SAN FRANCISCO ELECTRICAL WORKERS
HEALTH & WELFARE TRUST
720 MARKET STREET, SUITE 700 • SAN FRANCISCO, CA 94102
(415) 263-3670 • FAX (415) 263-3672

2016-2017 OPEN ENROLLMENT NOTICE

June 2016

TO: SAN FRANCISCO ELECTRICAL WORKERS ACTIVE/EARLY RETIREE PLAN PARTICIPANTS

FROM: PLAN OFFICE

RE: OPEN ENROLLMENT- Plan selection for 8/1/2016 – 7/31/2017

The Open Enrollment is being held during the month of July for coverage effective August 1, 2016. **Depending on where you reside,** you may choose from the following medical plans:

- **SELF FUNDED PPO**
- **KAISER HMO**
- **BLUE SHIELD HMO**

A comparison of the more significant benefits along with the Summary of Benefits Coverage for each medical plan as required by the Affordable Care Act, are enclosed. You are urged to study this comparison carefully and select the Plan you feel best meets the needs of your family. **Note that only under special circumstances, will participants be allowed to change plans outside the open enrollment period. This is why it is important for you to review all of the information before you make a change.** You may also contact the Fund Office if you would like additional information regarding the Plans.

If you wish to remain under your present coverage, no action is required. If you are changing coverage, complete the enclosed Request Form and return it to the Plan Office immediately. ALL CHANGE APPLICATIONS MUST BE RECEIVED NO LATER THAN July 25, 2016. If you wish to add a dependent, please contact the Fund Office.

Please check the applicable box(es) on the enclosed form to request a change in beneficiary or dependent status.

If you have any questions concerning this information or require additional information, do not hesitate to contact the Plan Office at (415) 263-3670.

SAN FRANCISCO ELECTRICAL WORKERS HEALTH & WELFARE PLAN
2016-2017 COMPARISON OF BENEFITS SUMMARY

PRINCIPAL FEATURES	COMPREHENSIVE MEDICAL COVERAGE	HEALTH MAINTENANCE ORGANIZATIONS	
	SELF-FUNDED PPO Coverage Worldwide	KAISER PERMANENTE	BLUE SHIELD HMO
CHOICE OF PROVIDERS	Choose any physician or hospital. Reduced charges available from PPO hospital and physician networks.	Must use Kaiser Permanente facilities and providers.	Must use Health Plan Providers.
ANNUAL PLAN MAXIMUMS	No annual maximum effective 1/1/2014.	No plan maximum.	No plan maximum.
BENEFITS/ OUT OF POCKET MAXIMUMS	In Network Providers: All benefits paid at 80% of the PPO Contract rate after satisfying deductible of $150 per person/$300 family. All covered benefits paid at 100% of the PPO Contract rate after incurring $1,500 per person in "out of pocket" covered expenses in a calendar year. Out of Network Providers: All benefits paid at 60% of usual and customary charges after satisfying deductible of $150 per person/$300 family. All covered benefits paid at 80% of usual and customary charges after incurring $1,500 per person in "out of pocket" covered expenses in a calendar year.	Maximum Out of Pocket: $1,500 Individual $3,000 Family See Co-pay information under categories listed below.	Maximum out of Pocket: $2,000 individual $4,000 two-party $6,000 family See Co-pay information under categories listed below.
HOSPITAL CONFINEMENT Room and Board, surgery, anesthesia and miscellaneous	See Benefits for In and Out of Network Treatment Described under Benefits/Out-Of Pocket Maximums.	No charge	$100 Co-pay
DOCTOR VISITS Office Hospital	See Benefits for In and Out of Network Treatment Described under Benefits/Out-Of Pocket Maximums.	$20 per visit No charge	$25 per visit No charge
OUTPATIENT LAB & X-RAYS	See Benefits for In and Out of Network Treatment Described under Benefits/Out-Of Pocket Maximums	No charge	No charge
OUTPATIENT SURGICAL SERVICES	First $5,000 paid at 100% (in network), 80% (Out of network); After first $5,000, See Benefits for In and Out of Network Treatment Described under Benefits/Out-Of Pocket Maximums.	$20 per procedure	$50 per surgery
PREVENTIVE HEALTH CARE	In Network 100% coverage for preventive care treatment, as required under PPACA. Information regarding services that are covered is available at: http//www.healthcare.gov/law/about/provisions/services/lists.html; 60 % out of network coverage for limited preventive care services.	No Charge; includes all preventive services mandated under the Affordable Care Act.	No Charge; includes all preventive services mandated under the Affordable Care Act.
AMBULANCE SERVICES	See Benefits for In and Out of Network Treatment Described under Benefits/Out-Of Pocket Maximums. Coverage available if required to move patient from place of injury or illness to nearest hospital equipped to provide necessary care.	No charge if authorized and medically necessary	No charge
MATERNITY CARE Mother's Expenses Newborn Care	(Members & Spouses/Domestic Partners only) Same as hospital confinement shown above for 48 hours following vaginal delivery and 96 hours following deliver by caesarian section. See Benefits for In and Out of Network Treatment Described under Benefits/Out-Of Pocket Maximums.	No charge $5 Prenatal Care & First Post Partum Visit No charge in hospital. Well newborns must be enrolled within 31 days of birth.	In patient:: $100 Co-pay Pre/Post Natal Care: No Charge. No charge in hospital if enrolled within 31 days of birth
EYE EXAMINATIONS EYE GLASSES	Covered by Vision Service Plan. $10 co-payment; Examination and lenses provided every 12 months; new frames available every 24 months.	$20 per visit (Exams Only) through Kaiser Covered by Vision Service Plan. $10 co-payment; Examination and lenses provided every 12 months; $200 new frame allowance available every 24 months.	Covered by Vision Service Plan. $10 co-payment; Examination and lenses provided every 12 months; $200 new frame allowance available every 24 months.

