SBCSS Health Plans Offered for 2026-2027

CSEA Bargaining Members Only 10-Pay

The monthly contribution is the same for employees only and family.

Medical Plan Choices	Total Employee Monthly Cost			
	W/Option A	W/Option B	W/Option C	W/Option D
Kaiser Permanente Options				
Kaiser - Plan #1 (Kaiser Plan 8) *$20 co-payment / Pharmacy $10 Generic / $20 Brand* *100% hospital covered*	$228.22	$238.06	$224.62	$234.46
Kaiser - Plan #2 (Kaiser Plan 12) *$30 co-payment/ Pharmacy $15 Generic/ $30 Brand* *$250 co-payment for hospital admission*	$87.80	$97.64	$84.20	$94.04
Kaiser - Plan #3 HDHP (Kaiser Plan 1) $1,700 Single / $3,400 Family deductible Pharmacy $10/ $30 after deductible *$20 co-payment after reaching deductible*	$0	$0	$0	$0
Blue Shield TRIO ACO - Plan #1 (Blue Shield HMO Trio C20) *$20 co-payment /100% hospital covered*	$0	$1.80	$0	$0
Blue Shield Access Plus - Plan #2 (Blue Shield HMO Access+ C20) *$20 co-payment / $500 co-payment hospital*	$305.16	$315.00	$301.56	$311.40
Blue Shield TRIO ACO - Plan #7 (Blue Shield HMO Trio 7) *$30 co-payment / $500 co-payment hospital*	$0	$0	$0	$0
Blue Shield Access Plus - Plan #7 (Blue Shield HMO Access+ 7) *$30 co-payment / $500 co-payment hospital*	$234.36	$244.20	$230.76	$240.60
Blue Shield PPO - Plan #1 (Blue Shield PPO Cust 20-500) *$500 single/ $1,000 family* In-Network deductible	$3,306.36	$3,316.20	$3,302.76	$3,312.60
Blue Shield PPO – Plan #1A Tandem (Blue Shield PPO Tandem Cust 20-500) $500 single/ $1,000 family In-Network deductible	$2,977.56	$2,987.40	$2,973.96	$2,983.80
Blue Shield HDHP CSEBA Premier - Plan #2 (Blue Shield Premier PPO Savings 1650) $1,700 single / $3,400 family In-Network deductible	$115.56	$125.40	$111.96	$121.80
Blue Shield HDHP CSEBA Tandem - #2A (Blue Shield PPO Premier Tandem Savings 1650) $1,700 single/ $3,400 family In-network deductible	$0	$0	$0	$0

Delta Dental PPO Options	EYEMED Vision Options
Dental Plan #1 Each enrolled family member: *$2,500 In-Network/$2,000 out-of-network*	**Vision Plan #1** Each enrolled family member is entitled to: $150 frames or contacts In-Network
Dental Plan #2 Each enrolled family member: *$2,000 In-Network/$1,500 out-of-network* ***with ortho***	**Vision Plan #2** Each enrolled family member is entitled to: $200 frames or contacts In-Network
Life Insurance	**Opt-out Option**
Employer-sponsored life/accidental death & dismemberment of $50,000 for employee.	Monthly cash incentive for declining medical. Enrollment continues for dental, vision, and life.

Option Descriptions	
Option A – Dental #1/Vision #1/Life	Option C – Dental #2/Vision #1/Life
Option B – Dental #1/Vision #2/Life	Option D – Dental #2/Vision #2/Life

Benefitfocus plan names are highlighted in red above, and online, the plan name starts with "CSEBA".

For any questions, please contact – Maria Alvarez at: Benefits@sbcss.net - 909 386-9562.

5/27/2026 – 9:00 am

SBCSS Health Plans Offered for 2026-2027

CSEA Bargaining Members Only 11-Pay

The monthly contribution is the same for employees only and family.

Medical Plan Choices	Total Employee Monthly Cost			
	W/Option A	W/Option B	W/Option C	W/Option D
Kaiser Permanente Options				
Kaiser - Plan #1 (Kaiser Plan 8) *$20 co-payment / Pharmacy $10 Generic / $20 Brand* *100% hospital covered*	$207.47	$216.41	$204.20	$213.14
Kaiser - Plan #2 (Kaiser Plan 12) *$30 co-payment/ Pharmacy $15 Generic/ $30 Brand* *$250 co-payment for hospital admission*	$79.82	$88.77	$76.55	$85.49
Kaiser - Plan #3 HDHP (Kaiser Plan 1) $1,700 Single / $3,400 Family deductible Pharmacy $10/ $30 after deductible *$20 co-payment after reaching deductible*	$0	$0	$0	$0
Blue Shield TRIO ACO - Plan #1 (Blue Shield HMO Trio C20) *$20 co-payment /100% hospital covered*	$0	$1.64	$0	$0
Blue Shield Access Plus - Plan #2 (Blue Shield HMO Access+ C20) *$20 co-payment / $500 co-payment hospital*	$277.42	$286.36	$274.15	$283.09
Blue Shield TRIO ACO - Plan #7 (Blue Shield HMO Trio 7) *$30 co-payment / $500 co-payment hospital*	$0	$0	$0	$0
Blue Shield Access Plus - Plan #7 (Blue Shield HMO Access+ 7) *$30 co-payment / $500 co-payment hospital*	$213.05	$222.00	$209.78	$218.73
Blue Shield PPO - Plan #1 (Blue Shield PPO Cust 20-500) *$500 single/ $1,000 family* In-Network deductible	$3,005.78	$3,014.73	$3,002.51	$3,011.45
Blue Shield PPO – Plan #1A Tandem (Blue Shield PPO Tandem Cust 20-500) $500 single/ $1,000 family In-Network deductible	$2,706.87	$2,715.82	$2,703.60	$2,712.55
Blue Shield HDHP CSEBA Premier - Plan #2 (Blue Shield Premier PPO Savings 1650) $1,700 single / $3,400 family In-Network deductible	$105.05	$114.00	$101.78	$110.73
Blue Shield HDHP CSEBA Tandem - #2A (Blue Shield PPO Premier Tandem Savings 1650) $1,700 single/ $3,400 family In-network deductible	$0	$0	$0	$0

