



School District of Philadelphia employees have the PPO network.

 **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 your Summary Plan Description visit <http://health.32bjfunds.org/> or call 1-800-551-3225. 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 <https://www.healthcare.gov/sbc-glossary> or call 1-800-551-3225 to request a copy.

Important Questions	Answers	Why This Matters:
<b>What is the overall deductible?</b>	\$0 for <a href="#">in-network providers</a> \$250 person/\$500 family for <a href="#">out-of-network providers</a> .	Generally, you must pay all of the costs from <a href="#">providers</a> up to the <a href="#">deductible</a> amount before this <a href="#">plan</a> begins to pay. If you have other family members on the <a href="#">plan</a> , each family member must meet their own individual <a href="#">deductible</a> until the total amount of <a href="#">deductible</a> expenses paid by all family members meets the overall family <a href="#">deductible</a> .
<b>Are there services covered before you meet your deductible?</b>	Yes, in-network because there is no <a href="#">deductible</a> .  No, when out-of-network.	This <a href="#">plan</a> covers some items and services even if you haven't yet met the <a href="#">deductible</a> amount. But a <a href="#">copayment</a> or <a href="#">coinsurance</a> may apply. For example, this <a href="#">plan</a> covers certain <a href="#">preventive services</a> without <a href="#">cost-sharing</a> and before you meet your <a href="#">deductible</a> . See a list of covered <a href="#">preventive services</a> at <a href="https://www.healthcare.gov/coverage/preventive-care-benefits/">https://www.healthcare.gov/coverage/preventive-care-benefits/</a> .  You will have to meet the <a href="#">deductible</a> before the <a href="#">plan</a> pays for any services.
<b>Are there other deductibles for specific services?</b>	No.	You don't have to meet specific <a href="#">deductibles</a> for specific services.
<b>What is the out-of-pocket limit for this plan?</b>	For <a href="#">in-network providers</a> \$8,550 individual/\$17,100 family; for <a href="#">out-of-network providers</a> \$750 individual/\$1,500 family.	The in-network <a href="#">out-of-pocket limit</a> 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 <a href="#">out-of-pocket limits</a> until the overall family <a href="#">out-of-pocket limit</a> has been met.
<b>What is not included in the out-of-pocket limit?</b>	<a href="#">Premiums</a> , <a href="#">balance billing</a> charges, penalties for failure to obtain preauthorization, & health care this <a href="#">plan</a> doesn't cover.	Even though you pay these expenses, they don't count toward the <a href="#">out-of-pocket limit</a> .
<b>Will you pay less if you use a network provider?</b>	Yes. See <a href="http://www.32bjfunds.org">www.32bjfunds.org</a> or call 1-800-551-3225 for a list of <a href="#">in-network providers</a> .	This <a href="#">plan</a> uses a <a href="#">provider network</a> . You pay the least if you use a 5 Star Center <a href="#">provider</a> . You pay more if you use a preferred <a href="#">provider</a> in the plan's <a href="#">network</a> . You pay even more if you use a non-preferred <a href="#">provider</a> in the plan's <a href="#">network</a> . You pay the most if you use an <a href="#">out-of-network provider</a> , and you might receive a bill from a <a href="#">provider</a> for the difference between the <a href="#">provider's</a> charge and what your <a href="#">plan</a> pays ( <a href="#">balance billing</a> ). Be aware, your <a href="#">in-network provider</a> might use an <a href="#">out-of-network provider</a> for some services (such as lab work). Check with your <a href="#">provider</a> before you get services.
<b>Do you need a referral to see a specialist?</b>	No.	You can see the <a href="#">specialist</a> you choose without a <a href="#">referral</a> .