COVERED FEATURES	COMPREHENSIVE MEDICAL COVERAGE	HEALTH MAINTENANCE ORGANIZATIONS	
	SELF-FUNDED PPO (Coverage Worldwide)	KAISER PERMANENTE	BLUE SHIELD HMO
MENTAL HEALTH	In Network: 100% of Contract Rate. See Benefits for Out of Network Treatment Described under Benefits/Out-Of Pocket Maximums.	Outpatient: $20 co-pay for Individual Visits $10 co-pay for Group Visits Inpatient: Hospital covered in full	$0 Co-pay per out patient treatment $0 Co-pay per in patient confinement
SUBSTANCE ABUSE TREATMENT *(Alcohol and Drug dependency)*	In Network: 100% of Contract Rate. See Benefits for Out of Network Treatment Described under Benefits / Out-Of Pocket Maximums.	No Charge for inpatient Detox. $20 Outpatient Visits. $5 Outpatient Group Visits.	$0 Co-pay per out patient treatment $0 Co-pay per in patient confinement;
PHYSICAL THERAPY	See Benefits for In and Out of Network Treatment Described under Benefits/Out-Of Pocket Maximums; Claims subject to peer review for medical necessity and determination of appropriate treatment..	$20 Co-pay (short term)	Short-term therapy $25 copay.
EMPLOYEE ASSISTANCE PROGRAM (EAP)	Life Referrals (800) 985-2405; 3 Complimentary counseling sessions; Parenting / Childcare; Legal Advice; Financial Advice, Eldercare, etc.	Not Applicable	Life Referrals (800) 985-2405; 3 Complimentary counseling sessions; Parenting / Childcare; Legal Advice; Financial Advice, Eldercare, etc.
PRESCRIPTION DRUGS	Administered through Catamaran. Individual responsible for 20% co-payment (maximum co-pay for generics of $7 retail and $17.50 mail order) payable to pharmacy at time prescription is filled.	$10 generic / $30 brand named per prescription or refill at Kaiser Permanente Pharmacies up to a 30-day supply. $20 generic / $60 brand for a 90-day supply of mail–order only	$15 (generic) / $30 (brand named) per prescription or refill for a 30-day supply. $30 (generic) / $60 (brand named) for a 90-day supply of mail order prescriptions. Home Self-injectable 20% up to $100 co-pay maximum per prescription
PROSTHETIC DEVICES & DURABLE MEDICAL EQUIPMENT	See Benefits for In and Out of Network Treatment Described under Benefits/Out of Pocket Maximums. Rental of medical equipment, not to exceed the purchase price.	No charge in accord with Kaiser Permanente's durable medical equipment formulary guidelines	Prosthetics & Orthotics equipment and devices no charge. Durable Medical Equip. no charge.
EMERGENCY ROOM AND OUT OF AREA SERVICE *(Outside of Plan facilities)*	Worldwide Coverage. In Network: First $5,000 paid at 100%. After first $5,000, See Benefits for In and Out of [Network Treatment due to serious threat of health as defined by PPACA is covered without regard to whether a provider is in or out-of-network]	$100 Co-pay. Worldwide coverage for urgent or emergency services. Follow-up and routine care covered at Kaiser facility. Waived if admitted directly to hospital.	$100 copay, waived if admitted to hospital. Routine care not covered.
DENTAL COVERAGE	Self Funded Plan Administered by Delta Dental.	Self Funded Plan Administered by Delta Dental.	Self Funded Plan Administered By Delta Dental
SPECIAL NOTES Your eligible dependents are: - Lawful Spouse, Registered Domestic Partner, Natural / Step / Adopted Children through age 18; Adult Children ages 19 through 25	Chiropractic & Acupuncture treatments covered as any other medical expense, limited to 30 visits per calendar year. Self Funded payments are based on allowable charges. Blood donations for your own surgery covered if physician recommends.	Chiropractic covered at $15 per visit, limited to 30 visits per calendar year. Acupuncture services are not covered. $20 per Visit Allergy and / or Testing $3 Allergy Injection Visits	Chiropractic and Acupuncture services not covered. $25 per visit for allergy testing, allergy serum is included. Home health care maximum of 100 visits per calendar year. Diagnosis and treatment of Causes of Infertility paid at 50% of allowed charges. (Excludes in vitro fertilization, injectables for infertility, artificial insemination and GIFT.)

NOTE: This comparison of benefit coverage is intended only as a general description of the principal features of the benefit plans. Each Plan's benefit booklet should be consulted for additional information.

SAN FRANCISCO ELECTRICAL WORKERS HEALTH & WELFARE TRUST
720 Market Street, Suite 700, San Francisco, CA 94102
(415) 263-3670

PLAN and DEPENDENT CHANGE REQUEST FORM

I have read the enclosed Comparison of Benefits and would like to change to the following Plan. (Please check the appropriate box, fill in the information requested below and return this form and the information, along with the appropriate enrollment form and/or identification card, will be sent to you.)

- ☐ SELF-FUNDED PPO (AVAILABLE WORLD WIDE)
- ☐ KAISER (Limited to certain geographic areas in California Only- contact Plan Office for more information)
- ☐ BLUE SHIELD HMO (Limited to certain geographic areas in California Only- contact Plan Office for more information or the Blue Shield website @ www.blueshieldca.com)

If you 1) have had a change in dependent status or wish to add an eligible dependent not currently enrolled in the Plan, or 2) wish to change your beneficiary designation, please check the applicable box below and the Plan Office will see that you receive the appropriate form:

- ☐ CHANGE IN BENEFICIARY STATUS
- ☐ CHANGE IN DEPENDENT STATUS

_____
Your Name (please print)

_____
Signature

_____
Social Security Number

_____
Street Address

_____
City, State, Zip Code

San Francisco Electrical Workers Health & Welfare Trust
❖❖Notice of Privacy Practices❖❖

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

USE AND DISCLOSURE OF HEALTH INFORMATION

The San Francisco Electrical Workers Health & Welfare Trust ("the Health Plan") may use your health information, that is, information that constitutes protected health information as defined in the Privacy Rule of the Administrative Simplification provision of the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), for purposes of making or obtaining payment for your care and conducting health care operations. The Health Plan has established a policy to guard against unnecessary disclosure of your health information.

