan Document to see when the **deductible** starts over (usually, but not always, January 1st). See the chart starting on page 2 for how much you pay for covered services after you meet the **deductible**.
Are there other deductibles for specific services?	No.	You don't have to meet **deductibles** for specific services, but see the chart starting on page 2 for other costs for services this Plan covers.
Is there an out–of–pocket limit on my expenses?	Yes. For **$1,500** per person in Covered Charges	The **out-of-pocket limit** is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.
What is not included in the out–of–pocket limit?	Deductibles, balance-billed charges, and health care this Plan does not cover.	Even though you pay these expenses, they don't count toward the **out-of-pocket limit**.
Is there an overall annual limit on what the plan pays?	**No annual limit effective January 1, 2014**	The chart starting on page 2 describes *specific* coverage limits, such as limits on the number of office visits.
Does this plan use a network of providers?	Yes. See www.blueshieldca.com or call 1-800-541-6652 for a list of participating providers	If you use an in-network doctor or other health care **provider**, this Plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network **provider** for some services. Plans use the term in-network, **preferred**, or participating for **providers** in their **network**. See the chart starting on page 2 for how this Plan pays different kinds of providers.

Questions: Call **415-263-3670** or visit us at **www.eisb.org.**
If you aren't clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary at **www.dol.gov/ebsa/healthreform or www.cciio.cms.gov** or call **415-263-3670** to request a copy.

Do I need a referral to see a specialist?	No.	You can see the **specialist** you choose without permission from this Plan.
Are there services this plan doesn't cover?	Yes.	Some of the services this Plan doesn't cover are listed on page 4. See your Plan Document for additional information about **excluded services**.

- **Copayments** are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.
- **Coinsurance** is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is $1,000, your **coinsurance** payment of 20% would be $200. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges $1,500 for an overnight stay and the **allowed amount** is $1,000, you may have to pay the $500 difference. (This is called **balance billing**.)
- This plan may encourage you to use **Preferred Providers** by charging you lower **deductibles**, **copayments** and **coinsurance** amounts.

Common Medical Event	Services You May Need	Your Cost If You Use a Preferred Provider	Your Cost If You Use a Non-Preferred Provider	Limitations & Exceptions
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	20% coinsurance	40% coinsurance	Amount in excess of Reasonable and Customary charge is not covered.
	Specialist visit	20% coinsurance	40% coinsurance	
	Other practitioner office visit	20% coinsurance	40% coinsurance	
	Preventive care/screening/immunization	No charge	40% coinsurance	
If you have a test	Diagnostic test (x-ray, blood work)	20% coinsurance	40% coinsurance	Amount in excess of Reasonable and Customary charge is not covered.
	Imaging (CT/PET scans, MRIs)	20% coinsurance	40% coinsurance	

Common Medical Event	Services You May Need	Your Cost If You Use a Preferred Provider	Your Cost If You Use a Non-Preferred Provider	Limitations & Exceptions
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.Optumrx.com.	Generic drugs	Lesser of 20% of retail price or $7/script (pharmacy); $17.50/script (mail order)	40% coinsurance	Covers up to 30-day supply (retail pharmacy); Covers up to 90-day supply (mail order)
	Brand Name drugs	20% of retail price	40% coinsurance	
	Specialty drugs	20% coinsurance up to $150	40% coinsurance	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance	40% coinsurance	If required, your cost for out-patient **Hospital facility** charges will be $0 for the first $5,000. Amount in excess of Reasonable and Customary charge is not covered.
	Physician/surgeon fees	20% coinsurance	40% coinsurance	
If you need immediate medical attention	Emergency room services	20% coinsurance	40% coinsurance	Out-of-network at 20% if treatment is required due to a serious threat to health Amount in excess of Reasonable and Customary charge is not covered.
	Emergency medical transportation	20% coinsurance	40% coinsurance	
	Urgent care	20% coinsurance	40% coinsurance	
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance	40% coinsurance	Amount in excess of Reasonable and Customary charge is not covered.
	Physician/surgeon fee	20% coinsurance	40%coinsurance	
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	No charge	40% coinsurance	Amount in excess of Reasonable and Customary charge is not covered.
	Mental/Behavioral health inpatient services	No charge	40% coinsurance	
	Substance use disorder outpatient services	No charge	40% coinsurance	
	Substance use disorder inpatient services	No charge	40% coinsurance	
If you are pregnant	Prenatal and postnatal care	20% coinsurance	40% coinsurance	

