


Summary of Benefits and Coverage: What this Plan Covers & What You Pay For Covered Services



Coverage Period: Beginning On or After 1/1/2023


San Francisco Health Service System Custom Trio HMO 25

Coverage for: Individual + Family | Plan Type: HMO

 **The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately. This is only a summary.** For more information about your coverage, or to get a copy of the complete terms of coverage, visit bsca.com/policies or call 1-855-747-5800. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms see the Glossary. You can view the Glossary at healthcare.gov/sbc-glossary or call 1-866-444-3272 to request a copy.

| Important Questions | Answers | Why This Matters: |
|--------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| What is the overall deductible? | \$0. | See the Common Medical Events chart below for your costs for services this <u>plan</u> covers. |
| Are there services covered before you meet your deductible? | Yes. <u>Preventive care</u> and services listed in your complete terms of coverage. | This <u>plan</u> covers some items and services even if you haven't yet met the <u>deductible</u> amount. But a <u>copayment</u> or <u>coinsurance</u> may apply. For example, this <u>plan</u> covers certain <u>preventive services</u> without <u>cost-sharing</u> and before you meet your <u>deductible</u> . See a list of covered <u>preventive services</u> at healthcare.gov/coverage/preventive-care-benefits . |
| Are there other deductibles for specific services? | No. | You don't have to meet <u>deductibles</u> for specific services. |
| What is the out-of-pocket limit for this plan? | \$2,000 per individual / \$4,000 per family for <u>participating providers</u> . | The <u>out-of-pocket limit</u> is the most you could pay in a year for covered services. If you have other family members in this <u>plan</u> , they have to meet their own <u>out-of-pocket limits</u> until the overall family <u>out-of-pocket limit</u> has been met. |
| What is not included in the out-of-pocket limit? | <u>Copayments</u> for certain services, <u>premiums</u> , and health care this <u>plan</u> doesn't cover. | Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u> . |
| Will you pay less if you use a network provider? | Yes. See blueshieldca.com/fad or call 1-855-747-5800 for a list of <u>network providers</u> . | This <u>plan</u> uses a <u>provider network</u> . You will pay less if you use a <u>provider</u> in the <u>plan's</u> network. You will pay the most if you use an <u>out-of-network provider</u> , and you might receive a bill from a <u>provider</u> for the difference between the <u>provider's</u> charge and what your <u>plan</u> pays (<u>balance billing</u>). Be aware, your <u>network provider</u> might use an <u>out-of-network provider</u> for some services (such as lab work). Check with your <u>provider</u> before you get services. |
| Do you need a referral to see a specialist? | Yes. | This <u>plan</u> will pay some or all of the costs to see a <u>specialist</u> for covered services but only if you have a <u>referral</u> before you see the <u>specialist</u> . |

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

| Common Medical Event | Services You May Need | What You Will Pay | | Limitations, Exceptions, & Other Important Information |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| | | <u>Participating Provider</u> (You will pay the least) | <u>Non-Participating Provider</u> (You will pay the most) | |
| If you visit a health care provider's office or clinic | Primary care visit to treat an injury or illness | \$25/visit | Not Covered | -----None----- |
| | <u>Specialist</u> visit | <i>Trio+ Specialist: \$30/visit</i> <i>Other Specialist: \$25/visit</i> | Not Covered | Self-referral is available for Trio+ Specialist visits. |
| | <u>Preventive care/screening</u> /immunization | No Charge | Not Covered | You may have to pay for services that aren't <u>preventive</u> . Ask your <u>provider</u> if the services needed are <u>preventive</u> . Then check what your <u>plan</u> will pay for. |
| If you have a test | <u>Diagnostic test</u> (x-ray, blood work) | <i>Lab & Path: No Charge</i> <i>X-Ray & Imaging: No Charge</i> <i>Other Diagnostic Examination: No Charge</i> | <i>Lab & Path: Not Covered</i> <i>X-Ray & Imaging: Not Covered</i> <i>Other Diagnostic Examination: Not Covered</i> | <u>Preauthorization</u> is required. Failure to obtain <u>preauthorization</u> may result in non-payment of benefits. The services listed are at a freestanding location. |
| | Imaging (CT/PET scans, MRIs) | <i>Outpatient Radiology Center: No Charge</i> <i>Outpatient Hospital: No Charge</i> | <i>Outpatient Radiology Center: Not Covered</i> <i>Outpatient Hospital: Not Covered</i> | <u>Preauthorization</u> is required. Failure to obtain <u>preauthorization</u> may result in non-payment of benefits. |
| If you need drugs to treat your illness or condition More information about prescription drug coverage is available at blueshieldca.com/formulary | Generic Drugs | <i>Retail: \$10/prescription</i> <i>Mail Service: \$20/prescription</i> | <i>Retail: Not Covered</i> <i>Mail Service: Not Covered</i> | <u>Preauthorization</u> is required for select drugs. Failure to obtain <u>preauthorization</u> may result in non-payment of benefits. Formulary exception is required for Tier 3 Drugs. <i>Retail: Covers up to a 30-day supply;</i> <i>Mail Service: Covers up to a 90-day supply</i> |
| | Brand Formulary Drugs | <i>Retail: \$25/prescription</i> <i>Mail Service: \$50/prescription</i> | <i>Retail: Not Covered</i> <i>Mail Service: Not Covered</i> | |
| | Brand Non-Formulary Drugs | <i>Retail: \$50/prescription</i> <i>Mail Service: \$100/prescription</i> | <i>Retail: Not Covered</i> <i>Mail Service: Not Covered</i> | |