THE FOLLOWING IS A SUMMARY OF THE CIRCUMSTANCES UNDER WHICH AND PURPOSES FOR WHICH YOUR HEALTH INFORMATION MAY BE USED AND DISCLOSED:

To Make or Obtain Payment. The Health Plan may use or disclose your health information to make payment to or collect payment from third parties, such as other health plans or providers, for the care you receive. For example, the Health Plan may provide information regarding your coverage or health care treatment to other health plans to coordinate payment of benefits.

To Conduct Health Care Operations. The Health Plan may use or disclose health information for its own operations to facilitate the administration of the Health Plan and as necessary to provide coverage and services to all of the Health Plan's participants. Health care operations may include such activities as:

- Quality assessment and improvement activities.
- Activities designed to improve health or reduce health care costs.
- Clinical guideline and protocol development, case management and care coordination.
- Contacting health care providers and participants with information about treatment alternatives and other related functions.
- Underwriting, premium rating or related functions to create, renew or replace health insurance or health benefits.
- Review and auditing, including compliance reviews, medical reviews, legal services and compliance programs.
- Business planning and development including cost management and planning related analyses and formulary development.
- Business management and general administrative activities of the Health Plan, including customer service and resolution of internal grievances.

For example, the Health Plan may use your health information to conduct case management, quality improvement and utilization review, or to engage in customer service and grievance resolution activities.

For Treatment Alternatives. The Health Plan may use and disclose your health information to tell you about or recommend possible treatment options or alternatives that may be of interest to you.

For Distribution of Health-Related Benefits and Services. The Health Plan may use or disclose your health information to provide to you information on health-related benefits and services that may be of interest to you.

For Disclosure to the Plan Sponsor. The Health Plan may disclose your health information to the Board of Trustees for plan administration functions performed by the Board of Trustees on behalf of the Health Plan. In addition, the Health Plan may provide summary health information to the Board of Trustees so that the Board of Trustees may solicit premium bids from health insurers or modify, amend or terminate the plan. The Health Plan also may disclose to the Board of Trustees information on whether you are participating in the health plan.

When Legally Required. The Health Plan will disclose your health information when it is required to do so by any federal, state or local law.

To Conduct Health Oversight Activities. The Health Plan may disclose your health information to a health oversight agency for authorized activities including audits, civil administrative or criminal investigations, inspections, licensure or disciplinary action, or other activities necessary for appropriate oversight of government benefit programs (such as investigations of Medicare fraud).

Lawsuits and Similar Proceedings/Subpoenas. As permitted or required by state law, the Health Plan may disclose your health information in the course of any judicial or administrative proceeding in response to an order of a court or administrative tribunal as expressly authorized by such order or in response to a subpoena, discovery request or other lawful process, but only if the Health Plan has evidence or information such as a proof of service that you or your attorney received notice of the subpoena, discovery request or other lawful process (or the Health Plan has otherwise notified or attempted to notify you).

For Law Enforcement Purposes. As permitted or required by state law, the Health Plan may disclose your health information to a law enforcement official for certain law enforcement purposes, including, but not limited to, if the Health Plan has a suspicion that your death was the result of criminal conduct or in an emergency to report a crime.

In the Event of a Serious Threat to Health or Safety. The Health Plan may, consistent with applicable law and ethical standards of conduct, disclose your health information if the Health Plan, in good faith, believes that such disclosure is necessary to prevent or lessen a serious threat to your health or safety or to the health and safety of the public.

Military and Other Specified Government Functions. In certain circumstances, federal regulations require the Health Plan to use or disclose your health information to facilitate specified government functions related to the military and veterans, national security and intelligence activities, protective services for the president and others, and correctional institutions and inmates.

For Worker's Compensation. The Health Plan may release your health information to the extent necessary to comply with laws related to worker's compensation or similar programs.

AUTHORIZATION TO USE OR DISCLOSE HEALTH INFORMATION

Other than as stated above, the Health Plan will not disclose your health information other than with your written authorization. If you authorize the Health Plan to use or disclose your health information, you may revoke that authorization in writing at any time.

YOUR RIGHTS WITH RESPECT TO YOUR HEALTH INFORMATION

You have the following rights regarding your health information that the Health Plan maintains:

Right to Request Restrictions. You may request restrictions on certain uses and disclosures of your health information. You have the right to request a limit on the Health Plan's disclosure of your health information to someone involved in the payment of your care. The Health Plan is not required to comply with the agreed upon restriction(s) in emergency situations when the restricted PHI is needed for treatment. Additionally, the Health Plan is not required to agree to your request. If you wish to make a request for restrictions, please make your request in writing to the Health Plans "Privacy Official" at 720 Market St., Suite 700, San Francisco, CA 94102 or Fax to (415) 263-3674. For your convenience a "Request for Restrictions" Form is available.

Right to Receive Confidential Communications. You have the right to request that the Health Plan communicate with you in a certain way if you feel the disclosure of your health information could endanger you. For example, you may ask that the Health Plan only communicate with you at a certain telephone number or by email. If you wish to receive confidential communications, please make your request in writing to the Health Plans "Privacy Official" at 720 Market St., Suite 700, San Francisco, CA 94102 or Fax to (415) 263-3674. For your convenience a "Request for Confidential Communications" form is available. The Health Plan will attempt to honor your reasonable requests for confidential communications.

