Summary of Benefits and Coverage: What this Plan Covers & What You Pay for Covered Services
Reta Trust
Coverage Option: 5237 Reta Plan HPN EPO 500 90

blue of california

Coverage Period: 07/01/2025 – 06/30/2026
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:
What is the overall deductible?	**$500**/individual or **$1,000**/family for network providers	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.
Are there services covered before you meet your deductible?	Yes. Some preventive care is covered before you meet your deductible.	This plan covers some preventive care without cost-sharing and before you meet your deductible. See the Benefit Booklet for more details. The full list of preventive care services is found at https://www.healthcare.gov/coverage/preventive-care-benefits/, but not all of the listed preventive care services are covered by this plan.
Are there other deductibles for specific services?	No.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	**$2,500**/individual or **$5,000**/family for network providers	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.
What is not included in the out-of-pocket limit?	Copayments on certain services, premiums, balance-billing charges, and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out-of-pocket limit.
Will you pay less if you use a network provider?	Yes. See blueshieldca.com/fad or call **1-888-772-1076** for a list of network providers.	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware, your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist?	No.	You can see the specialist you choose without a referral.

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

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$25/visit; deductible does not apply	Not Covered	None
	Specialist visit	$25/visit; deductible does not apply	Not Covered	
	Preventive care/screening /immunization	No Charge	Not Covered	You may have to pay for services that are not preventive care. Ask your provider if the services needed are preventive care. Then check what your plan will pay for because not all preventive care services are paid for by this plan.
If you have a test	Diagnostic test (x-ray, blood work)	*Lab & Pathology*: 10% coinsurance *X-Ray & Imaging*: 10% coinsurance *Other Diagnostic Examination*: 10% coinsurance	*Lab & Pathology*: Not Covered *X-Ray & Imaging*: Not Covered *Other Diagnostic Examination*: Not Covered	
	Imaging (CT/PET scans, MRIs)	*Outpatient Radiology Center*: No Charge *Outpatient Hospital*: 10% coinsurance	*Outpatient Radiology Center*: Not Covered *Outpatient Hospital*: Not Covered	Preauthorization is required. Failure to obtain preauthorization may result in non-payment of benefits.
If you need drugs to treat your illness or condition **Sign up at www.caremark.com to check your specific drug coverage and**	Generic drugs	$10 copay/prescription 30-day supply (retail) $20 copay/prescription 60-day supply (retail) $30 copay/prescription 61-90 day supply (retail) $20 copay/prescription (mail order)	Not Covered	You can use Caremark mail order to fill your prescription for 90 days at the cost of only 2 times the copay that would apply to a 30-day retail supply. 30-day, 60-day, 90-day supply limit for retail.

