Chouest Group Health Plan: Port/Shipyard 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** or **www.ccio.cms.gov** or call **1-877-705-5427** to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	In-Network **$850** person/**$2,550** family. Out-of-Network **$850** person/**$2,550** family.	Generally, you must pay all 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	Yes. In-Network preventive care services are covered before you meet your deductible.	This plan covers certain preventive services without cost sharing and before you meet your deductible. See a list of covered preventive services at See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/.This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply.
Are there other deductibles for specific services?	Yes. Prescription Drug Deductible. **$50** Individual / **$100** 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;
What is the out-of-pocket limit for this plan?	Medical: In-Network **$3,100** Individual / **$6,200** family. Medical: Out-of-Network **$5,100** Individual **/$10,900** family. Prescription: **$4,800** Individual / **$9,600** 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?	Deductible, 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 **www.MyHealthToolkitLA.com** or call **1-800-810-BLUE (2583)** 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.
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	$33 Copay/visit then 20% Coinsurance after deductible	$33 Copay/visit then 30% Coinsurance after deductible	Copay applies to office visit only. All other services are covered with coinsurance after deductible.
	Specialist visit	$50 Copay/visit then 20% Coinsurance after deductible	$50 Copay/visit then 30% Coinsurance after deductible	Copay applies to office visit only. All other services are covered with coinsurance after deductible
	Preventive care/screening/ immunization	No Charge	$33 copay then 30% coinsurance after deductible OR $50 copay then 30% after deductible	Out of Network copay applies to office visit only and will be determined on what type of provider you choose to see. See www.healthcare.gov for preventive care guidelines. 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.
If you have a test	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	Pre-authorization is required. Penalty for not obtaining pre-authorization is denial of all charges.
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.express-scripts.com	Generic (30 day)	30% after deductible ($25 min | $100 max)	Not Covered	Prescription Drug Deductible: $50 Individual $100 Family Prescription Drug Out of Pocket Maximum: $4,800 Individual $9,600 Family Prescription Drug deductible must be satisfied before copayments are applicable. Prescription drug costs do not apply to the medical health deductible or out of pocket maximum – only the prescription drug deductible and out of pocket maximums.
	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	
	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	
	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

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	Copayment 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	Copay applies to office visit only. All other services are covered with coinsurance after deductible
If you have a hospital stay	Facility fee (e.g., hospital room)	20% Coinsurance after deductible	30% Coinsurance after deductible	Pre-authorization is required. Penalty for not obtaining pre-authorization 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	Copay for office visit only. Does not apply to therapy services.
	Outpatient treatment services	20% Coinsurance after deductible	30% Coinsurance after deductible	Pre-authorization is required. Penalty for not obtaining pre-authorization 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	Copay applies to office visit only. Depending on the type of services a copayment, coinsurance or deductible may apply. Cost sharing does not apply to certain preventive services.
	Childbirth/delivery professional services	20% Coinsurance after deductible	30% Coinsurance after deductible	Pre-authorization for facility services is required. Penalty of not obtaining pre-authorization 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	

* For more information about limitations and exceptions, see the plan or policy document at 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 need help recovering or have other special health needs	Home health care	20% Coinsurance after deductible	30% Coinsurance after deductible	100 visits/benefit year. Pre-authorization is required. Penalty for not obtaining pre-authorization 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. Pre-authorization is required. Penalty for not obtaining pre-authorization is denial of all charges.
	Durable medical equipment	20% Coinsurance after deductible	30% Coinsurance after deductible	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.
	Hospice services	20% Coinsurance after deductible	30% Coinsurance after deductible	Pre-authorization is required. Penalty for not obtaining pre-authorization is denial of all charges for In-Network outpatient and all Out-of-Network services.
If your child needs dental or eye care	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

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
- Bariatric Surgery
- Cosmetic Surgery
- Dental Care (Adult)
- Dental Care (Child)
- Gender Dysphoria and Gender Reassignment Surgery
- Infertility Treatment
- Long-Term Care
- Routine Eye Care (Adult)
- Routine Eye Care (Child)
- 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.)

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

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, kwiijigo holne' [insert telephone number].]

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 plan or policy document at www.MyHealthToolkitLA.com

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	$850
Copayment	$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

Total Example Cost	**$10,500**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$850
Copayments	$33
Coinsurance	$2,000
What isn't covered	
Limits or exclusions	$0
The total Peg would pay is	**$2,883**

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

The plan's overall deductible	$850
Copayment	$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)*

Total Example Cost	**$5,400**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$900
Copayments	$228
Coinsurance	$198
What isn't covered	
Limits or exclusions	$300
The total Joe would pay is	**$1,626**

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

The plan's overall deductible	$850
ER Copayment	$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)*

Total Example Cost	**$1,900**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$850
Copayments	$200
Coinsurance	$300
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,350**

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