Right to Inspect and Copy Your Health Information. You have the right to inspect and copy your health information. A request to inspect and copy records containing your health information must be made in writing to the Health Plans "Privacy Official" at 720 Market St., Suite 700, San Francisco, CA 94102 or Fax to (415) 263-3674. If you request a copy of your health information, the request must be made in writing to the Health Plans "Privacy Official", the Health Plan may charge a reasonable fee for copying, assembling costs and postage, if applicable, associated with your request. The requested information will be provided within 30 days if the information is maintained on site or within 60 days if the information is maintained off site. A one-time 30 day extension may be necessary in unique circumstances. Please note that under government regulations, you do not have a right to copies of psychotherapy notes.

Right to Amend Your Health Information. If you believe that your health information records are inaccurate or incomplete, you may request that the Health Plan amend the records. That request may be made as long as the information is maintained by the Health Plan. A request for an amendment of records must be made in writing to the Health Plans "Privacy Official" at 720 Market St., Suite 700, San Francisco, CA 94102 or Fax to (415) 263-3674. The Health Plan may deny the request if it does not include a reason to support the amendment. The request also may be denied if your health information records were not created by the Health Plan, if the health information you are requesting to amend is not part of the Health Plan's records, if the health information you wish to amend falls within an exception to the health information you are permitted to inspect and copy, or if the Health Plan determines the records containing your health information are accurate and complete.

Right to an Accounting of Disclosures. You have the right to request a list of certain disclosures of your health information that the Health Plan is required to keep a record of under the Privacy Rule, such as disclosures for public purposes authorized by law or disclosures that are not in accordance with the Plan's privacy policies and applicable law. The request must be made in writing to the Health Plans "Privacy Official" at 720 Market St., Suite 700, San Francisco, CA 94102 or Fax to (415) 263-3674. The request should specify the time period for which you are requesting the information, but may not start earlier than April 14, 2003 and may not be made for periods of time going back more than six (6) years. The Health Plan will provide the first accounting you request during any 12-month period without charge. Subsequent accounting requests may be subject to a reasonable cost-based fee. The Health Plan will inform you in advance of the fee, if applicable.

Right to a Paper Copy of this Notice. You have a right to request and receive a paper copy of this Notice at any time, even if you have received this Notice previously or agreed to receive the Notice electronically. To obtain a paper copy, please contact the Health Plans "Privacy Official" at (415) 263-3670. [You also may obtain a copy of the current version of the Health Plan's Notice at its Web site, *www.eisb.org*]

DUTIES OF THE HEALTH PLAN

The Health Plan is required by law to maintain the privacy of your health information as set forth in this Notice and to provide to you this Notice of its duties and privacy practices. The Health Plan is required to abide by the terms of this Notice, which may be amended from time to time. The Health Plan reserves the right to change the terms of this Notice and to make the new Notice provisions effective for all health information that it maintains. If the Health Plan changes its policies and procedures, the Health Plan will revise the Notice and will provide a copy of the revised Notice to you within 60 days of the change.

RIGHT TO FILE A COMPLAINT

You have the right to express complaints to the Health Plan and to the Secretary of the Department of Health and Human Services if you believe that your privacy rights have been violated. Any complaints to the Health Plan should be made in writing to the Health Plans "Privacy Official" at 720 Market St., Suite 700, San Francisco, CA 94102 or Fax to (415) 263-3674. The Health Plan encourages you to express any concerns you may have regarding the privacy of your information. You will not be retaliated against in any way for filing a complaint.

CONTACT PERSON

The Health Plan has designated the Health Plans "Privacy Official" as its contact person for all issues regarding patient privacy and your privacy rights. You may contact this person at 720 Market St., Suite 700, San Francisco, CA 94102 or (415) 263-3670.

APPEALS PROCESS

If the Privacy Official or any other plan representative denies any request of takes other action (or fails to take such actions) with respect to this Privacy Notice and your Privacy Rights under the plan, you may submit a written appeal to the Board of Trustees in accordance with the appeal procedures set forth in the Plan's Summary Plan Description.

EFFECTIVE DATE[1]

This Notice is effective April 14, 2003.

IF YOU HAVE ANY QUESTIONS REGARDING THIS NOTICE, PLEASE CONTACT THE HEALTH PLANS "PRIVACY OFFICIAL" AT 720 MARKET ST., SUITE 700, SAN FRANCISCO, CA 94102 OR (415) 263-3670.

[1] Reviewed/Revised 06/2016

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ANNUAL NOTICE
[This information is included in your Summary Plan Description]

Women's Health and Cancer Rights Act of 1998

On October 21, 1998, President Clinton Signed the Omnibus Appropriations Bill which included a new federal law called the Women's Health and Cancer Rights Act of 1998. Under this new federal law, group health plans, group health plans, insurers and HMOs that provide medical and surgical benefits in connection with a mastectomy must provide benefits for certain reconstructive surgery. In the case of a participant or beneficiary who is receiving benefits under the plan in connection with a mastectomy and who elects breast reconstruction, the law requires coverage in a manner determined in consultation with the attending physician and the patient, for 1) reconstruction of the breast on which the mastectomy was performed, 2) surgery and reconstruction on the other breast to produce a symmetrical appearance, and 3) prostheses and physical complications of all stages of mastectomy, including lymphedemas. This coverage is subject to the plan's annual deductibles and coinsurance provisions.

Newborn's and Mother's Health Protection Act

Group health plans and health insurance issuers generally may not, under federal law, restrict benefits for any hospital length of stay in connections with childbirth for the mother or newborn child less than 48 hours following a normal delivery, or less than 96 hours following a cesarean section. (However, federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother her newborn earlier than the 48 hours, or 96 hours as applicable.) In any case, plans and issuers may not, under federal law, require that a provider obtain authorization from the plan or the issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

If you have any questions concerning these matters, please contact the Fund Office at (415) 263-3670.

