


**Chouest Group Health Plan: Land/Sea Plan**



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, 1-877-705-5427. 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 [www.dol.gov/ebsa/healthreform](http://www.dol.gov/ebsa/healthreform) or [www.ccio.cms.gov](http://www.ccio.cms.gov) or call 1-877-705-5427 to request a copy.

Important Questions	Answers	Why This Matters:
<b>What is the overall deductible?</b>	In-Network <b>\$500</b> person/ <b>\$1,000</b> family. Out-of-Network <b>\$500</b> person/ <b>\$1,000</b> family.	Generally, you must pay all 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</b>	Yes. In-Network <u>preventive care services</u> are covered before you meet your <u>deductible</u> .	This plan covers certain preventive services without cost sharing and before you meet your deductible. See a list of covered preventive services at <a href="https://www.healthcare.gov/coverage/preventive-care-benefits/">https://www.healthcare.gov/coverage/preventive-care-benefits/</a> . This plan 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.
<b>Are there other deductibles for specific services?</b>	Yes. Prescription Drug Deductible. <b>\$50</b> Individual / <b>\$100</b> Family per Calendar year	You must pay all the costs for these services up to the specific deductible amount before this plan begins to pay for these services;
<b>What is the out-of-pocket limit for this plan?</b>	Medical: In-Network <b>\$3,100</b> Individual / <b>\$6,200</b> family. Medical: Out-of-Network <b>\$4,825</b> Individual / <b>\$9,650</b> family. Prescription: <b>\$4,800</b> Individual / <b>\$9,600</b> Family	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>Deductible</u> , <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="http://www.MyHealthToolkitLA.com">www.MyHealthToolkitLA.com</a> or call <b>1-800-810-BLUE (2583)</b> 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 network</u> . 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>Referral to see a specialist?</b>	No.	You can see the <u>specialist</u> you choose without a <u>referral</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
		Network Provider (You will pay the least)	Out-of-Network Provider (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	\$33 Copay/visit then 20% Coinsurance after deductible	\$33 Copay/visit then 30% Coinsurance after deductible	<u>Copay</u> applies to office visit only. All other services are covered with <u>coinsurance</u> after <u>deductible</u> .
	Specialist visit	\$50 Copay/visit then 20% Coinsurance after deductible	\$50 Copay/visit then 30% Coinsurance after deductible	<u>Copay</u> applies to office visit only. All other services are covered with <u>coinsurance</u> after <u>deductible</u> .
	Preventive care/screening/immunization	No Charge	\$33 copay then 30% coinsurance after deductible OR \$50 copay then 30% after deductible	Out of Network <u>copay</u> applies to office visit only and will be determined on what type of provider you choose to see. See <a href="http://www.healthcare.gov">www.healthcare.gov</a> for <u>preventive</u> care guidelines. You may have to pay for services that aren't <u>preventive</u> . Ask your provider if the services needed are <u>preventive</u> . Then check what your plan will pay for.
<b>If you have a test</b>	Diagnostic test (x-ray, blood work)	20% Coinsurance after deductible	30% Coinsurance after deductible	-----None-----
	Imaging (CT/PET scans, MRIs)	20% Coinsurance after deductible	30% Coinsurance after deductible	<u>Pre-authorization</u> is required. Penalty for not obtaining <u>pre-authorization</u> is denial of all charges.
<b>If you need drugs to treat your illness or condition</b> More information about <b>prescription drug coverage</b> is available at <a href="http://www.express-scripts.com">www.express-scripts.com</a>	Generic (30 day)	30% after deductible (\$25 min   \$100 max)	Not Covered	<u>Prescription Drug Deductible:</u> \$50 Individual \$100 Family
	Brand Preferred (30 day)	35% after deductible (\$35 min   \$125 max)	Not Covered	
	Brand Non-Preferred (30 day)	40% after deductible (\$50 min   \$175 max)	Not Covered	<u>Prescription Drug Out of Pocket Maximum:</u> \$4,800 Individual \$9,600 Family
	Generic (90 day)	25% after deductible (\$15 min   \$200 max)	Not Covered	
	Brand Preferred (90 day)	30% after deductible (\$30 min   \$250 max)	Not Covered	Prescription Drug <u>deductible</u> must be satisfied before <u>copayments</u> are applicable. Prescription drug costs do not apply to the medical health <u>deductible</u> or out of pocket maximum – only the prescription drug <u>deductible</u> and out of pocket maximums.
	Brand Non-Preferred (90 day)	35% after deductible (\$45 min   \$350 max)	Not Covered	
	Specialty drugs	25% after deductible \$500 max	Not Covered	