Delta Dental PPO Options	EYEMED Vision Options
Dental Plan #1 Each enrolled family member: *$2,500 In-Network/$2,000 out-of-network*	**Vision Plan #1** Each enrolled family member is entitled to: $150 frames or contacts In-Network
Dental Plan #2 Each enrolled family member: *$2,000 In-Network/$1,500 out-of-network* ***with ortho***	**Vision Plan #2** Each enrolled family member is entitled to: $200 frames or contacts In-Network
Life Insurance	**Opt-out Option**
Employer-sponsored life/accidental death & dismemberment of $50,000 for employee.	Monthly cash incentive for declining medical. Enrollment continues for dental, vision, and life.

Option Descriptions	
Option A – Dental #1/Vision #1/Life	Option C – Dental #2/Vision #1/Life
Option B – Dental #1/Vision #2/Life	Option D – Dental #2/Vision #2/Life

Benefitfocus plan names are highlighted in red above, and online, the plan name starts with "CSEBA".

For any questions, please contact – Maria Alvarez at: Benefits@sbcss.net - 909 386-9562.

SBCSS Health Plans Offered for 2026-2027

CSEA Bargaining Members Only 12-Pay

The monthly contribution is the same for employees only and family.

Medical Plan Choices	Total Employee Monthly Cost			
	W/Option A	W/Option B	W/Option C	W/Option D
Kaiser Permanente Options				
Kaiser - Plan #1 (Kaiser Plan 8) *$20 co-payment / Pharmacy $10 Generic / $20 Brand* *100% hospital covered*	$190.18	$198.38	$187.18	$195.38
Kaiser - Plan #2 (Kaiser Plan 12) *$30 co-payment/ Pharmacy $15 Generic/ $30 Brand* *$250 co-payment for hospital admission*	$73.17	$81.37	$70.17	$78.37
Kaiser - Plan #3 HDHP (Kaiser Plan 1) $1,700 Single / $3,400 Family deductible Pharmacy $10/ $30 after deductible *$20 co-payment after reaching deductible*	$0	$0	$0	$0
Blue Shield TRIO ACO - Plan #1 (Blue Shield HMO Trio C20) *$20 co-payment /100% hospital covered*	$0	$1.50	$0	$0
Blue Shield Access Plus - Plan #2 (Blue Shield HMO Access+ C20) *$20 co-payment / $500 co-payment hospital*	$254.30	$262.50	$251.30	$259.50
Blue Shield TRIO ACO - Plan #7 (Blue Shield HMO Trio 7) *$30 co-payment / $500 co-payment hospital*	$0	$0	$0	$0
Blue Shield Access Plus - Plan #7 (Blue Shield HMO Access+ 7) *$30 co-payment / $500 co-payment hospital*	$195.30	$203.50	$192.30	$200.50
Blue Shield PPO - Plan #1 (Blue Shield PPO Cust 20-500) *$500 single/ $1,000 family* In-Network deductible	$2,755.30	$2,763.50	$2,752.30	$2,760.50
Blue Shield PPO – Plan #1A Tandem (Blue Shield PPO Tandem Cust 20-500) $500 single/ $1,000 family In-Network deductible	$2,481.30	$2,489.50	$2,478.30	$2,486.50
Blue Shield HDHP CSEBA Premier - Plan #2 (Blue Shield Premier PPO Savings 1650) $1,700 single / $3,400 family In-Network deductible	$96.30	$104.50	$93.30	$101.50
Blue Shield HDHP CSEBA Tandem - #2A (Blue Shield PPO Premier Tandem Savings 1650) $1,700 single/ $3,400 family In-network deductible	$0	$0	$0	$0

Delta Dental PPO Options	EYEMED Vision Options
Dental Plan #1 Each enrolled family member: *$2,500 In-Network/$2,000 out-of-network*	**Vision Plan #1** Each enrolled family member is entitled to: $150 frames or contacts In-Network
Dental Plan #2 Each enrolled family member: *$2,000 In-Network/$1,500 out-of-network* ***with ortho***	**Vision Plan #2** Each enrolled family member is entitled to: $200 frames or contacts In-Network
Life Insurance	**Opt-out Option**
Employer-sponsored life/accidental death & dismemberment of $50,000 for employee.	Monthly cash incentive for declining medical. Enrollment continues for dental, vision, and life.

