


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




Coverage Period: Beginning On or After 1/1/2018

Walnut Valley Unified School District Custom Trio HMO® Zero Admit 15

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](https://bsca.com/policies) or call 1-855-829-3566. 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](https://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 plan 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 plan covers some items and services even if you haven't yet met the deductible amount. But a <u>copayment</u> or <u>coinsurance</u> may apply. For example, this plan covers certain <u>preventive services</u> without <u>cost-sharing</u> and before you meet your deductible. See a list of covered <u>preventive services</u> at <a href="https://healthcare.gov/coverage/preventive-care-benefits">healthcare.gov/coverage/preventive-care-benefits</a> .
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?	\$1,000 per individual /\$2,000 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 plan, the overall family <u>out-of-pocket limit</u> must be met.
What is not included in the out-of-pocket limit?	<u>Copayments</u> for certain services, <u>premiums</u> , and health care this plan 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 <a href="https://blueshieldca.com/fap">blueshieldca.com/fap</a> or call 1-855-829-3566 for a list of <u>network providers</u> .	This plan uses a <u>provider network</u> . You will pay less if you use a <u>provider</u> in the plan's 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 charge</u> and what your plan 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 plan 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> .

 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)	
<b>If you visit a health care provider's office or clinic</b>	Primary care visit to treat an injury or illness	\$15/visit	Not Covered	-----None-----
	<u>Specialist visit</u>	<i>Trio+ Specialist:</i> \$30/visit <i>Other Specialist:</i> \$15/visit	Not Covered	
	<u>Preventive care/screening</u> /immunization	No Charge	Not Covered	
<b>If you have a test</b>	<u>Diagnostic test</u> (x-ray, blood work)	<i>Lab &amp; Path:</i> No Charge <i>X-Ray &amp; Imaging:</i> No Charge <i>Other Diagnostic Examination:</i> No Charge	<i>Lab &amp; Path:</i> Not Covered <i>X-Ray &amp; Imaging:</i> Not Covered <i>Other Diagnostic Examination:</i> Not Covered	<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:</i> No Charge <i>Outpatient Hospital:</i> No Charge	<i>Outpatient Radiology Center:</i> Not Covered <i>Outpatient Hospital:</i> Not Covered	<u>Preauthorization</u> is required. Failure to obtain <u>preauthorization</u> may result in non-payment of benefits.

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)	
<b>If you need drugs to treat your illness or condition</b> More information about prescription drug coverage is available at <a href="http://blueshieldca.com/formulary">blueshieldca.com/formulary</a>	Tier 1	<i>Retail:</i> \$10 /prescription <i>Mail Service:</i> \$20 /prescription	<i>Retail:</i> Not Covered <i>Mail Service:</i> Not Covered	<u>Preauthorization</u> is required for select drugs. Failure to obtain <u>preauthorization</u> may result in non-payment of benefits. <i>Retail:</i> Covers up to a 30-day supply; <i>Mail Service:</i> Covers up to a 90-day supply.
	Tier 2	<i>Retail:</i> \$20 /prescription <i>Mail Service:</i> \$40 /prescription	<i>Retail:</i> Not Covered <i>Mail Service:</i> Not Covered	
	Tier 3	<i>Retail:</i> Not Covered <i>Mail Service:</i> Not Covered	<i>Retail:</i> Not Covered <i>Mail Service:</i> Not Covered	
	Tier 4 (excluding <u>Specialty drugs</u> )	<i>Retail:</i> 20% <u>coinsurance</u> up to \$200 maximum/prescription <i>Mail Service:</i> 20% <u>coinsurance</u> up to \$400 maximum/prescription	<i>Retail:</i> Not Covered <i>Mail Service:</i> Not Covered	<u>Preauthorization</u> is required. Failure to obtain <u>preauthorization</u> may result in non-payment of benefits.
<b>If you have outpatient surgery</b>	Facility fee (e.g., ambulatory surgery center)	<i>Ambulatory Surgery Center:</i> No Charge <i>Outpatient Hospital:</i> No Charge	<i>Ambulatory Surgery Center:</i> Not Covered <i>Outpatient Hospital:</i> Not Covered	-----None-----
	Physician/surgeon fees	No Charge	Not Covered	-----None-----
<b>If you need immediate medical attention</b>	<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>	\$100/transport	\$100/transport	-----None-----
	<u>Urgent care</u>	<i>Within <u>Plan</u> Service Area:</i> \$15/visit <i>Outside <u>Plan</u> Service Area:</i> \$15/visit	<i>Within <u>Plan</u> Service Area:</i> Not Covered <i>Outside <u>Plan</u> Service Area:</i> \$15/visit	-----None-----