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

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 have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% Coinsurance after deductible	30% Coinsurance after deductible	-----None-----
	Physician/surgeon fees	20% Coinsurance after deductible	30% Coinsurance after deductible	-----None-----
If you need immediate medical attention	Emergency room care	\$150 Copay/ visit then 20% Coinsurance after deductible	\$150 Copay/ visit then 20% Coinsurance after deductible	<u>Copayment</u> will be waived if admitted
	Emergency medical transportation	20% Coinsurance after deductible	30% Coinsurance after deductible	-----None-----
	Urgent care	\$33 Copay/visit then 20% Coinsurance after deductible	\$33 Copay/visit then 30% Coinsurance after deductible	<u>Copay</u> applies to office visit only. All other services are covered with <u>coinsurance</u> after <u>deductible</u> .
If you have a hospital stay	Facility fee (e.g., hospital room)	20% Coinsurance after deductible	30% Coinsurance after deductible	<u>Pre-authorization</u> is required. Penalty for not obtaining <u>pre-authorization</u> is denial of all charges Out-of-Network
	Physician/surgeon fees	20% Coinsurance after deductible	30% Coinsurance after deductible	-----None-----
If you need mental health, behavioral health, or substance abuse services	Office Visits	\$33 Primary Care \$50 Specialist	\$33 Primary Care \$50 Specialist	<u>Copay</u> for office visit only. Does not apply to therapy services.
	Outpatient treatment services	20% Coinsurance after deductible	30% Coinsurance after deductible	<u>Pre-authorization</u> is required. Penalty for not obtaining <u>pre-authorization</u> is denial of all charges out-of-network.
	Inpatient treatment services	20% Coinsurance after deductible	30% Coinsurance after deductible	
If you are pregnant	Office visits	\$33 Copay/ visit then 20% Coinsurance after deductible	\$33 Copay/ visit then 30% Coinsurance after deductible	<u>Copay</u> applies to office visit only. Depending on the type of services a <u>copayment</u> , <u>coinsurance</u> or <u>deductible</u> may apply. Cost sharing does not apply to certain preventive services.
	Childbirth/delivery professional services	20% Coinsurance after deductible	30% Coinsurance after deductible	<u>Pre-authorization</u> for facility services is required. Penalty of not obtaining <u>pre-authorization</u> is denial of all charges out of network. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound)
	Childbirth/delivery facility services	20% Coinsurance after deductible	30% Coinsurance after deductible	

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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 help recovering or have other special health needs</b>	Home health care	20% Coinsurance after deductible	30% Coinsurance after deductible	100 visits/benefit year. <u>Pre-authorization</u> is required. Penalty for not obtaining <u>pre-authorization</u> is denial of all charges.
	Rehabilitation services	20% Coinsurance after deductible	30% Coinsurance after deductible	60 combined visits/benefit year for Occupational Therapy, Physical Therapy and Speech Therapy.
	Habilitation services	20% Coinsurance after deductible	30% Coinsurance after deductible	60 combined visits/benefit year for Occupational Therapy, Physical Therapy and Speech Therapy.
	Skilled nursing care	20% Coinsurance after deductible	30% Coinsurance after deductible	90 days/benefit year. <u>Pre-authorization</u> is required. Penalty for not obtaining <u>pre-authorization</u> is denial of all charges.
	Durable medical equipment	20% Coinsurance after deductible	30% Coinsurance after deductible	<u>Purchase or rentals of \$300 or more require pre-authorization. Penalty for not obtaining pre-authorization is denial of all charges. Hearing aids are covered to age 17, 1 hearing aid/ear every 36 months, up to \$1,400/hearing aid. C-PAP equipment covered with 50% Coinsurance. Electric wheelchairs and shoe inserts are Not Covered.</u>
	Hospice services	20% Coinsurance after deductible	30% Coinsurance after deductible	<u>Pre-authorization</u> is required. Penalty for not obtaining <u>pre-authorization</u> is denial of all charges for In-Network outpatient and all Out-of-Network services.
<b>If your child needs dental or eye care</b>	Children's eye exam	Not Covered	Not Covered	Separate Dental/Vision policies available. Contact your Employer for details.
	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 plan or policy document at [www.MyHealthToolkitLA.com](http://www.MyHealthToolkitLA.com)