Option Descriptions	
Option A – Dental #1/Vision #1/Life	Option C – Dental #2/Vision #1/Life
Option B – Dental #1/Vision #2/Life	Option D – Dental #2/Vision #2/Life

Benefitfocus plan names are highlighted in red above, and online, the plan name starts with "CSEBA".

For any questions, please contact – Maria Alvarez at: Benefits@sbcss.net - 909 386-9562.

Eligible Dependents

Eligible Individuals	Required Original Documents
Eligible Active Employees	NONE
Spouse	Original Certified Marriage Certificate
Domestic Partners	Original Certificate of Domestic Partnership issued by the State of California.
Biological children under age 26	Original Certified Birth Certificate
Step-children under age 26 with current spouse	Original Marriage Certificate or Certificate of Domestic Partnership issued by the State of California and Original Certified Birth Certificate.
Legally adopted children or the intent to adopt	Copy of court decree for adoption or appropriate application/documentation indicating the intent to adopt.
Grandchildren	Original Birth Certificate. Eligible only if parent of grandchild is under age 26 and is currently covered under an SBCSS employee's Kaiser health plan. Not allowed on any Blue Shield Health Plans, dental, or vision. This benefits called dependent-to-dependent coverage.
Legal Guardianship	Copy of court documents awarding legal guardianship (Granted to someone who is not the child's biological parent)
Foster children with the intent to adopt	Documents from the courts or adoption agency is required
Disabled unmarried children over age 26 (Determined disabled by carrier prior to age 26)	Eligibility is determined by your current medical carrier. Employees will receive an approval or denial letter from the carrier.

San Bernardino County Superintendent of Schools
2026-27 Kaiser Comparison Sheet - All Benefit Eligible Employees

	Kaiser Plan #1 (8) (Benefitfocus Kaiser Plan #8)	Kaiser Plan #2 (12) (Benefitfocus Kaiser Plan #12)	Kaiser Plan #3 (1) (Benefitfocus Kaiser Plan #1)
Deductible	None	None	$1,700 Single / $3,400 Family
Out-of-Pocket Maximum	$1,500 Single / $3,000 Family	$4,000 Single / $8,000 Family	$3,400 Single / $6,800 Family
Office Visit & Specialist	$20	$30	$20 per visit after deductible
Hospital Stay	No Cost	$250 per admission	$250 per admission after deductible
Outpatient Procedure	$20 per procedure	$250 per procedure	$150 per procedure after deductible
X-Rays & Lab Test	No Cost	$10 per encounter	$10 per encounter per procedure after deductible
MRI, PET, and CT Scans	No Cost	$50 per procedure	$50 per procedure after deductible
Allergy Injections	No Cost	$5 per visit	$5 per visit after deductible
Emergency Room*	$100 per visit waived if admitted	$150 per visit If admitted-$250	$100 per visit after deductible Inpatient Cost Share if admitted
Ambulance	No Cost	$150 per trip	$100 per trip after deductible
Chiropractic and Acupuncture	$10 per visit, 30 visits a year Contracted with ASH Plans 1-800-678-9133	$10 per visit/30 visits a year Contracted with ASH Plans 1-800-678-9133	**No Coverage**
Medication - Kaiser Pharmacy 30-day supply	$10 Generic / $20 Brand Name	$15 Generic / $30 Brand Name	$10 Generic / $30 Brand Name after deductible
Medication - Kaiser Mail Order Up to 100-day supply	$20 Generic / $40 Brand Name	$30 Generic / $60 Brand Name	$20 Generic / $60 Brand Name after deductible

Deductible: The amount you owe for health care services before your health insurance begins to pay. Deductibles are calendar year.
Out-of-Pocket Maximum: You will not pay any more during the calendar year if co-payments and co-insurance add up to the indicated amount.
Calendar Year: January 1 through December 31
Outpatient Procedure: Surgery that does not require an overnight hospital stay.

For a more detailed summary, please request a copy of your plan summary to Benefits@sbcss.net

San Bernardino County Superintendent of Schools
2026-2027 Blue Shield Trio HMO Plans Comparison Sheet – All Groups

SBCSS Plan Names	Blue Shield TRIO ACO #1 (Blue Shield HMO Trio C20)	Blue Shield TRIO ACO #7 (Blue Shield HMO Trio 7)
Deductible	None	None
Out-of-Pocket Maximum (In-network)	$1,000 Single / $2,000 Family	$2,500 Individual / $5,000 Family
Office Visit (in-network)	$20 for all visits	$30 for all visits
Access+ Specialist	$35 per visit	$40 per visit
Hospital Stay	No Cost	$500 per admission
Outpatient Procedure	No Cost	$250
X-Rays & Lab Test	No Cost	No Cost
MRI, PET, and CT Scans	No Cost	$100
Allergy Serum	50%	No Cost
Diabetes care services	20% Devices, equipment, and supplies	No Cost – Devices, equipment, and supplies
Emergency Room*	$100 per visit waived if admitted	$150 per visit waived if admitted
Ambulance	$100	$100
Chiropractic and Acupuncture	$10/30 visits	$10/30 visits
Medication Retail –30-day supply	$10 Generic / $20 Brand Name 20% up to $200 Specialty	$10 Generic / $20 Brand Name $20 Specialty
Medication Mail Order Up to 90-day supply	$20 Generic / 20% up to $400 Specialty	$20 Generic / $40 Specialty

Deductible: The amount you owe for health care services before your health insurance begins to pay. Deductibles are calendar year.
Out-of-Pocket Maximum: You will not pay any more during the calendar year if co-payments and co-insurance add up to the indicated amount.
Calendar Year: January 1 through December 31
Outpatient Procedure: Surgery that does not require an overnight hospital stay.
Co-insurance: Your percentage share of the cost you will pay of the bill from services rendered.