*** 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)	
costs or call 1-800-844-0719	Brand formulary drugs	$20 copay/prescription 30-day supply (retail) $40 copay/prescription 60-day supply (retail) $60 copay/prescription 61-90 day supply (retail) $40 copay/prescription (mail order)	Not Covered	90-day supply limit for mail order. Specialty Medications must be filled at CVS Specialty Pharmacy. Visit CVSSpecialty.com or call Specialty Customer Care at 1-800-237-2767.
	Brand non-formulary drugs	$40 copay/prescription 30-day supply (retail) $80 copay/prescription 60-day supply (retail) $120 copay/prescription 61-90 day supply (retail) $80 copay/prescription (mail order)	Not Covered	
	Specialty drugs	$30 copay/prescription	Not Covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	*Ambulatory Surgery Center*: No Charge *Outpatient Hospital*: 10% coinsurance	*Ambulatory Surgery Center*: Not Covered *Outpatient Hospital*: Not Covered	None
	Physician/surgeon fees	10% coinsurance	Not Covered	
If you need immediate medical attention	Emergency room care	*Facility Fee*: $200/visit + 10% coinsurance; deductible does not apply *Physician Fee*: 10% coinsurance; deductible does not apply	*Facility Fee*: Not Covered *Physician Fee*: Not Covered	None
	Emergency medical transportation	10% coinsurance	Not Covered	Benefit is for emergency or authorized transport.
	Urgent care	$50/visit; deductible does not apply	Not Covered	None
If you have a hospital stay	Facility fee (e.g., hospital room)	10% coinsurance	Not Covered	Preauthorization is required. Failure to obtain preauthorization may result in non-payment of benefits.
	Physician/surgeon fees	10% coinsurance	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)	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	*Office Visit*: $25/visit; deductible does not apply *Other Outpatient Services*: 10% coinsurance *Partial Hospitalization*: 10% coinsurance *Psychological Testing*: 10% coinsurance	*Office Visit*: Not Covered *Other Outpatient Services*: Not Covered *Partial Hospitalization*: Not Covered *Psychological Testing*: Not Covered	Preauthorization is required except for office visits and office-based opioid treatment. Failure to obtain preauthorization may result in non-payment of benefits.
	Inpatient services	*Physician Inpatient Services*: 10% coinsurance *Hospital Services*: 10% coinsurance *Residential Care*: 10% coinsurance	*Physician Inpatient Services:* Not Covered *Hospital Services:* Not Covered *Residential Care:* Not Covered	Preauthorization is required. Failure to obtain preauthorization may result in non-payment of benefits.
If you are pregnant	Office visits	No Charge	Not Covered	Maternity care may include tests and services described elsewhere in this document (e.g. ultrasound).
	Childbirth/delivery professional services	10% coinsurance	Not Covered	
	Childbirth/delivery facility services	10% coinsurance	Not Covered	
If you need help recovering or have other special health needs	Home health care	10% coinsurance	Not Covered	Preauthorization is required. Failure to obtain preauthorization may result in non-payment of benefits. Coverage limited to 120 visits per member per Calendar Year.
	Rehabilitation services	*Office Visit*: $25/visit; deductible does not apply *Outpatient Hospital*: 10% coinsurance	*Office Visit*: Not Covered *Outpatient Hospital*: Not Covered	None
	Habilitation services	*Office Visit*: $25/visit; deductible does not apply *Outpatient Hospital*: 10% coinsurance	*Office Visit*: Not Covered *Outpatient Hospital*: 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)	
	Skilled nursing care	*Freestanding Skilled Nursing Facility*: 10% coinsurance *Hospital-based Skilled Nursing Facility*: 10% coinsurance	*Freestanding Skilled Nursing Facility*: Not Covered *Hospital-based Skilled Nursing Facility*: Not Covered	Preauthorization is required. Failure to obtain preauthorization may result in non-payment of benefits. Coverage limited to 120 days per member per benefit period.
	Durable medical equipment	10% coinsurance	Not Covered	Preauthorization is required. Failure to obtain preauthorization may result in non-payment of benefits.
	Hospice services	10% coinsurance	Not Covered	Preauthorization is required except for pre-hospice consultation. Failure to obtain preauthorization 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	

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

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
- 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
- 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 drugs used or prescribed for weight loss or weight control
- 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 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 www.dol.gov/ebsa/healthreform

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

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 tulongsa Tagalog tumawag sa 1-866-346-7198
Traditional 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
Pennsylvania Dutch (Deitsch): Fer Hilf griege in Deitsch, ruf 1-866-346-7198
Samoan (Gagana Samoa): Mo se fesoasoani i le Gagana Samoa, vala'au mai i le numera telefoni 1-866-346-7198
Carolinian (Kapasal Falawasch): ngere aukke ghut alillis reel kapasal Falawasch au fafaingi tilifon ye t 1-866-346-7198
Chamorro (Chamoru): Para un ma ayuda gi finu Chamoru, å'gang 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.

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

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

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	$500
Specialist copayment	$25
Hospital (facility) coinsurance	10%
Other coinsurance	10%

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	
Deductibles	$500
Copayments	$0
Coinsurance	$1,200
What isn't covered	
Limits or exclusions	$70
The total Peg would pay is	**$1,770**

Managing Joe's Type 2 Diabetes
(a year of routine participating care of a well-controlled condition)

The plan's overall deductible	$500
Specialist copayment	$25
Hospital (facility) coinsurance	10%
Other coinsurance	10%

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	
Deductibles	$500
Copayments	$300
Coinsurance	$40
What isn't covered	
Limits or exclusions	$3,500
The total Joe would pay is	**$4,340**

Mia's Simple Fracture
(participating emergency room visit and follow up care)

The plan's overall deductible	$500
Specialist copayment	$25
Hospital (facility) coinsurance	10%
Other coinsurance	10%

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	
Deductibles	$500
Copayments	$100
Coinsurance	$200
What isn't covered	
Limits or exclusions	$10
The total Mia would pay is	**$810**

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