* For more information about limitations and exceptions, see the plan or policy document at bsca.com/policies.

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| Common Medical Event | Services You May Need | What You Will Pay | | Limitations, Exceptions, & Other Important Information |
|---------------------------------------------------------------------------|------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| | | Participating Provider (You will pay the least) | Non-Participating Provider (You will pay the most) | |
| | Specialty Drugs | 20% up to \$100/prescription | Not Covered | <u>Preauthorization</u> is required. Failure to obtain <u>preauthorization</u> may result in non-payment of benefits. <i>Retail and Network Specialty Pharmacies:</i> Covers up to a 30-day supply; Specialty drugs must be obtained at a Network Specialty Pharmacy. <i>Mail Service:</i> Covers up to a 90-day supply. |
| If you have outpatient surgery | Facility fee (e.g., ambulatory surgery center) | <i>Ambulatory Surgery Center:</i> \$100/surgery <i>Outpatient Hospital:</i> \$100/surgery | <i>Ambulatory Surgery Center:</i> Not Covered <i>Outpatient Hospital:</i> Not Covered | -----None----- |
| | Physician/surgeon fees | No Charge | Not Covered | |
| If you need immediate medical attention | <u>Emergency room care</u> | <i>Facility Fee:</i> \$100/visit <i>Physician Fee:</i> No Charge | <i>Facility Fee:</i> \$100/visit <i>Physician Fee:</i> No Charge | -----None----- |
| | <u>Emergency medical transportation</u> | \$50/transport | \$50/transport | This payment is for emergency or authorized transport. |
| | <u>Urgent care</u> | \$25/visit | <i>Within Plan Service Area:</i> Not Covered <i>Outside Plan Service Area:</i> \$25/visit | -----None----- |
| If you have a hospital stay | Facility fee (e.g., hospital room) | \$200/admission | Not Covered | <u>Preauthorization</u> is required. Failure to obtain <u>preauthorization</u> may result in non-payment of benefits. |
| | Physician/surgeon fees | No Charge | Not Covered | -----None----- |
| If you need mental health, behavioral health, or substance abuse services | Outpatient services | <i>Office Visit:</i> \$25/visit <i>Other Outpatient Services:</i> No Charge <i>Partial Hospitalization:</i> No Charge <i>Psychological Testing:</i> No Charge | <i>Office Visit:</i> Not Covered <i>Other Outpatient Services:</i> Not Covered <i>Partial Hospitalization:</i> Not Covered <i>Psychological Testing:</i> Not Covered | <u>Preauthorization</u> is required except for office visits. Failure to obtain <u>preauthorization</u> may result in non-payment of benefits. |