For a more detailed summary, please request a copy of your plan summary to Benefits@sbcss.net

San Bernardino County Superintendent of Schools
2026-2027 Blue Shield Access Plus HMO Plans Comparison Sheet – All Groups

SBCSS Plan Names	Blue Shield Access Plus #2 (Blue Shield HMO Access+ C20)	Blue Shield Access Plus #7 (Blue Shield HMO Access+ 7)
Deductible	None	None
Out-of-Pocket Maximum (In-network)	$2,000 Individual / $4,000 Family	$2,500 Individual / $5,000 Family
Office Visit (in-network)	$20 for all visits	$30 for all visits
Access+ Specialist	$30 per visit	$40 per visit
Hospital Stay	$500 per admission	$500 per admission
Outpatient Procedure	$125 or $250	$250
X-Rays & Lab Test	No Cost	No Cost
MRI, PET, and CT Scans	No Cost	$100
Allergy Serum	50%	$30 per visit & treatment
Diabetes care services	20% Devices, equipment, and supplies	No Cost – Devices, equipment, and supplies
Emergency Room*	$100 per visit waived if admitted	$150 per visit waived if admitted
Ambulance	$100	$100
Chiropractic and Acupuncture	$10/30 visits	$10/30 visits
Medication Retail –30-day supply	$10 Generic / $20 Brand Name 20% up to $200 Specialty	$10 Generic / $20 Brand Name $35 Specialty
Medication Mail Order up to 90-day supply	$20 Generic / $40 Brand Name 20% up to $400 Specialty	$20 Generic / $40 Brand Name $70 Specialty

Deductible: The amount you owe for health care services before your health insurance begins to pay. Deductibles are calendar year.
Out-of-Pocket Maximum: You will not pay any more during a calendar year if co-payments and co-insurance add up to the indicated amount.
Calendar Year: January 1 through December 31
Outpatient Procedure: Surgery that does not require an overnight hospital stay.
Co-insurance: Your percentage share of the cost you will pay of the bill from services rendered.

For a more detailed summary, please request a copy of your plan summary to Benefits@sbcss.net

San Bernardino County Superintendent of Schools
2026-2027 Blue Shield PPO Comparison Sheet – All Groups

SBCSS Plan Names	**Blue Shield PPO #1 & Blue Shield PPO #1A Tandem**	**Blue Shield PPO #2 & Blue Shield PPO # 2A Tandem**
Benefitfocus Plan Names	**Blue Shield PPO Cust 20-500 & Blue Shield PPO Tandem Cust 20-500**	**Blue Shield Premier PPO Savings 1700 Blue Shield PPO Premier Tandem Savings 1700**
Plan Differences – "Tandem"	Tandem has a narrower network of providers, including about 58% of doctors and 93% of hospitals from our broader PPO network	
Enhancements at no additional cost	Not Offered	Critical Illness, Hospital Indemnity, and Accident Insurance coverage
Deductible (In-Network)	$500 Member / $1,000 Family	$1,700 Individual / $3,400 Family
Out-of-Pocket Maximum (In-network)	$2,500 Single / $5,000 Family	$3,400 Individual / $6,800 Family
Office Visit & Specialist (in-network)	$20 per visit	10% co-insurance after deductible
Hospital Stay	$100 per admit plus 20%	10% co-insurance after deductible
Outpatient Procedure	20% co-insurance after deductible	10% co-insurance after deductible
X-Rays & Lab Test	$20 or $45 per visit after deductible	10% co-insurance after deductible
MRI, PET, and CT Scans	20% co-insurance after deductible	10% co-insurance after deductible
Allergy Serum	20% co-insurance after deductible	10% co-insurance after deductible
Emergency Room*	$100 per visit plus 20% co-insurance after deductible	10% co-insurance after deductible
Ambulance	20% co-insurance after deductible	10% co-insurance after deductible
Chiropractic and Acupuncture	$25 per visit – after deductible	10% co-insurance after deductible
Pharmacy Retail –30-day supply	$10 Generic / $25 Brand Name $40 non-formulary 30% up to $200 Specialty After deductible	$10 Generic / $25 Brand Name $40 non-formulary – after deductible
Pharmacy Mail Order Up to 90-day supply	$20 Generic / $80 Brand Name After deductible	$20 Generic / $80 Brand Name After deductible

Deductible: The amount you owe for health care services before your health insurance begins to pay. Deductibles are calendar year.
Out-of-Pocket Maximum: You will not pay any more during the calendar year if co-payments and co-insurance add up to the indicated amount.
Calendar Year: January 1 through December 31
Outpatient Procedure: Surgery that does not require an overnight hospital stay.
Co-insurance: Your percentage share of the cost you will pay of the bill from services rendered.