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.myCatamaranrx.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	Only covered for Participant, Spouse, or Domestic Partner, not Dependent

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	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.

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.

San Francisco Electrical Workers Custom HMO

Summary of Benefits and Coverage: What this Plan Covers & What it Costs

Coverage Period: 08/01/2016-07/31/2017

Coverage for: Individual + Family | **Plan Type:** HMO

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.blueshieldca.com~~ or by calling **1-855-256-9404**.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	**$0**.	See the chart starting on page 2 for your costs for services this plan covers.
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 plan providers: **$2,000** per individual /**$4,000** per two persons./ **$6,000** per family.	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?	Premiums, cost sharing for certain services listed in formal contract of coverage, and health care this plan doesn't 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.	The chart starting on page 2 describes any limits on what the plan will pay for *specific* covered services, such as office visits.
Does this plan use a network of providers?	Yes. See **www.blueshieldca.com or call 1-855-256-9404** for a list of plan 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**.
Do I need a referral to see a specialist?	Yes. Members need written approval to see a specialist except for OB/GYN or pediatrician serving as Primary Care Physician. Members may self refer using the Access+ Self Referral feature or for	The plan will pay some or all of the costs to see a **specialist** for covered services but only if you have the plan's permission before you see the **specialist**.

Important Questions	Answers	Why this Matters:
	OB/GYN services. Please see the formal contract of coverage for details.	
Are there services this plan doesn't cover?	Yes.	Some of the services this plan doesn't cover are listed on page 10. See your policy or 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 plan **providers** by charging you lower **deductibles**, **copayments** and **coinsurance** amounts.

Common Medical Event	Services You May Need	Your Cost If You Use a Plan Provider	Your Cost If You Use a Non-Plan Provider	Limitations & Exceptions
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$25 copayment / visit	Not Covered	For other services received during the office visit, additional member cost-share may apply.
	Specialist visit	$25 copayment / visit	Not Covered	For other services received during the office visit, additional member cost-share may apply. $30 copayment per visit for Access+ Specialist Self Referral.
	Other practitioner office visit	Not Covered	Not Covered	----------None----------

Common Medical Event	Services You May Need	Your Cost If You Use a Plan Provider	Your Cost If You Use a Non-Plan Provider	Limitations & Exceptions
	Preventive care/screening /immunization	No Charge	Not Covered	Preventive health services are only covered when provided by plan providers. Coverage for services consistent with ACA requirements and California laws. Please refer to your plan contract for details.
If you have a test	Diagnostic test (x-ray, blood work)	Lab & Path at Free Standing Location: No Charge X-Ray & Imaging at Free Standing Radiology Center: No Charge Other Diagnostic Examination at Free Standing Location: No Charge X-Ray, Lab & Other Examination at Outpatient Hospital: No Charge	Not Covered	Benefits in this section are for diagnostic, non-preventive health services. Pre-authorization from primary care physician and medical plan is required. Failure to obtain pre-authorization may result in non-payment of benefits.
	Imaging (CT/PET scans, MRIs)	Radiological & Nuclear Imaging at Free Standing Radiology Center: No Charge Radiological & Nuclear Imaging at Outpatient Hospital: No Charge	Not Covered	Benefits in this section are for diagnostic, non-preventive health services. Pre-authorization from primary care physician and medical plan is required. Failure to obtain pre-authorization may result in non-payment of benefits.

Common Medical Event	Services You May Need	Your Cost If You Use a Plan Provider	Your Cost If You Use a Non-Plan Provider	Limitations & Exceptions
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.blueshieldca.com	Generic drugs	Retail: $15 copayment / prescription Mail Order: $30 copayment / prescription	Not Covered	Retail: Covers up to a 30-day supply; Mail Order: Covers up to a 90-day supply. Select formulary and non-formulary drugs require pre-authorization.
	Brand Formulary Drugs	Retail: $30 copayment / prescription Mail Order: $60 copayment / prescription	Not Covered	
	Brand Non-Formulary Drugs	Not Covered	Not Covered	----------None----------
	Specialty drugs	20% coinsurance up to $100 copayment maximum / prescription	Not Covered	Covers up to a 30-day supply. Coverage limited to drugs dispensed by select pharmacies in the Specialty Pharmacy Network unless medically necessary for a covered emergency. Pre-authorization is required.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	No Charge	Not Covered	----------None----------
	Physician/surgeon fees	No Charge	Not Covered	----------None----------
If you need immediate medical attention	Emergency room services	$100 copayment / visit	$100 copayment / visit	Copayment waived if admitted; standard inpatient hospital facility benefits apply. This is for the hospital/facility charge only. The ER physician charge is separate. Coverage outside of California under BlueCard.
	Emergency medical transportation	No Charge	No Charge	----------None----------

Common Medical Event	Services You May Need	Your Cost If You Use a Plan Provider	Your Cost If You Use a Non-Plan Provider	Limitations & Exceptions
	Urgent care	Within Plan service area: $25 copayment / visit Outside Plan service area: $25 copayment / visit	Within Plan service area: Not Covered Outside Plan service area: $25 copayment / visit	Pre-authorization from primary care physician and medical plan is required. Failure to obtain pre-authorization may result in non-payment of benefits.
If you have a hospital stay	Facility fee (e.g., hospital room)	$100 copayment / visit	Not Covered	Pre-authorization from primary care physician and medical plan is required. Failure to obtain pre-authorization may result in non-payment of benefits.
	Physician/surgeon fee	No Charge	Not Covered	----------None----------

Common Medical Event	Services You May Need	Your Cost If You Use a Plan Provider	Your Cost If You Use a Non-Plan Provider	Limitations & Exceptions
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	Mental Health Routine Outpatient Services: No Charge Mental Health Non-Routine Outpatient Services: No Charge	Not Covered	Mental Health Routine Outpatient Services: Services include professional/physician office visits. Mental Health Non-Routine Outpatient Services: Services include behavioral health treatment, electroconvulsive therapy, intensive outpatient programs, partial hospitalization programs, and transcranial magnetic stimulation. Higher copayment and facility charges per episode of care may apply for partial hospitalization programs. Pre-authorization from Mental Health Service Administrator (MHSA) is required for non-routine outpatient mental health services. Failure to obtain pre-authorization may result in non-payment of benefits.
	Mental/Behavioral health inpatient services	Mental Health Inpatient Hospital Services: No Charge Mental Health Residential Services: No Charge Mental Health Inpatient Physician Services: No Charge	Not Covered	Pre-authorization from Mental Health Service Administrator (MHSA) is required. Failure to obtain pre-authorization may result in non-payment of benefits.