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| Common Medical Event | Services You May Need | What You Will Pay | | Limitations, Exceptions, & Other Important Information |
|----------------------------------------------------------------|-------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| | | Participating Provider (You will pay the least) | Non-Participating Provider (You will pay the most) | |
| | Inpatient services | <i>Physician Inpatient Services:</i> No Charge <i>Hospital Services:</i> \$200/admission <i>Residential Care:</i> \$200/admission | <i>Physician Inpatient Services:</i> Not Covered <i>Hospital Services:</i> Not Covered <i>Residential Care:</i> Not Covered | <u>Preauthorization</u> is required. Failure to obtain <u>preauthorization</u> may result in non-payment of benefits. |
| If you are pregnant | Office visits | No Charge | Not Covered | -----None----- |
| | Childbirth/delivery professional services | No Charge | Not Covered | |
| | Childbirth/delivery facility services | \$200/admission | Not Covered | |
| If you need help recovering or have other special health needs | <u>Home health care</u> | \$25/visit | Not Covered | <u>Preauthorization</u> is required. Failure to obtain <u>preauthorization</u> may result in non-payment of benefits. Coverage limited to 100 visits per member per calendar year. |
| | <u>Rehabilitation services</u> | <i>Office Visit:</i> \$25/visit <i>Outpatient Hospital:</i> \$25/visit | <i>Office Visit:</i> Not Covered <i>Outpatient Hospital:</i> Not Covered | -----None----- |
| | <u>Habilitation services</u> | <i>Office Visit:</i> \$25/visit <i>Outpatient Hospital:</i> \$25/visit | <i>Office Visit:</i> Not Covered <i>Outpatient Hospital:</i> Not Covered | -----None----- |
| | <u>Skilled nursing care</u> | <i>Freestanding SNF:</i> No Charge <i>Hospital-based SNF:</i> No Charge | <i>Freestanding SNF:</i> Not Covered <i>Hospital-based SNF:</i> Not Covered | <u>Preauthorization</u> is required. Failure to obtain <u>preauthorization</u> may result in non-payment of benefits. Coverage limited to 100 days per member per benefit period. |
| | <u>Durable medical equipment</u> | No Charge | Not Covered | <u>Preauthorization</u> is required. Failure to obtain <u>preauthorization</u> may result in non-payment of benefits. |
| | <u>Hospice services</u> | No Charge | Not Covered | <u>Preauthorization</u> is required except for pre-hospice consultation. Failure to obtain <u>preauthorization</u> may result in non-payment of benefits. |

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| Common Medical Event | Services You May Need | What You Will Pay | | Limitations, Exceptions, & Other Important Information |
|----------------------------------------|----------------------------|----------------------------------------------------|-------------------------------------------------------|--------------------------------------------------------|
| | | Participating Provider (You will pay the least) | Non-Participating Provider (You will pay the most) | |
| If your child needs dental or eye care | Children's eye exam | Not Covered | Not Covered | -----None----- |
| | Children's glasses | Not Covered | Not Covered | |
| | Children's dental check-up | Not Covered | Not Covered | |

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)

- | | | | |
|-----------------------|------------------------------------------------------|----------------------------|------------------------|
| • Cosmetic surgery | • Long-term care | • Private-duty nursing | • Routine foot care |
| • Dental care (Adult) | • Non-emergency care when traveling outside the U.S. | • Routine eye care (Adult) | • Weight loss programs |

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

- | | | | |
|---------------------|---------------------|----------------|-------------------------|
| • Acupuncture | • Chiropractic Care | • Hearing Aids | • Infertility Treatment |
| • Bariatric surgery | | | |

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, at 1-877-267-2323 x61565 or cciio.cms.gov. Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit HealthCare.gov or call 1-800-318-2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice or assistance, contact: Blue Shield Customer Service at 1-855-747-5800 or the Department of Labor's Employee Benefits Security Administration at **1-866-444-EBSA (3272)** or dol.gov/ebsa/healthreform. Additionally, you can contact the California Department of Managed Health Care Help at 1-888-466-2219 or visit helpline@dmhc.ca.gov or visit <http://www.healthhelp.ca.gov>.

Does this plan provide Minimum Essential Coverage? Yes

Minimum Essential Coverage generally includes plans, health insurance available through the Marketplace or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of Minimum Essential Coverage, you may not be eligible for the premium tax credit.

Does this plan meet the Minimum Value Standards? Yes

If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

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Language Access Services:

English: For assistance in English at no cost, call 1-866-346-7198.

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

Tagalog (Tagalog): Kung kailanganninyo ang libreng tulongsa Tagalog tumawag sa 1-866-346-7198.

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

Navajo (Dine): Diné k'ehjí doo bąąh ílínígó shíka' at'oowoł nínízingo, kwijí' hodíílnih 1-866-346-7198.

Vietnamese (Tiếng Việt): Để được hỗ trợ miễn phí tiếng Việt, vui lòng gọi đến số 1-866-346-7198.

Korean (한국어): 한국어 도움이 필요하시면, 1-866-346-7198 무료전화 로전화하십시오.

Armenian (Հայերեն): Հայերեն լեզվով անվճար օգնություն ստանալու համար խնդրում ենք զանգահարել 1-866-346-7198.

Russian (Русский): если нужна бесплатная помощь на русском языке, то позвоните 1-866-346-7198.