For a more detailed summary, please request a copy of your plan summary to Benefits@sbcss.net

San Bernardino County Superintendent of Schools
2026-27 Dental Comparison Sheet - SBCSS Employees & Families

	Dental Plan #1	Dental Plan #2 (with Ortho)
Incentive Plan	**The dental incentive plan** through SBCSS is designed to encourage employees to have regular dental visits to maintain healthy teeth and gums. **If you and your dependents do not visit the dentist at least once during the calendar year (January – December) for your cleaning and exam**, your benefits will **drop** by 10% beginning January 1st. Note: Your coverage level will never decrease below 70%.	
In-network Allowance	$2500 for each employee and eligible family member Per Calendar Year	$2000 for each employee and eligible family member Per Calendar Year
Out-of-network Allowance	$2000 for each employee and eligible family member Per Calendar Year	$1500 for each employee and eligible family member Per Calendar Year
Office Visit – In-network	Your incentive level will determine whether you have any costs to pay. Example: 100% level, no cost 70% level, you pay 30% of cost.	Your incentive level will determine whether you have any costs to pay. Example: 100% level, no cost 70% level, you pay 30% of cost.
Office Visit – **Out-of-network**	$100 deductible plus cost service depending on your incentive level. Deductible applies when services are beyond routine cleaning, x-rays or exam.	$100 deductible plus cost of service depending on your incentive level. Deductible applies when services are beyond routine cleaning, x-rays or exam.
Orthodontics	No Coverage	$2000 lifetime limit for Employee and family Includes In Office Invisalign (not mail order) **Must stay in the plan for minimum of 2 fiscal years.**
Dental implants, bridges, and dentures	Up to 50% of the Available Calendar Year Allowance	Up to 50% of the Available Calendar Year Allowance
SmileWay Enhancement*	One periodontal scaling, root planning procedure per quadrant per calendar year. **Up to four cleanings per calendar year.** **To qualify you or a covered family member must be diagnosed with any of the following:** ALS, Cancer, Chronic kidney disease, Diabetes, Heart disease, HIV/AIDS, Huntington's disease, Joint replacement, Lupus, Opioid misuse and addiction, Parkinson's disease, Rheumatoid arthritis, Sjogren's syndrome, Stroke. **Enroll by visiting** – www1.deltadentalins.com/smileway or calling 1-866-499-3001	
Teeth Whitening - **New**	Effective July 1, 2026, teeth whitening is included in both Dental plans under basic services. Employees can receive external bleaching in a dentist's office or for home use once every 24 months. Since this is a cosmetic procedure, some providers may mistakenly assume it is not covered. If this happens, ask them to verify with Delta Dental.	

Deductible: The amount you owe for health care services before your health insurance begins to pay. Deductibles are calendar year.
Calendar Year: January 1 through December 31

For a more detailed summary, please request a copy of your plan summary to Benefits@sbcss.net

San Bernardino County Superintendent of Schools
2026-27 Vision Plan Comparison Sheet - SBCSS Employees & Families

EYE MED Vision	Vision Plan #1	Vision Plan #2
In-Network – **Frame** Allowance	**$0 for Frames up to $150; 20% off balance over $150** $0 Standard Progressive $85 -175 Copay Progressive – Premium Tier 1-4 $0 Conventional Contacts;15% off balance over $150 allowance $0 Disposable Contacts; 100% of balance over $150 allowance $0 Contacts Medically Necessary; Paid in full **Every 12 Months from last utilization**	**$0 for Frames up to $200; 20% off balance over $200** $0 Standard Progressive $0- $90 Copay Progressive – Premium Tier 1-4 $0 Conventional Contacts;15% off balance over $200 allowance $0 Disposable Contacts; 100% of balance over $200 allowance $0 Contacts Medically Necessary; Paid in full **Every 12 Months from last utilization**
In-Network -**Frame** Allowance - Enhancement **Visit a Plus Provider (Eye360)**	Receive an additional $50 dollars towards your frames at a Plus Provider – Click here Find a Provider $200 towards your frames	Receive an additional $50 dollars towards your frames at a Plus Provider – Click here Find a Provider $250 towards your frames
Out-of-network Allowance	Up to $105 for Frames Up to $150 for Contacts See plan summary for additional limitations	Up to $140 for Frames Up to $200 for Contacts See plan summary for additional limitations
Office Visit – In-network	Eye examinations are free at participating providers Every 12 months Retinal Imaging Up to $39	Eye examinations are free at participating providers Every 12 months Retinal Imaging Up to $39
Office Visit – **Out-of-network**	Up to $60 is covered - Remainder paid by employee	Up to $60 is covered Remainder paid by employee

For a more detailed summary, please request a copy of your plan summary to Benefits@sbcss.net

Glossary of Health Coverage and Medical Terms

- This glossary defines many commonly used terms, but isn't a full list. These glossary terms and definitions are intended to be educational and may be different from the terms and definitions in your plan or health insurance policy. Some of these terms also might not have exactly the same meaning when used in your policy or plan, and in any case, the policy or plan governs. (See your Summary of Benefits and Coverage for information on how to get a copy of your policy or plan document.)
- Underlined text indicates a term defined in this Glossary.
- See page 6 for an example showing how deductibles, coinsurance and out-of-pocket limits work together in a real life situation.

Allowed Amount

This is the maximum payment the plan will pay for a covered health care service. May also be called "eligible expense", "payment allowance", or "negotiated rate".

Appeal

A request that your health insurer or plan review a decision that denies a benefit or payment (either in whole or in part).

