

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:
What is the overall deductible ?	\$0 for in-network providers \$250 person/\$500 family for out-of-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. There is no deductible for in-network services . No, when out-of-network.	This plan covers some items and services even if you haven't met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost-sharing and before you meet your deductible . See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/ . You will have to meet the deductible before the plan pays for any services.
Are there other deductibles for specific services?	No.	You don't have to meet specific deductibles for specific services.
What is the out-of-pocket limit for this plan ?	For in-network providers \$10,600 individual / \$21,200 family; for out-of-network providers \$10,600 individual / \$21,200 family.	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 ?	Premiums , balance billing charges, penalties for failure to obtain preauthorization, & 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 www.32bjfunds.org or call 1-800-551-3225 for a list of in-network providers .	This plan uses a provider network . You pay the least if you use a 5 Star Center provider . You pay more if you use a preferred provider in the plan's network . You pay even more if you use a non-preferred provider in the plan's network . You 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 in-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**
		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)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness.	No charge.	\$15 copay /office visit.		30% coinsurance .	None.
	Specialist visit.	No charge.	\$40 copay /office visit.		30% coinsurance .	
	Preventive care/screening/ Immunization.	No charge.	No charge.		30% coinsurance .	\$75 copay /visit for preventive procedures (e.g., mammogram, colonoscopy) at a preferred provider hospital or hospital based facility. \$250 copay /visit for preventive procedures (e.g., mammogram, colonoscopy) at a non- preferred provider hospital or hospital based facility. When utilizing an out-of-network provider Plan pays 70% coinsurance of the allowed amount after the deductible . You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for.
Other practitioner office visit.	No charge for chiropractic.	\$40 copay /visit chiropractic.		30% coinsurance for chiropractic care.	Chiropractic care coverage is limited to 10 visits/year. Acupuncture coverage is limited to 20 visits/year.	
	No charge for acupuncture.	\$40 copay /visit acupuncture.		Not covered. Not covered.		
If you have a test	Diagnostic test (x-ray, blood work).	No charge.	No charge.		30% coinsurance .	\$75 facility copay /visit for diagnostic tests (excluding blood work) at a preferred hospital-based facility. \$250 facility copay /visit for diagnostic tests (excluding blood work) 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.

** For more information about limitations and exceptions, see the plan or policy document at 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)
	Imaging (CT/PET scans, MRIs).	\$75 copay /scan.	\$75 copay /scan	\$250 copay /scan	30% coinsurance .	Preauthorization required. Failure to preauthorize out-of-network services results in a \$250 penalty.
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.optumrx.com	Generic drugs.	Not applicable.	\$10 copay /up to 30-day supply.		Not covered.	Formulary Only. Covers up to a 30-day supply for retail pharmacy and up to a 90-day supply of maintenance medications. Maintenance medications require a 90-day supply fill (84-day for weekly dosage drugs) at CVS pharmacy or through OptumRx Home Delivery after a retail allowance (typically two fills) has been met.
	Brand drugs.	Not applicable.	\$20 copay /up to 90-day supply.	\$30 copay /up to 30-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 name drug and generic equivalent plus the copay . Ask your doctor to call OptumRx at 1-844-569-4148 for information on alternatives.
	Specialty drugs .	Not applicable.	Same copays as generic and brand drugs above.	\$60 copay /up to 90-day supply.		Not covered.

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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*		Out-of-network Provider (You will pay the most)
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center).	No charge.	Charges may apply.**		30% coinsurance .	\$75 facility copay /visit for outpatient services at a preferred hospital-based facility. \$250 facility copay /visit for outpatient services at a non-preferred hospital-based facility.
	Physician/surgeon fees.	No charge.	Charges may apply.**		30% coinsurance .	
If you need immediate medical attention	Emergency room care .	Not applicable.	\$100 copay /visit.		\$100 copay /visit.	The copay increases to \$200 for all emergency room visits after the 2nd visit within the same calendar year.
	Emergency medical transportation .	Not applicable.	No charge.		No charge.	Not covered if after transport you do not receive treating services.
	Urgent care .	No charge.	\$40 copay /office visit.		30% coinsurance .	\$40 copay/urgent care visit at 5 Star Center Providers Westmed and Summit.
If you have a hospital stay	Facility fee (e.g., hospital room).	Not applicable.	\$100 copay /admission.	\$1,000 copay /admission.	30% coinsurance .	Private rooms not covered. \$100 copay /emergency admission at preferred and non-preferred facilities.
	Physician/surgeon fees.	Not applicable.	No charge.		30% coinsurance .	Preauthorization required for most facility admissions. Failure to preauthorize out-of-network services results in a \$250 penalty. Certain procedures are subject to higher copays or are not covered if not performed at certain hospitals. For more information see your SPD or call Member Services at 1-800-551-3225.