 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**	
		5 Star Center Provider (You will pay the least)	In-network Preferred Provider*	In-network Non-Preferred Provider*		Out-of-network Provider (You will pay the most)
<b>If you visit a health care <a href="#">provider's</a> office or clinic</b>	Primary care visit to treat an injury or illness	No charge	\$15 <a href="#">copay</a> /office visit		30% <a href="#">coinsurance</a>	None.
	<a href="#">Specialist</a> visit	No charge	\$40 <a href="#">copay</a> /office visit		30% <a href="#">coinsurance</a>	
	<a href="#">Preventive care/screening/immunization</a>	No charge	No charge		30% <a href="#">coinsurance</a>	\$75 <a href="#">copay</a> /visit for preventive procedures (e.g., mammogram, colonoscopy) at a preferred provider hospital or hospital based facility. \$250 <a href="#">copay</a> /visit for preventive procedures (e.g., mammogram, colonoscopy) at a non- preferred provider hospital or hospital based facility. When utilizing an <a href="#">out-of-network provider</a> Plan pays 70% <a href="#">coinsurance</a> of the <a href="#">allowed amount</a> after the <a href="#">deductible</a> . You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your <a href="#">plan</a> will pay for.
	Other practitioner office visit	No charge for chiropractic No charge for acupuncture No charge for occupational, vision, physical, speech therapy	\$40 <a href="#">copay</a> /visit chiropractic \$40 <a href="#">copay</a> /visit acupuncture \$40 <a href="#">copay</a> /visit occupational, vision, physical, speech therapy		30% <a href="#">coinsurance</a> for chiropractic care Not covered Not covered	Chiropractic care coverage is limited to 10 visits/year. Acupuncture coverage is limited to 20 visits/year. Occupational, vision and speech therapy combined coverage is limited to 30 visits/year. Outpatient physical therapy coverage is limited to 30 separate visits/year. Preauthorization required. \$75 facility <a href="#">copay</a> /visit for out-patient physical therapy services at a preferred hospital based facility; \$250 facility <a href="#">copay</a> /visit for out-patient physical therapy services at a non-preferred hospital based facility.

\*A list of preferred providers as well as a list of non-preferred providers is available on the plan's website at [www.32bjfunds.org](http://www.32bjfunds.org).

\*\* For more information about limitations and exceptions, see the plan or policy document at [www.32bjfunds.org](http://www.32bjfunds.org).

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information**	
		5 Star Center Provider (You will pay the least)	In-network Preferred Provider*	In-network Non-Preferred Provider*		Out-of-network Provider (You will pay the most)
<b>If you have a test</b>	<a href="#">Diagnostic test</a> (x-ray, blood work)	No charge	No charge		30% <a href="#">coinsurance</a>	\$75 facility <a href="#">copay</a> /visit for diagnostic tests (excluding blood work) at a preferred hospital based facility. \$250 facility <a href="#">copay</a> /visit for diagnostic tests (excluding blood work) at a non-preferred hospital based facility.
	Imaging (CT/PET scans, MRIs)	\$75 <a href="#">copay</a> /scan	\$75 <a href="#">copay</a> /scan	\$250 <a href="#">copay</a> /scan	30% <a href="#">coinsurance</a>	Preauthorization required. Failure to preauthorize out-of-network services results in a \$250 penalty.
<b>If you need drugs to treat your illness or condition</b> More information about <a href="#">prescription drug coverage</a> is available at <a href="http://www.optumrx.com">www.optumrx.com</a>	Generic drugs	Not applicable	\$10 <a href="#">copay</a> /up to 30 day supply		Covered up to what Fund would pay a participating retail pharmacy.	Formulary Only. Covers up to a 30-day supply retail and up to a 90 day supply of maintenance medications at CVS pharmacy or through OptumRx Home Delivery.
			\$20 <a href="#">copay</a> /up to 90 day supply		Not covered	If you require a brand name drug that has a generic equivalent, you pay the difference in cost between the brand and generic plus the <a href="#">copay</a> .
	Brand drugs	Not applicable	\$30 <a href="#">copay</a> /up to 30 day supply		Covered up to what Fund would pay a participating retail pharmacy.	Ask your doctor to call OptumRx at 1-844-569-4148 for information on alternatives.
			\$60 <a href="#">copay</a> /up to 90 day supply		Not covered	Certain drugs are subject to prior authorization, step therapy and/or quantity limitations. Your doctor can call OptumRx at 1-844-569-4148 for additional information.
<a href="#">Specialty drugs</a>	Not applicable	Same <a href="#">copays</a> as generic and brand drugs above		Not covered	<a href="#">Specialty drugs</a> only available through OptumRx Specialty Pharmacy Program by calling 1-877-838-2907. Participation in Variable Copay Program may reduce specialty drug <a href="#">copays</a> .	