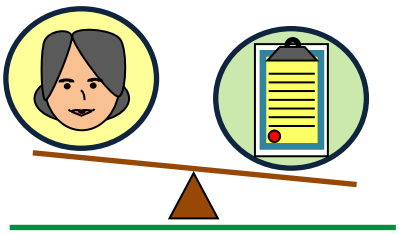
Balance Billing

When a provider bills you for the balance remaining on the bill that your plan doesn't cover. This amount is the difference between the actual billed amount and the allowed amount. For example, if the provider's charge is $200 and the allowed amount is $110, the provider may bill you for the remaining $90. This happens most often when you see an out-of-network provider (non-preferred provider). A network provider (preferred provider) may not bill you for covered services.

Claim

A request for a benefit (including reimbursement of a health care expense) made by you or your health care provider to your health insurer or plan for items or services you think are covered.

Coinsurance



Your share of the costs of a covered health care service, calculated as a percentage (for example, 20%) of the allowed amount for the service. You generally pay coinsurance ***plus*** any deductibles you owe. (For example, if the health insurance or plan's allowed amount for an office visit is $100 and you've met your deductible, your coinsurance payment of 20% would be $20. The health insurance or plan pays the rest of the allowed amount.)

(See page 6 for a detailed example.)

Complications of Pregnancy

Conditions due to pregnancy, labor, and delivery that require medical care to prevent serious harm to the health of the mother or the fetus. Morning sickness and a non-emergency caesarean section generally aren't complications of pregnancy.

Copayment

A fixed amount (for example, $15) you pay for a covered health care service, usually when you receive the service. The amount can vary by the type of covered health care service.

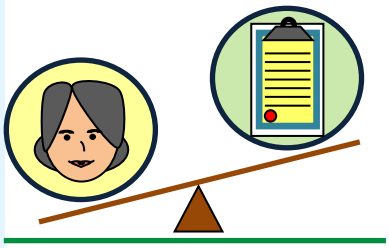
Cost Sharing

Your share of costs for services that a plan covers that you must pay out of your own pocket (sometimes called "out-of-pocket costs"). Some examples of cost sharing are copayments, deductibles, and coinsurance. Family cost sharing is the share of cost for deductibles and out-of-pocket costs you and your spouse and/or child(ren) must pay out of your own pocket. Other costs, including your premiums, penalties you may have to pay, or the cost of care a plan doesn't cover usually aren't considered cost sharing.

Cost-sharing Reductions

Discounts that reduce the amount you pay for certain services covered by an individual plan you buy through the Marketplace. You may get a discount if your income is below a certain level, and you choose a Silver level health plan or if you're a member of a federally-recognized tribe, which includes being a shareholder in an Alaska Native Claims Settlement Act corporation.

Deductible



Jane pays 100% | Her plan pays 0%

(See page 6 for a detailed example.)

An amount you could owe during a coverage period (usually one year) for covered health care services before your plan begins to pay. An overall deductible applies to all or almost all covered items and services. A plan with an overall deductible may also have separate deductibles that apply to specific services or groups of services. A plan may also have only separate deductibles. (For example, if your deductible is $1000, your plan won't pay anything until you've met your $1000 deductible for covered health care services subject to the deductible.)

Diagnostic Test

Tests to figure out what your health problem is. For example, an x-ray can be a diagnostic test to see if you have a broken bone.

Durable Medical Equipment (DME)

Equipment and supplies ordered by a health care provider for everyday or extended use. DME may include: oxygen equipment, wheelchairs, and crutches.

Emergency Medical Condition

An illness, injury, symptom (including severe pain), or condition severe enough to risk serious danger to your health if you didn't get medical attention right away. If you didn't get immediate medical attention you could reasonably expect one of the following: 1) Your health would be put in serious danger; or 2) You would have serious problems with your bodily functions; or 3) You would have serious damage to any part or organ of your body.

Emergency Medical Transportation

Ambulance services for an emergency medical condition. Types of emergency medical transportation may include transportation by air, land, or sea. Your plan may not cover all types of emergency medical transportation, or may pay less for certain types.

Emergency Room Care / Emergency Services

Services to check for an emergency medical condition and treat you to keep an emergency medical condition from getting worse. These services may be provided in a licensed hospital's emergency room or other place that provides care for emergency medical conditions.

Excluded Services

Health care services that your plan doesn't pay for or cover.

Formulary

A list of drugs your plan covers. A formulary may include how much your share of the cost is for each drug. Your plan may put drugs in different cost sharing levels or tiers. For example, a formulary may include generic drug and brand name drug tiers and different cost sharing amounts will apply to each tier.

Grievance

A complaint that you communicate to your health insurer or plan.

Habilitation Services

Health care services that help a person keep, learn or improve skills and functioning for daily living. Examples include therapy for a child who isn't walking or talking at the expected age. These services may include physical and occupational therapy, speech-language pathology, and other services for people with disabilities in a variety of inpatient and/or outpatient settings.

Health Insurance

A contract that requires a health insurer to pay some or all of your health care costs in exchange for a premium. A health insurance contract may also be called a "policy" or "plan".

Home Health Care

Health care services and supplies you get in your home under your doctor's orders. Services may be provided by nurses, therapists, social workers, or other licensed health care providers. Home health care usually doesn't include help with non-medical tasks, such as cooking, cleaning, or driving.