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 you have a hospital stay	Facility fee (e.g., hospital room)	No Charge	Not Covered	<u>Preauthorization</u> is required. Failure to obtain <u>preauthorization</u> may result in non-payment of benefits. -----None-----
	Physician/surgeon fees	No Charge	Not Covered	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	<i>Office Visit:</i> \$15/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.  <u>Preauthorization</u> is required. Failure to obtain <u>preauthorization</u> may result in non-payment of benefits.
	Inpatient services	<i>Physician Inpatient Services:</i> No Charge <i>Hospital Services:</i> No Charge <i>Residential Care:</i> No Charge	<i>Physician Inpatient Services:</i> Not Covered <i>Hospital Services:</i> Not Covered <i>Residential Care:</i> Not Covered	
If you are pregnant	Office visits	No Charge	Not Covered	-----None-----
	Childbirth/delivery professional services	No Charge	Not Covered	
	Childbirth/delivery facility services	No Charge	Not Covered	
If you need help recovering or have other special health needs	<u>Home health care</u>	\$15/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.

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)	
	<u>Rehabilitation services</u>	Office Visit: \$15/visit Outpatient Hospital: \$15/visit	Office Visit: Not Covered Outpatient Hospital: Not Covered	-----None-----
	<u>Habilitation services</u>	Office Visit: \$15/visit Outpatient Hospital: \$15/visit	Office Visit: Not Covered Outpatient Hospital: Not Covered	
	<u>Skilled nursing care</u>	Freestanding SNF: No Charge Hospital-based SNF: No Charge	Freestanding SNF: Not Covered Hospital-based SNF: 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>	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>	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.
<b>If your child needs dental or eye care</b>	Children's eye exam	Not Covered	Not Covered	-----None-----
	Children's glasses	Not Covered	Not Covered	-----None-----
	Children's dental check-up	Not Covered	Not Covered	-----None-----

## 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.)

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

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

- Bariatric surgery
- Infertility Treatment

**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](http://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](http://HealthCare.gov) or call 1-800-318-2596.

**Your Grievance and Appeals Rights: 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 1-855-836-9705 or the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or [dol.gov/ebsa/healthreform](http://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](mailto:helpline@dmhc.ca.gov) or visit <http://www.healthhelp.ca.gov>.

### Does this plan provide Minimum Essential Coverage? Yes

If you don't have Minimum Essential Coverage for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

### 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.





**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 \$15
- Hospital (facility) copayment \$0
- 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** \$12,800

**In this example, Peg would pay:**

Cost Sharing	
Deductibles	\$0
Copayments	\$60
Coinsurance	\$0
What isn't covered	
Limits or exclusions	\$60
<b>The total Peg would pay is</b>	<b>\$120</b>

**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 \$15
- Hospital (facility) copayment \$0
- 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** \$7,400

**In this example, Joe would pay:**

Cost Sharing	
Deductibles	\$0
Copayments	\$735
Coinsurance	\$0
What isn't covered	
Limits or exclusions	\$1,783
<b>The total Joe would pay is</b>	<b>\$2,518</b>

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

- The plan's overall deductible \$0
- Specialist copayment \$15
- Hospital (facility) copayment \$0
- 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** \$2,500

**In this example, Mia would pay:**

Cost Sharing	
Deductibles	\$0
Copayments	\$370
Coinsurance	\$18
What isn't covered	
Limits or exclusions	\$37
<b>The total Mia would pay is</b>	<b>\$425</b>

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

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