## 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         | • Gender Dysphoria and Gender Reassignment Surgery | • Routine Eye Care (Child) |
| • Bariatric Surgery   | • Infertility Treatment                            | • Routine Foot Care        |
| • Cosmetic Surgery    | • Long-Term Care                                   | • Weight Loss Programs     |
| • Dental Care (Adult) | • Routine Eye Care (Adult)                         |                            |
| • Dental Care (Child) |  |                            |

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

- |   |  |  |
|---|--|--|
| • Chiropractic Care (limited to \$1,000/benefit year) | • Non-emergency care when traveling outside the U.S. | • Private Duty Nursing, if part of pre-authorized home health care |
| • Hearing Aids  |  |  |

**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: 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). 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: 1-877-705-5427 or visit us at [www.MyHealthToolkitLA.com](http://www.MyHealthToolkitLA.com), 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**

If you don't have [Minimum Essential Coverage](#) for a month, you may 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](#).

## Language Access Services:

[Spanish (Español): Para obtener asistencia en Español, llame al [insert telephone number].]

[Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa [insert telephone number].]

[Chinese (中文): 如果需要中文的帮助, 请拨打这个号码 [insert telephone number].]

[Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijigo holne' [insert telephone number].]

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

## 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 <a href="#">plan's</a> overall <a href="#">deductible</a>	\$500
■ <a href="#">Copayment</a>	\$33
■ Hospital (facility)	20%
■ Other	20%

#### This EXAMPLE event includes services like:

Office visits (*prenatal care*)  
 Childbirth/Delivery Professional Services  
 Childbirth/Delivery Facility Services  
 Diagnostic tests (*ultrasounds and blood work*)  
 Anesthesia

<b>Total Example Cost</b>	<b>\$10,500</b>
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#### In this example, Peg would pay:

<i>Cost Sharing</i>	
Deductibles	\$500
Copayments	\$33
Coinsurance	\$2,000
<i>What isn't covered</i>	
Limits or exclusions	\$0
<b>The total Peg would pay is</b>	<b>\$2,533</b>

### Managing Joe's type 2 Diabetes

(a year of routine in-network care of a well-controlled condition)

■ The <a href="#">plan's</a> overall <a href="#">deductible</a>	\$500
■ <a href="#">Copayment</a>	\$33
■ Hospital (facility)	20%
■ Other	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>\$5,400</b>
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#### In this example, Joe would pay:

<i>Cost Sharing</i>	
Deductibles	\$550
Copayments	\$228
Coinsurance	\$198
<i>What isn't covered</i>	
Limits or exclusions	\$300
<b>The total Joe would pay is</b>	<b>\$1,276</b>

### Mia's Simple Fracture

(in-network emergency room visit and one follow up)

■ The <a href="#">plan's</a> overall <a href="#">deductible</a>	\$500
■ ER <a href="#">Copayment</a>	\$150
■ Hospital (facility)	20%
■ Other	20%

#### This EXAMPLE event includes services like:

Emergency room care (*including medical supplies*)  
 Specialist Visit  
 Diagnostic test (*x-ray*)  
 Durable medical equipment (*crutches*)

<b>Total Example Cost</b>	<b>\$1,900</b>
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#### In this example, Mia would pay:

<i>Cost Sharing</i>	
Deductibles	\$500
Copayments	\$200
Coinsurance	\$300
<i>What isn't covered</i>	
Limits or exclusions	\$0
<b>The total Mia would pay is</b>	<b>\$1,000</b>