Hospice Services

Services to provide comfort and support for persons in the last stages of a terminal illness and their families.

Hospitalization

Care in a hospital that requires admission as an inpatient and usually requires an overnight stay. Some plans may consider an overnight stay for observation as outpatient care instead of inpatient care.

Hospital Outpatient Care

Care in a hospital that usually doesn't require an overnight stay.

Individual Responsibility Requirement
Sometimes called the "individual mandate", the duty you may have to be enrolled in health coverage that provides minimum essential coverage. If you don't have minimum essential coverage, you may have to pay a penalty when you file your federal income tax return unless you qualify for a health coverage exemption.

In-network Coinsurance
Your share (for example, 20%) of the allowed amount for covered healthcare services. Your share is usually lower for in-network covered services.

In-network Copayment
A fixed amount (for example, $15) you pay for covered health care services to providers who contract with your health insurance or plan. In-network copayments usually are less than out-of-network copayments.

Marketplace
A marketplace for health insurance where individuals, families and small businesses can learn about their plan options; compare plans based on costs, benefits and other important features; apply for and receive financial help with premiums and cost sharing based on income; and choose a plan and enroll in coverage. Also known as an "Exchange". The Marketplace is run by the state in some states and by the federal government in others. In some states, the Marketplace also helps eligible consumers enroll in other programs, including Medicaid and the Children's Health Insurance Program (CHIP). Available online, by phone, and in-person.

Maximum Out-of-pocket Limit
Yearly amount the federal government sets as the most each individual or family can be required to pay in cost sharing during the plan year for covered, in-network services. Applies to most types of health plans and insurance. This amount may be higher than the out-of-pocket limits stated for your plan.

Medically Necessary
Health care services or supplies needed to prevent, diagnose, or treat an illness, injury, condition, disease, or its symptoms, including habilitation, and that meet accepted standards of medicine.

Minimum Essential Coverage
Health coverage that will meet the individual responsibility requirement. 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.

Minimum Value Standard
A basic standard to measure the percent of permitted costs the plan covers. If you're offered an employer plan that pays for at least 60% of the total allowed costs of benefits, the plan offers minimum value and you may not qualify for premium tax credits and cost sharing reductions to buy a plan from the Marketplace.

Network
The facilities, providers and suppliers your health insurer or plan has contracted with to provide health care services.

Network Provider (Preferred Provider)
A provider who has a contract with your health insurer or plan who has agreed to provide services to members of a plan. You will pay less if you see a provider in the network. Also called "preferred provider" or "participating provider."

Orthotics and Prosthetics
Leg, arm, back and neck braces, artificial legs, arms, and eyes, and external breast prostheses after a mastectomy. These services include: adjustment, repairs, and replacements required because of breakage, wear, loss, or a change in the patient's physical condition.

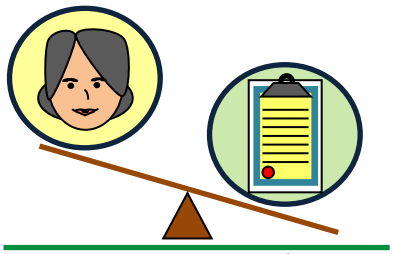
Out-of-network Coinsurance
Your share (for example, 40%) of the allowed amount for covered health care services to providers who don't contract with your health insurance or plan. Out-of-network coinsurance usually costs you more than in-network coinsurance.

Out-of-network Copayment
A fixed amount (for example, $30) you pay for covered health care services from providers who do ***not*** contract with your health insurance or plan. Out-of-network copayments usually are more than in-network copayments.

Out-of-network Provider (Non-Preferred Provider)

A provider who doesn't have a contract with your plan to provide services. If your plan covers out-of-network services, you'll usually pay more to see an out-of-network provider than a preferred provider. Your policy will explain what those costs may be. May also be called "non-preferred" or "non-particiapting" instead of "out-of-network provider".

Out-of-pocket Limit



(See page 6 for a detailed example.)

The most you *could* pay during a coverage period (usually one year) for your share of the costs of covered services. After you meet this limit the plan will usually pay 100% of the allowed amount. This limit helps you plan for health care costs. This limit never includes your premium, balance-billed charges or health care your plan doesn't cover. Some plans don't count all of your copayments, deductibles, coinsurance payments, out-of-network payments, or other expenses toward this limit.

Physician Services

Health care services a licensed medical physician, including an M.D. (Medical Doctor) or D.O. (Doctor of Osteopathic Medicine), provides or coordinates.

Plan

Health coverage issued to you directly (individual plan) or through an employer, union or other group sponsor (employer group plan) that provides coverage for certain health care costs. Also called "health insurance plan", "policy", "health insurance policy" or "health insurance".

Preauthorization

A decision by your health insurer or plan that a health care service, treatment plan, prescription drug or durable medical equipment (DME) is medically necessary. Sometimes called prior authorization, prior approval or precertification. Your health insurance or plan may require preauthorization for certain services before you receive them, except in an emergency. Preauthorization isn't a promise your health insurance or plan will cover the cost.

Premium

The amount that must be paid for your health insurance or plan. You and/or your employer usually pay it monthly, quarterly, or yearly.

Premium Tax Credits

Financial help that lowers your taxes to help you and your family pay for private health insurance. You can get this help if you get health insurance through the Marketplace and your income is below a certain level. Advance payments of the tax credit can be used right away to lower your monthly premium costs.