Common Medical Event	Services You May Need	Your Cost If You Use a Plan Provider	Your Cost If You Use a Non-Plan Provider	Limitations & Exceptions
	Substance use disorder outpatient services	Substance Abuse Routine Outpatient Services: No Charge Substance Abuse Non-Routine Outpatient Services: No Charge	Not Covered	Substance Abuse Routine Outpatient Services: Services include professional/physician office visits. Substance Abuse Non-Routine Outpatient Services: Services include partial hospitalization program, intensive outpatient program, and office-based opioid treatment. Higher copayment and facility charges per episode of care may apply for partial hospitalization programs. Pre-authorization from Mental Health Service Administrator (MHSA) is required for non-routine outpatient substance abuse services. Failure to obtain pre-authorization may result in non-payment of benefits.
	Substance use disorder inpatient services	Substance Abuse Inpatient Hospital Services: No Charge Substance Abuse Residential Services: No Charge Substance Abuse Inpatient Physician Services: No Charge	Not Covered	Pre-authorization from Mental Health Service Administrator (MHSA) is required. Failure to obtain pre-authorization may result in non-payment of benefits.

Common Medical Event	Services You May Need	Your Cost If You Use a Plan Provider	Your Cost If You Use a Non-Plan Provider	Limitations & Exceptions
If you are pregnant	Prenatal and postnatal care	Prenatal: No Charge Postnatal: No Charge	Not Covered	Prenatal: $10 copayment for initial visit only.
	Delivery and all inpatient services	$100 copayment / visit	Not Covered	----------None----------

Common Medical Event	Services You May Need	Your Cost If You Use a Plan Provider	Your Cost If You Use a Non-Plan Provider	Limitations & Exceptions
If you need help recovering or have other special health needs	Home health care	No Charge	Not Covered	Coverage limited to 100 visits per member per calendar year. Pre-authorization from primary care physician and medical plan is required. Failure to obtain pre-authorization may result in non-payment of benefits.
	Rehabilitation services	Office visit: $25 copayment / visit Outpatient hospital: $25 copayment / visit	Not Covered	Coverage for physical, occupational and respiratory therapy services.
	Habilitation services	Office visit: $25 copayment / visit Outpatient hospital: $25 copayment / visit	Not Covered	
	Skilled nursing care	No Charge	Not Covered	Coverage limited to 100 days per member per benefit period combined with hospital/free-standing skilled nursing facility. Pre-authorization from primary care physician and medical plan is required. Failure to obtain pre-authorization may result in non-payment of benefits.
	Durable medical equipment	No Charge	Not Covered	Pre-authorization from primary care physician and medical plan is required. Failure to obtain pre-authorization may result in non-payment of benefits.

Common Medical Event	Services You May Need	Your Cost If You Use a Plan Provider	Your Cost If You Use a Non-Plan Provider	Limitations & Exceptions
	Hospice service	No Charge	Not Covered	Pre-authorization from primary care physician and medical plan is required. Failure to obtain pre-authorization may result in non-payment of benefits.
If your child needs dental or eye care	Eye exam	Not Covered	Not Covered	----------None----------
	Glasses	Not Covered	Not Covered	----------None----------
	Dental check-up	Not Covered	Not Covered	----------None----------

Excluded Services & Other Covered Services:

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

- Acupuncture
- Chiropractic care
- Cosmetic surgery
- Dental care (Adult/Child)
- Hearing aids
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Private -duty nursing (unless enrolled in a participating hospice program.)
- Routine eye care (Adult)
- Routine foot care (unless for treatment of diabetes.)
- Weight loss programs

Other Covered Services (This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)

- Bariatric surgery (pre-authorization from primary care physician and medical plan is required. Failure to obtain pre-authorization may result in non-payment of benefits.)
- Infertility treatment (coverage for diagnosis and treatment of cause of infertility only.)

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 **1-855-256-9404**. 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** X **61565** 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: **1-855-256-9404** or the Department of Labor's Employee Benefits Security Administration at **1-866-444-EBSA (3272)** or ~~www.dol.gov/ebsa/healthreform~~. Additionally, a consumer assistance program can help you file your ~~**appeal**~~. Contact California Department of Managed Health Care Help at **1-888-466-2219** or visit ~~http://www.healthhelp.ca.gov~~.

Does this Coverage Provide Minimum Essential Coverage?

The Affordable Care Act requires most people to have health care coverage that qualifies as "minimum essential coverage." **This plan or policy does provide minimum essential coverage.**

Does this Coverage Meet the Minimum Value Standard?

The Affordable Care Act establishes a minimum value standard of benefits of a health plan. The minimum value standard is 60% (actuarial value). **This health coverage does meet the minimum value standard for the benefits it provides.**

Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al 1-866-346-7198.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-866-346-7198.

Chinese (中文): 如果需要中文的帮助，**请拨打这个号码**1-866-346-7198.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-866-346-7198.

