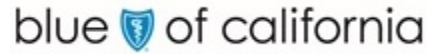



**Summary of Benefits and Coverage: What this Plan Covers & What You Pay for Covered Services**

Reta Plan: Reta Trust

Coverage Option: 5139 Blue Shield of California EPO 1000 80




Coverage Period: 07/01/ 2023 – 06/30/2024  
 Coverage for: Individual + Family | Plan Type: EPO

 **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, see the Benefit Booklet for this coverage option or call 1-888-772-1076. 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 <http://www.healthcare.gov/sbc-glossary> or call 1-866-444-3272 to request a copy.

Important Questions	Answers	Why This Matters:
<b>What is the overall deductible?</b>	<b>\$1,000/individual or \$2,000/family for network providers</b>	Generally, you must pay all of the costs from <u>providers</u> up to the <u>deductible</u> amount before this <u>plan</u> begins to pay. If you have other family members on the <u>plan</u> each family member must meet their own individual <u>deductible</u> until the total amount of <u>deductible</u> expenses paid by all family members meets the overall family <u>deductible</u> .
<b>Are there services covered before you meet your deductible?</b>	Yes. Some <u>preventive care</u> is covered before you meet your <u>deductible</u> .	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 <u>preventive services</u> at <a href="https://www.healthcare.gov/coverage/preventive-care-benefits/">https://www.healthcare.gov/coverage/preventive-care-benefits/</a> . Note that not all <u>preventive services</u> listed are covered by this <u>plan</u> . See the Benefit Booklet for details.
<b>Are there other deductibles for specific services?</b>	No.	You don't have to meet <u>deductibles</u> for specific services.
<b>What is the out-of-pocket limit for this plan?</b>	<b>\$5,000/individual or \$10,000/family for network providers</b>	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.
<b>What is not included in the out-of-pocket limit?</b>	<u>Copayments</u> on certain services, <u>premiums</u> , <u>balance-billing</u> charges, 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> .
<b>Will you pay less if you use a network provider?</b>	Yes. See <a href="https://blueshieldca.com/fad">blueshieldca.com/fad</a> or call 1-888-772-1076 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.
<b>Do you need a referral to see a specialist?</b>	No.	You can see the <u>specialist</u> you choose without a <u>referral</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>Network Provider</u> (You will pay the least)	<u>Out-of-Network Provider</u> (You will pay the most)	
<b>If you visit a health care <u>provider's</u> office or clinic</b>	Primary care visit to treat an injury or illness	\$25/visit; <u>deductible</u> does not apply	Not Covered	None
	<u>Specialist</u> visit	\$40/visit; <u>deductible</u> does not apply	Not Covered	
	<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.
<b>If you have a test</b>	<u>Diagnostic test</u> (x-ray, blood work)	<i>Lab &amp; Pathology: 20% <u>coinsurance</u></i> <i>X-Ray &amp; Imaging: 20% <u>coinsurance</u></i> <i>Other Diagnostic Examination: 20% <u>coinsurance</u></i>	<i>Lab &amp; Pathology: Not Covered</i> <i>X-Ray &amp; Imaging: Not Covered</i> <i>Other Diagnostic Examination: Not Covered</i>	The services listed are at a freestanding location.
	Imaging (CT/PET scans, MRIs)	<i>Outpatient Radiology Center: 20% <u>coinsurance</u></i> <i>Outpatient Hospital: 20% <u>coinsurance</u></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.
<b>If you need drugs to treat your illness or condition. More information about prescription drug coverage is available at <a href="https://www.cvs.com/drug">https://www.cvs.com/drug</a></b>	Generic drugs	\$10 <u>copay</u> /prescription 30-day supply (retail) \$20 <u>copay</u> /prescription 60-day supply (retail) \$30 <u>copay</u> /prescription 61-90 day supply (retail) \$20 <u>copay</u> /prescription (mail order)	Not Covered	Reta Trust contracts with CVS Caremark to manage outpatient prescription Drug Benefits. CVS Caremark authorizes services, processes claims, and addresses complaints and grievances for those outpatient prescription Drug Benefits on behalf of Reta Trust. If you receive a Covered Service from CVS Caremark, you should contact CVS Caremark directly at 1-800-844-0719.