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Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information**
		5 Star Center Provider (You will pay the least)	In-network Preferred Provider*	In-network Non-Preferred Provider*	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	No charge	No charge		\$75 facility <a href="#">copay</a> /visit for outpatient services at a preferred hospital-based facility. \$250 facility <a href="#">copay</a> /visit for outpatient services at a non-preferred hospital-based facility.
	Physician/surgeon fees	No charge	No charge		
If you need immediate medical attention	<a href="#">Emergency room care</a>	Not applicable	\$100 <a href="#">copay</a> /visit		The <a href="#">copay</a> increases to \$200 for all emergency room visits after the 2nd visit within the same calendar year.
	<a href="#">Emergency medical transportation</a>	Not applicable	No charge		Not covered if after transport you do not receive treating services.
	<a href="#">Urgent care</a>	No charge	\$40 <a href="#">copay</a> /office visit		None.
If you have a hospital stay	Facility fee (e.g., hospital room)	Not applicable	\$100 <a href="#">copay</a> /admission	\$1,000 <a href="#">copay</a> /admission	Private rooms not covered. \$100 <a href="#">copay</a> /emergency admission at preferred and non-preferred facilities. Preauthorization required. Failure to preauthorize out-of-network services results in a \$250 penalty.
	Physician/surgeon fees	Not applicable	No charge		

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Common Medical Event	Services You May Need	What You Will Pay				Limitations, Exceptions, & Other Important Information**
		5 Star Center (You will pay the least)	In-network Preferred Provider*	In-network Non-Preferred Provider*	Out-of-network Provider (You will pay the most)	
<b>If you need mental health, behavioral health, or substance abuse services</b>	Outpatient services	No charge	\$15 <u>copay</u> /visit		30% <u>coinsurance</u> ***	<p>Inpatient, and some outpatient, services require preauthorization. Failure to preauthorize results in a \$250 penalty.</p> <p>\$75 <u>copay</u>/episode of treatment for outpatient services at preferred provider hospital-based facilities. \$250 <u>copay</u>/episode of treatment for outpatient services at non-preferred provider hospital-based facilities.</p> <p>***Non-participating NY inpatient and outpatient substance abuse providers that are not certified and/or licensed by the Office of Alcoholism and Substance Abuse Services and non-participating providers in all other states that are not certified by a similar state agency and which are not accredited by The Joint Commission are not covered.</p>
	Inpatient services	Not applicable	\$100 <u>copay</u> /visit	\$1,000 <u>copay</u> /visit	30% <u>coinsurance</u> ***	
<b>If you are pregnant</b>	Office visits	No charge	\$15 <u>copay</u> /1 <sup>st</sup> visit only		30% <u>coinsurance</u>	Maternity care may include tests and services described elsewhere in the SBC (e.g., ultrasound.)
	Childbirth/delivery professional services	Not applicable	No charge		30% <u>coinsurance</u>	None.
	Childbirth/delivery facility services	Not applicable	\$100 <u>copay</u> /admission	\$1,000 <u>copay</u> /admission	30% <u>coinsurance</u>	Preauthorization required. Failure to preauthorize out-of-network services results in a \$250 penalty.

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Common Medical Event	Services You May Need	What You Will Pay				Limitations, Exceptions, & Other Important Information**
		5 Star Center (You will pay the least)	In-network Preferred Provider*	In-network Non-Preferred Provider*	Out-of-network Provider (You will pay the most)	
<b>If you need help recovering or have other special health needs</b>	<a href="#">Home health care</a>	Not applicable	No charge		Not covered	Coverage is limited to 200 visits/year.
	<a href="#">Rehabilitation services</a>	Not applicable	No charge		Not covered	Preauthorization required.
	<a href="#">Habilitation services</a>	Not covered	Not covered		Not covered	<a href="#">Excluded services.</a>
	<a href="#">Skilled nursing care</a>	Not applicable	No charge		Not covered	Coverage is limited to 60 days/year. Preauthorization required.
	<a href="#">Durable medical equipment</a>	Not applicable	No charge		Not covered	Preauthorization required.
	<a href="#">Hospice services</a>	Not applicable	No charge		Not covered	
<b>If your child needs dental or eye care</b>	Children's eye exam	Not applicable	No charge		Not covered under 19	Coverage limited to 1 exam/12 months, if you have family coverage, through Davis Vision.
	Children's glasses	Not applicable	No charge		Not covered under 19	Coverage is limited to 1 pair/24 months, if you have family coverage, through Davis Vision.
	Children's dental check-up	Not applicable	No charge		The amount in excess of the <a href="#">allowed amount</a>	Coverage is limited to 2 visits in a calendar year, if you have family coverage, through Delta Dental.