Prescription Drug Coverage

Coverage under a plan that helps pay for prescription drugs. If the plan's formulary uses "tiers" (levels), prescription drugs are grouped together by type or cost. The amount you'll pay in cost sharing will be different for each "tier" of covered prescription drugs.

Prescription Drugs

Drugs and medications that by law require a prescription.

Preventive Care (Preventive Service)

Routine health care, including screenings, check-ups, and patient counseling, to prevent or discover illness, disease, or other health problems.

Primary Care Physician

A physician, including an M.D. (Medical Doctor) or D.O. (Doctor of Osteopathic Medicine), who provides or coordinates a range of health care services for you.

Primary Care Provider

A physician, including an M.D. (Medical Doctor) or D.O. (Doctor of Osteopathic Medicine), nurse practitioner, clinical nurse specialist, or physician assistant, as allowed under state law and the terms of the plan, who provides, coordinates, or helps you access a range of health care services.

Provider

An individual or facility that provides health care services. Some examples of a provider include a doctor, nurse, chiropractor, physician assistant, hospital, surgical center, skilled nursing facility, and rehabilitation center. The plan may require the provider to be licensed, certified, or accredited as required by state law.

Reconstructive Surgery
Surgery and follow-up treatment needed to correct or improve a part of the body because of birth defects, accidents, injuries, or medical conditions.

Referral
A written order from your primary care provider for you to see a specialist or get certain health care services. In many health maintenance organizations (HMOs), you need to get a referral before you can get health care services from anyone except your primary care provider. If you don't get a referral first, the plan may not pay for the services.

Rehabilitation Services
Health care services that help a person keep, get back, or improve skills and functioning for daily living that have been lost or impaired because a person was sick, hurt, or disabled. These services may include physical and occupational therapy, speech-language pathology, and psychiatric rehabilitation services in a variety of inpatient and/or outpatient settings.

Screening
A type of preventive care that includes tests or exams to detect the presence of something, usually performed when you have no symptoms, signs, or prevailing medical history of a disease or condition.

Skilled Nursing Care
Services performed or supervised by licensed nurses in your home or in a nursing home. Skilled nursing care is ***not*** the same as "skilled care services", which are services performed by therapists or technicians (rather than licensed nurses) in your home or in a nursing home.

Specialist
A provider focusing on a specific area of medicine or a group of patients to diagnose, manage, prevent, or treat certain types of symptoms and conditions.

Specialty Drug
A type of prescription drug that, in general, requires special handling or ongoing monitoring and assessment by a health care professional, or is relatively difficult to dispense. Generally, specialty drugs are the most expensive drugs on a formulary.

UCR (Usual, Customary and Reasonable)
The amount paid for a medical service in a geographic area based on what providers in the area usually charge for the same or similar medical service. The UCR amount sometimes is used to determine the allowed amount.

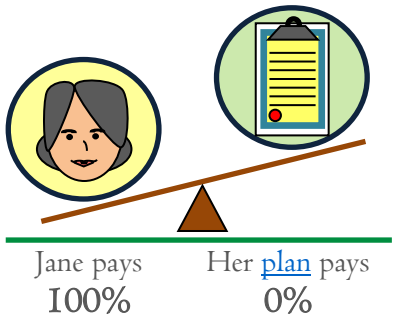
Urgent Care
Care for an illness, injury, or condition serious enough that a reasonable person would seek care right away, but not so severe as to require emergency room care.

How You and Your Insurer Share Costs - Example

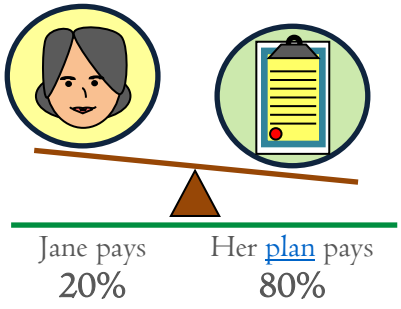
Jane's Plan Deductible: $1,500 **Coinsurance:** 20% **Out-of-Pocket Limit:** $5,000

January 1st
Beginning of Coverage Period

December 31st
End of Coverage Period



more costs



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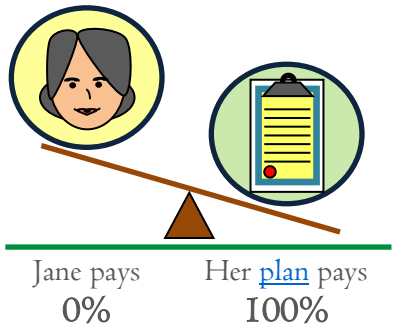

Jane hasn't reached her $1,500 deductible yet

Her plan doesn't pay any of the costs.

Office visit costs: $125
Jane pays: $125
Her plan pays: $0

Jane reaches her $1,500 deductible, coinsurance begins

Jane has seen a doctor several times and paid $1,500 in total, reaching her deductible. So her plan pays some of the costs for her next visit.

Office visit costs: $125
Jane pays: 20% of $125 = $25
Her plan pays: 80% of $125 = $100

Jane reaches her $5,000 out-of-pocket limit

Jane has seen the doctor often and paid $5,000 in total. Her plan pays the full cost of her covered health care services for the rest of the year.

Office visit costs: $125
Jane pays: $0
Her plan pays: $125