\* For more information about limitations and exceptions, see the Benefit Booklet

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Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
	Brand formulary drugs	\$30 <u>copay</u> /prescription 30-day supply (retail) \$60 <u>copay</u> /prescription 60-day supply (retail) \$90 <u>copay</u> /prescription 61-90 day supply (retail) \$60 <u>copay</u> /prescription (mail order)	Not Covered	Fill for 90 days at Caremark mail order for only 2 times the copay for a 30-day retail supply. Sign up for Caremark.com to check your specific drug coverage and costs.  Specialty Medications must be filled at CVS Specialty Pharmacy. Visit CVSSpecialty.com or call Specialty Customer Care at 1-800-237-2767.  30-day, 60-day, 90-day supply limit for retail. 90-day supply limit for mail order. 30-day supply limit for Specialty.
	Brand non-formulary drugs	\$50 <u>copay</u> /prescription 30-day supply (retail) \$100 <u>copay</u> /prescription 60-day supply (retail) \$150 <u>copay</u> /prescription 61-90 day supply (retail) \$100 <u>copay</u> /prescription (mail order)	Not Covered	
	Specialty drugs	\$50 <u>copay</u> /prescription	Not Covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	<i>Ambulatory Surgery Center:</i> 20% <u>coinsurance</u> <i>Outpatient Hospital:</i> 20% <u>coinsurance</u>	<i>Ambulatory Surgery Center:</i> Not Covered <i>Outpatient Hospital:</i> Not Covered	None
	Physician/surgeon fees	20% <u>coinsurance</u>	Not Covered	
If you need immediate medical attention	<u>Emergency room care</u>	<i>Facility Fee:</i> \$200/visit + 20% <u>coinsurance</u> ; <u>deductible</u> does not apply <i>Physician Fee:</i> 20% <u>coinsurance</u> ; <u>deductible</u> does not apply	<i>Facility Fee:</i> Not Covered <i>Physician Fee:</i> Not Covered	None
	<u>Emergency medical transportation</u>	20% <u>coinsurance</u>	Not Covered	Benefit is for emergency or authorized transport.
	<u>Urgent care</u>	\$50/visit; <u>deductible</u> does not apply	Not Covered	None
If you have a hospital stay	Facility fee (e.g., hospital room)	20% <u>coinsurance</u>	Not Covered	<u>Preauthorization</u> is required. Failure to obtain <u>preauthorization</u> may result in non-payment of benefits.
	Physician/surgeon fees	20% <u>coinsurance</u>	Not Covered	None

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Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
<b>If you need mental health, behavioral health, or substance abuse services</b>	Outpatient services	Office Visit: \$25/visit; deductible does not apply Other Outpatient Services: 20% <u>coinsurance</u> Partial Hospitalization: 20% <u>coinsurance</u> Psychological Testing: 20% <u>coinsurance</u>	Office Visit: Not Covered Other Outpatient Services: Not Covered Partial Hospitalization: Not Covered Psychological Testing: Not Covered	<u>Preauthorization</u> is required except for office visits and office-based opioid treatment. Failure to obtain <u>preauthorization</u> may result in non-payment of benefits.
	Inpatient services	Physician Inpatient Services: 20% <u>coinsurance</u> Hospital Services: 20% <u>coinsurance</u> Residential Care: 20% <u>coinsurance</u>	Physician Inpatient Services: Not Covered Hospital Services: Not Covered Residential Care: Not Covered	
<b>If you are pregnant</b>	Office visits	No Charge	Not Covered	Maternity care may include tests and services described elsewhere in the SBC (i.e., ultrasound).
	Childbirth/delivery professional services	20% <u>coinsurance</u>	Not Covered	
	Childbirth/delivery facility services	20% <u>coinsurance</u>	Not Covered	

\* For more information about limitations and exceptions, see the Benefit Booklet

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need help recovering or have other special health needs	<u>Home health care</u>	20% <u>coinsurance</u>	Not Covered	<u>Preauthorization</u> is required. Failure to obtain <u>preauthorization</u> may result in non-payment of benefits. Coverage limited to 120 visits per member per calendar year.
	<u>Rehabilitation services</u>	<i>Office Visit: \$40/visit; deductible does not apply</i> <i>Outpatient Hospital: 20% <u>coinsurance</u></i>	<i>Office Visit: Not Covered</i> <i>Outpatient Hospital: Not Covered</i>	None
	<u>Habilitation services</u>	<i>Office Visit: \$40/visit; deductible does not apply</i> <i>Outpatient Hospital: 20% <u>coinsurance</u></i>	<i>Office Visit: Not Covered</i> <i>Outpatient Hospital: Not Covered</i>	
	<u>Skilled nursing care</u>	<i>Freestanding Skilled Nursing Facility: 20% <u>coinsurance</u></i> <i>Hospital-based Skilled Nursing Facility: 20% <u>coinsurance</u></i>	<i>Freestanding Skilled Nursing Facility: Not Covered</i> <i>Hospital-based Skilled Nursing Facility: Not Covered</i>	<u>Preauthorization</u> is required. Failure to obtain <u>preauthorization</u> may result in non-payment of benefits. Coverage limited to 120 days per member per Plan Year.
	<u>Durable medical equipment</u>	20% <u>coinsurance</u>	Not Covered	<u>Preauthorization</u> is required. Failure to obtain <u>preauthorization</u> may result in non-payment of benefits.
	<u>Hospice services</u>	20% <u>coinsurance</u>	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.
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	

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## Excluded Services & Other Covered Services:

### Services Your Plan Generally Does NOT Cover (Check your Benefit Booklet for more information and a list of any other excluded services.)