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** $7,370
- **Patient pays** $170

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	$0
Copays	$120
Coinsurance	$0
Limits or exclusions	$150
Total	**$270**

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

- **Amount owed to providers:** $5,400
- **Plan pays** $4,470
- **Patient pays** $930

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	$0
Copays	$850
Coinsurance	$0
Limits or exclusions	$80
Total	**$930**

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.
- Plan and patient payments are based on a single person enrolled on the plan or policy.

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.

Questions: Call **1-855-256-9404** or visit us at www.blueshieldca.com.
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 call **1-866-444-3272** to request a copy.

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.kp.org/plandocuments** or by calling **1-800-278-3296**.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	**$0**	See chart on page 2 for your costs for services this plan covers.
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**. **$1,500** Individual/**$3,000** Family	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?	Premiums, health care this plan doesn't cover, and cost sharing for certain services listed in plan documents.	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**.	The chart starting on page 2 describes any limits on what the plan will pay for *specific* covered services, such as office visits.
Does this plan use a network of providers?	**Yes**. For a list of **plan providers**, see **www.kp.org** or call **1-800-278-3296**.	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**.
Do I need a referral to see a specialist?	**Yes**, but you may self-refer to certain specialists.	This plan will pay some or all of the costs to see a **specialist** for covered services but only if you have the plan's permission before you see the **specialist**.
Are there services this plan doesn't cover?	**Yes**.	Some of the services this plan doesn't cover are listed on page 5. See your policy or 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 **plan providers** by charging you lower **deductibles**, **copayments** and **coinsurance** amounts.

Common Medical Event	Services You May Need	Your cost if you use a Plan Provider	Your cost if you use a Non-Plan Provider	Limitations & Exceptions
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$20 per visit	Not Covered	——————none——————
	Specialist visit	$20 per visit	Not Covered	Services related to infertility covered at $20 per visit.
	Other practitioner office visit	$15 per visit for chiropractic services, $20 per visit for acupuncture services.	Not Covered	Up to 30 visits per year for chiropractic services, Physician referred acupuncture.
	Preventive care/ screening/ immunization	No Charge	Not Covered	Some preventive screenings (such as lab and imaging) may be at a different cost share.
If you have a test	Diagnostic test (x-ray, blood work)	X-ray: No Charge; Lab tests: No Charge	Not Covered	——————none——————
	Imaging (CT/PET scans, MRI's)	No Charge	Not Covered	——————none——————

Common Medical Event	Services You May Need	Your cost if you use a Plan Provider	Your cost if you use a Non-Plan Provider	Limitations & Exceptions
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.kp.org/formulary .	Generic drugs	Plan pharmacy: $10 per prescription for 1 to 30 days; Mail order: Usually two times the plan pharmacy cost sharing for up to a 100-day supply	Not Covered	In accordance with formulary guidelines. Certain drugs may be covered at a different cost share.
	Preferred brand drugs	Plan pharmacy: $30 per prescription for 1 to 30 days; Mail order: Usually two times the plan pharmacy cost sharing for up to a 100-day supply	Not Covered	In accordance with formulary guidelines. Certain drugs may be covered at a different cost share.
	Non-preferred brand drugs	Same as preferred brand drugs.	Not Covered	Same as preferred brand drugs when approved through exception process.
	Specialty drugs	Same as preferred brand drugs.	Not Covered	Same as preferred brand drugs when approved through exception process.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	$20 per procedure	Not Covered	————————none————————
	Physician/surgeon fees	No Charge	Not Covered	————————none————————
If you need immediate medical attention	Emergency room services	$100 per visit	$100 per visit	————————none————————
	Emergency medical transportation	No Charge	No Charge	————————none————————
	Urgent care	$20 per visit	$20 per visit	Non-Plan providers covered when outside the service area.
If you have a hospital stay	Facility fee (e.g., hospital room)	No Charge	Not Covered	————————none————————
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Common Medical Event	Services You May Need	Your cost if you use a Plan Provider	Your cost if you use a Non-Plan Provider	Limitations & Exceptions
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	$20 per individual visit; $10 per group visit; No Charge for other outpatient services	Not Covered	——————none——————
	Mental/Behavioral health inpatient services	No Charge	Not Covered	——————none——————
	Substance use disorder outpatient services	$20 per individual visit; $5 per group visit; $5 per visit for other outpatient services	Not Covered	——————none——————
	Substance use disorder inpatient services	No Charge	Not Covered	——————none——————
If you are pregnant	Prenatal and postnatal care	Prenatal care: No Charge; Postnatal care: No Charge	Prenatal care: Not covered; Postnatal care: Not covered	Prenatal: Cost sharing is for routine preventive care only; Postnatal: Cost sharing is for the first postnatal visit only.
	Delivery and all inpatient services	No Charge	Not Covered	——————none——————
If you need help recovering or have other special health needs	Home health care	No Charge	Not Covered	Up to 2 hours maximum per visit, up to 3 visits maximum per day, up to 100 visits maximum per year.
	Rehabilitation services	Inpatient: No Charge; Outpatient: $20 per visit	Not Covered	——————none——————
	Habilitation services	$20 per visit	Not Covered	——————none——————
	Skilled nursing care	No Charge	Not Covered	Up to 100 days maximum per benefit period.
	Durable medical equipment	No Charge	Not Covered	Must be in accordance with formulary guidelines. Requires prior authorization.
	Hospice service	No Charge	Not Covered	Limited to diagnoses of a terminal illness with a life expectancy of twelve months or less.

Common Medical Event	Services You May Need	Your cost if you use a Plan Provider	Your cost if you use a Non-Plan Provider	Limitations & Exceptions
If your child needs dental or eye care	Eye exam	No Charge	Not Covered	——————none——————
	Glasses	Not Covered	Not Covered	——————none——————
	Dental check-up	Not Covered	Not Covered	You may have other dental coverage not described here.

Excluded Services & Other Covered Services:

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

- Cosmetic surgery
- Dental care (Adult)
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Does this Coverage Meet the Minimum Value Standard?