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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)	
If you need mental health, behavioral health, or substance abuse services	Outpatient services.	No charge.	\$15 <u>copay</u> /visit.		30% <u>coinsurance</u> .***	Inpatient, and some outpatient, services require preauthorization. Failure to preauthorize results in a \$250 penalty. \$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. ***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.
	Inpatient services.	Not applicable.	\$100 <u>copay</u> /visit.	\$1,000 <u>copay</u> /visit.	30% <u>coinsurance</u> .***	
If you are pregnant	Office visits.	No charge.	\$15 <u>copay</u> /1 st 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> .	
	<u>Home health care</u> .	Not applicable.	No charge.		Not covered.	Coverage is limited to 200 visits/year.

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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)	
If you need help recovering or have other special health needs	Rehabilitation services.	No charge for occupational, vision, physical, speech therapy.	\$40 copay /visit occupational, vision, physical, speech therapy.		Not covered.	<p>Preauthorization required. Occupational, vision and speech therapy combined coverage is limited to 30 visits/year.</p> <p>Outpatient physical therapy coverage is limited to 30 separate visits/year. Preauthorization required. \$75 facility copay/visit for out-patient physical therapy services at a preferred hospital based facility; \$250 facility copay/visit for out-patient physical therapy services at a non-preferred hospital based facility.</p> <p>\$0 copay for virtual physical therapy for 12 months when referred to by a Lantern Surgery Care provider, to a designated virtual PT provider.</p>
	Habilitation services.	Not covered.	Not covered.		Not covered.	Excluded services.
	Skilled nursing care.	Not applicable.	No charge.		Not covered.	Coverage is limited to 60 days/year. Preauthorization required.
	Durable medical equipment.	Not applicable.	No charge.		Not covered.	Preauthorization required.
	Hospice services.	Not applicable.	No charge.		Not covered.	
If your child needs dental or eye care	Children's eye exam.	Not applicable.	No charge.		Not covered under 19 years old.	Coverage limited to 1 exam/12 months, if you have family coverage, through Davis Vision.

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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)	
	Children's glasses.	Not applicable.	No charge.		Not covered under 19 years old.	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 allowed amount .	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 .)		
<ul style="list-style-type: none">• Cosmetic Surgery• Habilitation Services	<ul style="list-style-type: none">• Long-term care• Non-emergency care when traveling outside the U.S.	<ul style="list-style-type: none">• 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.)		
<ul style="list-style-type: none">• Acupuncture up to 20 visits per year• Bariatric, joint replacement, and spine surgery only at a 32BJ Health Fund Center of Excellence• Chiropractic care up to 10 visits per year	<ul style="list-style-type: none">• Dental care (Adult) through Delta Dental• Fertility services through Progyny• Hearing aids (in-network only/2 per lifetime)• Routine eye care (Adult) through Davis Vision	<ul style="list-style-type: none">• Routine foot care• Weight loss programs (excluding commercial programs, e.g., Weight Watchers)

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. 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 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.

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
- PCP [copay](#) (initial visit) \$15.00
- Preferred 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*)

Total Example Cost	\$12,642
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In this example, Peg would pay:

<i>Cost Sharing</i>	
Deductibles	\$0.00
Copayments	\$125.00
Coinsurance	\$0.00
<i>What isn't covered</i>	
Limits or exclusions	\$00.00
The total Peg would pay is	\$152.00

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
- PCP/[Specialist copay](#) per visit (2x) \$40.00
- Durable Medical Equipment [copay](#) \$00.00
- Other Rx [copay](#) per 90-day refill (4x) \$20.00

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*)

Total Example Cost	\$1,472
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In this example, Joe would pay:

<i>Cost Sharing</i>	
Deductibles	\$0.00
Copayments	\$160.00
Coinsurance	\$0.00
<i>What isn't covered</i>	
Limits or exclusions	\$0.00
The total Joe would pay is	\$160.00

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
- Rehabilitation services [copay](#) (5x) \$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*)

Total Example Cost	\$2,635
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In this example, Mia would pay:

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

The [plan](#) would be responsible for the other costs of these EXAMPLE covered services.