Common Medical Event	Services You May Need	Your Cost If You Use a Preferred Provider	Your Cost If You Use a Non-Preferred Provider	Limitations & Exceptions
	Delivery and all inpatient services	20% coinsurance	40% coinsurance	Only covered for Participant, Spouse, or Domestic Partner, not Dependent Child. Amount in excess of Reasonable and Customary charge is not covered.
If you need help recovering or have other special health needs	Home health care	20% coinsurance	40% coinsurance	Amount in excess of Reasonable and Customary charge is not covered.
	Rehabilitation services	20% coinsurance	40% coinsurance	
	Habilitation services	20% coinsurance	40% coinsurance	
	Skilled nursing care	20% coinsurance	40% coinsurance	After in-patient Hospital confinement of 3+ days, covers up to 100 days less days of Hospital confinement.
	Durable medical equipment	20% coinsurance	40% coinsurance	Covers rental not to exceed purchase price.
	Hospice service	20% coinsurance	40% coinsurance	Amount in excess of Reasonable and Customary charge is not covered.
If your child needs dental or eye care	Eye exam	$10 copayment	Cost in excess of $45	none
	Glasses	$10 copayment	Cost in excess of $45-$85 (lenses) & $47 (frames)	Covers lenses every 12 months and frames every 24 months.
	Dental check-up	No charge	20% coinsurance	20% coinsurance only applicable to Retirees

Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover (This isn't a complete list. Check your Plan Document for other excluded services.)

- Charges in excess of Reasonable and Customary
- Cosmetic Surgery
- Experimental or not generally accepted treatment
- Infertility treatment
- Hearing aids
- Long-term care
- Private-duty nursing
- Routine foot care
- Treatment not medically necessary
- Weight loss programs
- Non-emergency care when traveling outside the U.S.

Other Covered Services (This isn't a complete list. Check your Plan Document for other covered services and your costs for these services.)

- Acupuncture (limit 30 visits/year)
- Bariatric surgery
- Chiropractic care (limit 30 visits/year)
- Coverage provided outside the United States. See www.bcbs.com
- Dental care
- Routine eye care

Your Rights to Continue Coverage:

If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a **premium**, which may be significantly higher than the premium you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply.

For more information on your rights to continue coverage, contact the plan at 415-263-3670. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cciio.cms.gov.

Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to **appeal** or file a **grievance**. For questions about your rights, this notice, or assistance, you can contact: the Plan at 415-263-3670. You may also contact the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa/healthreform.

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

About these Coverage Examples:

These examples show how this Plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.

This is not a cost estimator.

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

Having a baby
(normal delivery)

- **Amount owed to providers:** $7,540
- **Plan pays** $5,920
- **Patient pays** $1,620

Sample care costs:

Hospital charges (mother)	$2,700
Routine obstetric care	$2,100
Hospital charges (baby)	$900
Anesthesia	$900
Laboratory tests	$500
Prescriptions	$200
Radiology	$200
Vaccines, other preventive	$40
Total	**$7,540**

Patient pays:

Deductibles	$150
Copays	$0
Coinsurance	$1,470
Limits or exclusions	$0
Total	**$1,620**

Managing type 2 diabetes
(routine maintenance of a well-controlled condition)

- **Amount owed to providers:** $5,400
- **Plan pays** $4,220
- **Patient pays** $1,180

Sample care costs:

Prescriptions	$2,900
Medical Equipment and Supplies	$1,300
Office Visits and Procedures	$700
Education	$300
Laboratory tests	$100
Vaccines, other preventive	$100
Total	**$5,400**

Patient pays:

Deductibles	$150
Copays	$0
Coinsurance	$1030
Limits or exclusions	$0
Total	**$1,180**

Questions and answers about the Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

- Costs don't include **premiums**.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network **providers**. If the patient had received care from out-of-network **providers**, costs would have been higher.

What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how **deductibles**, **copayments**, and **coinsurance** can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

Does the Coverage Example predict my own care needs?

✘ **No.** Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

Does the Coverage Example predict my future expenses?

✘ **No.** Coverage Examples are **not** cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your **providers** charge, and the reimbursement your health plan allows.

Can I use Coverage Examples to compare plans?

✓ **Yes.** When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

Are there other costs I should consider when comparing plans?

✓ **Yes.** An important cost is the **premium** you pay. Generally, the lower your **premium**, the more you'll pay in out-of-pocket costs, such as **copayments**, **deductibles**, and **coinsurance**. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.