- Alteration or reshaping body structures or tissues (other than reconstructive surgery)
- Abortion procedures
- Artificial insemination
- Assisted conception services
- Assisted suicide and euthanasia
- Contraceptives
- Cosmetic surgery
- Dental care (Adult and child)
- Experimental or investigational services
- Assisted conception services
- Eye surgery
- Gender reassignment services
- Genetic testing
- Hearing Aids
- Infertility treatment
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Non-medically necessary services
- Private-duty nursing
- Infertility Treatment
- Routine eye care (Adult)
- Religious, personal growth counseling or marriage counseling
- Routine eye care (Adult and child)
- Routine foot care
- Sex reassignment services
- Sterilization
- Third generation dependents
- Treatments using tissue from aborted fetuses or embryonic cells
- Weight loss programs

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

- Acupuncture
- Bariatric surgery
- Chiropractic Care

**Your Rights to Continue Coverage:** There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is shown in the chart below. Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit [www.HealthCare.gov](http://www.HealthCare.gov) or call 1-800-318-2596.

**Your Grievance and Appeals Rights:** There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice or assistance, contact the agencies in the chart below.

### Contact Information for Your Rights to Continue Coverage & Your Grievance and Appeals Rights:

Reta Customer Service	1-877-303-7382
Blue Shield Customer Service	1-888-772-1076
Department of Labor's Employee Benefits Security Administration	1-866-444-EBSA (3272) or <a href="http://www.dol.gov/ebsa/healthreform">www.dol.gov/ebsa/healthreform</a>

\* For more information about limitations and exceptions, see the Benefit Booklet

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### Does this [plan](#) provide **Minimum Essential Coverage**? Yes

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

### Does this [plan](#) meet the **Minimum Value Standards**? Yes

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

### Language Access Services:

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

Tagalog (Tagalog): Kung kailanganninyo 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, kwijigo holne' 1-866-346-7198

**Your health benefits will be self-insured by your [Plan](#) sponsor. Blue Shield of California will provide certain administrative services for the [Plan](#) and will not be an insurer of the [Plan](#) or financially liable for health care benefits under the [Plan](#).**

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

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About these Coverage Examples:



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

**Peg is Having a Baby**

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

- The plan's overall deductible \$1,000
- Specialist copayment \$40
- Hospital (facility) coinsurance 20%
- Other coinsurance 20%

This EXAMPLE event includes services like:

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

<b>Total Example Cost</b>	<b>\$12,700</b>
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In this example, Peg would pay:

<i>Cost Sharing</i>	
<u>Deductibles</u>	\$1,000
<u>Copayments</u>	\$0
<u>Coinsurance</u>	\$2,300
<i>What isn't covered</i>	
Limits or exclusions	\$70
<b>The total Peg would pay is</b>	<b>\$3,370</b>

**Managing Joe's Type 2 Diabetes**

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

- The plan's overall deductible \$1,000
- Specialist copayment \$40
- Hospital (facility) coinsurance 20%
- Other coinsurance 20%

This EXAMPLE event includes services like:

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

<b>Total Example Cost</b>	<b>\$5,600</b>
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In this example, Joe would pay:

<i>Cost Sharing</i>	
<u>Deductibles</u>	\$900
<u>Copayments</u>	\$300
<u>Coinsurance</u>	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$3,500
<b>The total Joe would pay is</b>	<b>\$4,700</b>

**Mia's Simple Fracture**

(participating emergency room visit and follow up care)

- The plan's overall deductible \$1,000
- Specialist copayment \$40
- Hospital (facility) coinsurance 20%
- Other coinsurance 20%

This EXAMPLE event includes services like:

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

<b>Total Example Cost</b>	<b>\$2,800</b>
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In this example, Mia would pay:

<i>Cost Sharing</i>	
<u>Deductibles</u>	\$1,000
<u>Copayments</u>	\$200
<u>Coinsurance</u>	\$300
<i>What isn't covered</i>	
Limits or exclusions	\$10
<b>The total Mia would pay is</b>	<b>\$1,510</b>

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