The Affordable Care Act establishes a minimum value standard of benefits of a health plan. The minimum value standard is 60% (actuarial value). **This health coverage does meet the minimum value standard for the benefits it provides.**

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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** $7,320
- **Patient pays** $220

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	$0
Copays	$20
Coinsurance	$0
Limits or exclusions	$200
Total	**$220**

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

- **Amount owed to providers:** $5,400
- **Plan pays** $4,620
- **Patient pays** $780

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	$0
Copays	$700
Coinsurance	$0
Limits or exclusions	$80
Total	**$780**

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.

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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.kp.org/plandocuments** or by calling **1-800-278-3296**.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	**$0**	See chart on page 2 for your costs for services this plan covers.
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**. **$1,500** Individual/**$3,000** Family	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?	Premiums, health care this plan doesn't cover, and cost sharing for certain services listed in plan documents.	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**.	The chart starting on page 2 describes any limits on what the plan will pay for *specific* covered services, such as office visits.
Does this plan use a network of providers?	**Yes**. For a list of **plan providers**, see **www.kp.org** or call **1-800-278-3296**.	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**.
Do I need a referral to see a specialist?	**Yes**, but you may self-refer to certain specialists.	This plan will pay some or all of the costs to see a **specialist** for covered services but only if you have the plan's permission before you see the **specialist**.
Are there services this plan doesn't cover?	**Yes**.	Some of the services this plan doesn't cover are listed on page 5. See your policy or 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 **plan providers** by charging you lower **deductibles**, **copayments** and **coinsurance** amounts.

Common Medical Event	Services You May Need	Your cost if you use a Plan Provider	Your cost if you use a Non-Plan Provider	Limitations & Exceptions
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$20 per visit	Not Covered	——————none——————
	Specialist visit	$20 per visit	Not Covered	Services related to infertility covered at $20 per visit.
	Other practitioner office visit	$15 per visit for chiropractic services, $20 per visit for acupuncture services.	Not Covered	Up to 30 visits per year for chiropractic services, Physician referred acupuncture.
	Preventive care/ screening/ immunization	No Charge	Not Covered	Some preventive screenings (such as lab and imaging) may be at a different cost share.
If you have a test	Diagnostic test (x-ray, blood work)	X-ray: No Charge; Lab tests: No Charge	Not Covered	——————none——————
	Imaging (CT/PET scans, MRI's)	No Charge	Not Covered	——————none——————

Common Medical Event	Services You May Need	Your cost if you use a Plan Provider	Your cost if you use a Non-Plan Provider	Limitations & Exceptions
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.kp.org/formulary .	Generic drugs	Plan pharmacy: $10 per prescription for 1 to 30 days; Mail order: Usually two times the plan pharmacy cost sharing for up to a 100-day supply	Not Covered	In accordance with formulary guidelines. Certain drugs may be covered at a different cost share.
	Preferred brand drugs	Plan pharmacy: $30 per prescription for 1 to 30 days; Mail order: Usually two times the plan pharmacy cost sharing for up to a 100-day supply	Not Covered	In accordance with formulary guidelines. Certain drugs may be covered at a different cost share.
	Non-preferred brand drugs	Same as preferred brand drugs.	Not Covered	Same as preferred brand drugs when approved through exception process.
	Specialty drugs	Same as preferred brand drugs.	Not Covered	Same as preferred brand drugs when approved through exception process.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	$20 per procedure	Not Covered	————————none————————
	Physician/surgeon fees	No Charge	Not Covered	————————none————————
If you need immediate medical attention	Emergency room services	$100 per visit	$100 per visit	————————none————————
	Emergency medical transportation	No Charge	No Charge	————————none————————
	Urgent care	$20 per visit	$20 per visit	Non-Plan providers covered when outside the service area.
If you have a hospital stay	Facility fee (e.g., hospital room)	No Charge	Not Covered	————————none————————
	Physician/surgeon fee	No Charge	Not Covered	————————none————————

Common Medical Event	Services You May Need	Your cost if you use a Plan Provider	Your cost if you use a Non-Plan Provider	Limitations & Exceptions
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	$20 per individual visit; $10 per group visit; No Charge for other outpatient services	Not Covered	——————none——————
	Mental/Behavioral health inpatient services	No Charge	Not Covered	——————none——————
	Substance use disorder outpatient services	$20 per individual visit; $5 per group visit; $5 per visit for other outpatient services	Not Covered	——————none——————
	Substance use disorder inpatient services	No Charge	Not Covered	——————none——————
If you are pregnant	Prenatal and postnatal care	Prenatal care: No Charge; Postnatal care: No Charge	Prenatal care: Not covered; Postnatal care: Not covered	Prenatal: Cost sharing is for routine preventive care only; Postnatal: Cost sharing is for the first postnatal visit only.
	Delivery and all inpatient services	No Charge	Not Covered	——————none——————
If you need help recovering or have other special health needs	Home health care	No Charge	Not Covered	Up to 2 hours maximum per visit, up to 3 visits maximum per day, up to 100 visits maximum per year.
	Rehabilitation services	Inpatient: No Charge; Outpatient: $20 per visit	Not Covered	——————none——————
	Habilitation services	$20 per visit	Not Covered	——————none——————
	Skilled nursing care	No Charge	Not Covered	Up to 100 days maximum per benefit period.
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Common Medical Event	Services You May Need	Your cost if you use a Plan Provider	Your cost if you use a Non-Plan Provider	Limitations & Exceptions
If your child needs dental or eye care	Eye exam	No Charge	Not Covered	——————none——————
	Glasses	Not Covered	Not Covered	——————none——————
	Dental check-up	Not Covered	Not Covered	You may have other dental coverage not described here.

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Anesthesia	$900
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Vaccines, other preventive	$40
Total	**$7,540**

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