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## 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
- Habilitation Services
- Infertility Treatment
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Non-preferred brand and specialty drugs
- Private-duty nursing

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

- Acupuncture up to 20 visits per year
- Bariatric surgery only at Blue Distinction hospitals within the Empire network
- Chiropractic care up to 10 visits per year
- Dental care (Adult) through Delta Dental
- Hearing aids ([in-network](#) only/2 per lifetime)
- Routine eye care (Adult) through Davis Vision
- Routine foot care
- Weight loss programs (excluding commercial programs, e.g., Weight Watchers, Jenny Craig)

**Your Rights to Continue Coverage:** For more information on your rights to continue your coverage, contact the [plan](#) at 1-800-551-3225. 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 Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or [www.dol.gov/ebsa/healthreform](http://www.dol.gov/ebsa/healthreform). 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 on how 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: Member Services at 1-800-551-3225 or the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or [www.dol.gov/ebsa/healthreform](http://www.dol.gov/ebsa/healthreform).

**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:

Para obtener asistencia en Español, llame al 1-800-551-3225

Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-551-3225

如果需要中文的帮助, 请拨打这个号码 1-800-551-3225

Dinek'ehgo shika at'ohwol ninisingo, kwijijgo holne' 1-800-551-3225

*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 in-network pre-natal care and a hospital delivery)

- The [plan's](#) overall [deductible](#) \$0.00
- [Specialist copay](#) \$40.00
- Hospital (facility) [copay](#) \$100.00
- Other Rx [copay](#) \$10.00

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>\$12,642</b>
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In this example, Peg would pay:

<i>Cost Sharing</i>	
<a href="#">Deductibles</a>	\$0.00
<a href="#">Copayments</a>	\$150.00
<a href="#">Coinsurance</a>	\$0.00
<i>What isn't covered</i>	
Limits or exclusions	\$20.00
<b>The total Peg would pay is</b>	<b>\$170.00</b>

This example assumes you have single coverage and delivered at a preferred hospital.

**Managing Joe's type 2 Diabetes**  
(a year of routine in-network care of a well-controlled condition)

- The [plan's](#) overall [deductible](#) \$0.00
- [Specialist copay](#) \$40.00
- Hospital (facility) [copay](#) \$100.00
- Other Rx [copay](#) \$10.00

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>\$1,472</b>
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In this example, Joe would pay:

<i>Cost Sharing</i>	
<a href="#">Deductibles</a>	\$0.00
<a href="#">Copayments</a>	\$810.00
<a href="#">Coinsurance</a>	\$0.00
<i>What isn't covered</i>	
Limits or exclusions	\$0.00
<b>The total Joe would pay is</b>	<b>\$810.00</b>

These numbers assume you use a preferred hospital but don't use a 5 Star Center Provider or participate in the [plan's](#) 5 Star Wellness Program. If you use a 5 Star Center Provider and participate in the [plan's](#) 5 Star Wellness Program, you may be able to reduce your costs. For more information about 5 Star Center Providers and the 5 Star Wellness Program, please call Member Services at 1-800-551-3225.

**Mia's Simple Fracture**  
(in-network emergency room visit and follow up care)

- The [plan's](#) overall [deductible](#) \$0.00
- [Specialist copay](#) \$40.00
- Hospital (facility) [copay](#) \$100.00
- Other Rx [copay](#) \$10.00

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>\$2,635</b>
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In this example, Mia would pay:

<i>Cost Sharing</i>	
<a href="#">Deductibles</a>	\$0.00
<a href="#">Copayments</a>	\$310.00
<a href="#">Coinsurance</a>	\$0.00
<i>What isn't covered</i>	
Limits or exclusions	\$0.00
<b>The total Mia would pay is</b>	<b>\$310.00</b>