Japanese (日本語): 日本語支援が必要な場合1-866-346-7198に電話をかけてください。無料で提供します。

Persian (فارسی): برای دریافت کمک رایگان زبان فارسی، لطفاً با شماره تلفن 1-866-346-7198 تماس بگیرید.

Punjabi (ਪੰਜਾਬੀ): ਪੰਜਾਬੀ ਵਿਚ ਸਹਾਇਤਾ ਲਈ ਵਿਰਾਮ ਕਰਕੇ 1-866-346-7198 'ਤੇ ਕਾਲ ਕਰੋ।

Khmer (ភាសាខ្មែរ): សូមជំនួយភាសាអង់គ្លេសដោយឥតគិតថ្លៃ សូមទាក់ទងមកលេខ 1-866-346-7198។

Arabic (العربية): للحصول على المساعدة في اللغة العربية مجاناً، تفضل باتصال على هذا الرقم: 1-866-346-7198.

Hmong (Hmoob): Xav tau kev pab dawb lub Hmoob, thov hu rau 1-866-346-7198.

Hindi (हिन्दी): हिन्दी में बिना खर्च के सहायता के लिए, 1-866-346-7198 पर कॉल करें।

Thai (ไทย): สำหรับความช่วยเหลือเป็นภาษาไทยโดยไม่มีค่าใช้จ่ายโปรดโทร 1-866-346-7198

Laotian (ພາສາລາວ): ສໍາລັບການຊ່ອຍເຫຼືອເປັນພາສາລາວແບບບໍ່ເສຍຄ່າ, ກະລຸນາໂທ 1-866-346-7198.

To see examples of how this [plan](#) might cover costs for a sample medical situation, see the next section.

PRA Disclosure Statement

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1146. The time required to complete this information collection is estimated to average 0.08 hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

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About these Coverage Examples:



This is not a cost estimator. Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby

(9 months of participating pre-natal care and a hospital delivery)

- The plan's overall deductible \$0
- Specialist copayment \$25
- Hospital (facility) copayment \$200
- Other copayment \$0

This **EXAMPLE** event includes services like:

- Specialist office visits (*prenatal care*)
- Childbirth/Delivery Professional Services
- Childbirth/Delivery Facility Services
- Diagnostic tests (*ultrasounds and blood work*)
- Specialist visit (*anesthesia*)

| | |
|---------------------------|-----------------|
| Total Example Cost | \$12,700 |
|---------------------------|-----------------|

In this example, Peg would pay:

| Cost Sharing | |
|-----------------------------------|--------------|
| <u>Deductibles</u> | \$0 |
| <u>Copayments</u> | \$200 |
| <u>Coinsurance</u> | \$0 |
| What isn't covered | |
| Limits or exclusions | \$70 |
| The total Peg would pay is | \$270 |

Managing Joe's Type 2 Diabetes

(a year of routine participating care of a well-controlled condition)

- The plan's overall deductible \$0
- Specialist copayment \$25
- Hospital (facility) copayment \$200
- Other copayment \$0

This **EXAMPLE** event includes services like:

- Primary care physician office visits (*including disease education*)
- Diagnostic tests (*blood work*)
- Prescription drugs
- Durable medical equipment (*glucose meter*)

| | |
|---------------------------|----------------|
| Total Example Cost | \$5,600 |
|---------------------------|----------------|

In this example, Joe would pay:

| Cost Sharing | |
|-----------------------------------|----------------|
| <u>Deductibles</u> | \$0 |
| <u>Copayments</u> | \$300 |
| <u>Coinsurance</u> | \$0 |
| What isn't covered | |
| Limits or exclusions | \$3,500 |
| The total Joe would pay is | \$3,800 |

Mia's Simple Fracture

(participating emergency room visit and follow up care)

- The plan's overall deductible \$0
- Specialist copayment \$25
- Hospital (facility) copayment \$200
- Other copayment \$0

This **EXAMPLE** event includes services like:

- Emergency room care (*including medical supplies*)
- Diagnostic test (*x-ray*)
- Durable medical equipment (*crutches*)
- Rehabilitation services (*physical therapy*)

| | |
|---------------------------|----------------|
| Total Example Cost | \$2,800 |
|---------------------------|----------------|

In this example, Mia would pay:

| Cost Sharing | |
|-----------------------------------|--------------|
| <u>Deductibles</u> | \$0 |
| <u>Copayments</u> | \$200 |
| <u>Coinsurance</u> | \$0 |
| What isn't covered | |
| Limits or exclusions | \$10 |
| The total Mia would pay is | \$210 |

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

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