




San Diego Premier Traditional PPO



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 Employees: [go/myQ](#) Dependents: <https://Qualcomm.service-now/hrpublic> or call 1-800-861-8417. 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.healthcare.gov/sbc-glossary or call 1-800-861-8417 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	<p>Network*: \$550 Individual / \$1,100 Individual + 1 / \$1,250 Individual +2 or more per calendar year.</p> <p>Non-Network*: \$2,050 Individual / \$4,100 Individual +1 / \$4,600 Individual +2 or more per calendar year.</p> <p>*Deductibles cross-apply</p>	<p>Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.</p>
Are there services covered before you meet your deductible?	<p>Yes. Preventive Care and primary care services are covered before you meet your deductible.</p>	<p>This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost sharing and before you meet your deductible. See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/</p>
Are there other deductibles for specific services?	<p>No, there are no other deductibles.</p>	<p>You don't have to meet deductibles for specific services, but see the chart starting on page 2 for other costs for services this plan covers.</p>
What is the out-of-pocket limit for this plan?	<p>For network provider*: \$3,250 Individual / \$6,500 Individual +1 / \$7,300 Individual +2 or more per calendar year.</p> <p>For out-of-network providers*: \$5,750 Individual / \$11,500 Individual + 1 / \$13,000 Individual +2 or more per calendar year.</p> <p>*Out-of-pockets cross-apply</p>	<p>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.</p>

Important Questions	Answers	Why This Matters:
What is not included in the out-of-pocket limit?	Premiums, <u>balance-billing</u> charges, health care this <u>plan</u> doesn't cover, penalties for failure to obtain <u>prior authorization</u> for services.	Even though you pay these expenses, they don't count toward the <u>out-of-pocket</u> .
Will you pay less if you use a network provider?	Yes. See www.myuhc.com or call 1-800-861-8417 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.
Do you need a <u>referral</u> to see a <u>specialist</u> ?	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
		<u>Network Provider</u> (You will pay the least)	<u>Out-of-Network Provider</u> (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	\$35 <u>copay</u> /visit	50% <u>coinsurance</u>	Premier <u>network</u> – \$35 <u>copay</u> , <u>deductible</u> does not apply. Virtual visit – \$10 <u>copay</u> per visit by a Designated Virtual <u>network provider</u> . No virtual visit coverage for non- <u>network</u> . If you receive services in addition to the office visit, additional copays, <u>deductibles</u> , or <u>coinsurance</u> may apply.
	Specialist visit	\$60 <u>copay</u> /visit	50% <u>coinsurance</u>	Premier <u>network</u> – \$60 <u>copay</u> , <u>deductible</u> does not apply. If you receive services in addition to the office visit, additional copays, <u>deductibles</u> , or <u>coinsurance</u> may apply.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		<u>Network Provider</u> (You will pay the least)	<u>Out-of-Network Provider</u> (You will pay the most)	
	Preventive care/ screening /immunization	No Charge	50% <u>coinsurance</u>	You may have to pay for services that aren't <u>preventive</u> . Ask your <u>provider</u> if the services needed are <u>preventive</u> . Then check what your <u>plan</u> will pay for. Premier <u>network</u> – 0% <u>coinsurance</u> , <u>deductible</u> does not apply. Includes preventive health services specified in the health care reform law.
If you have a test	Diagnostic test (x-ray, blood work)	10% <u>coinsurance</u>	50% <u>coinsurance</u>	Premier <u>network</u> – 10% <u>coinsurance</u> after <u>deductible</u> . Non- <u>network</u> <u>advanced notification</u> requested for certain services.
	Imaging (CT/PET scans, MRIs)	10% <u>coinsurance</u>	50% <u>coinsurance</u>	Premier <u>network</u> – 10% <u>coinsurance</u> after <u>deductible</u> .

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		<u>Network Provider</u> (You will pay the least)	<u>Out-of-Network Provider</u> (You will pay the most)	
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.optumrx.com	Generic Drugs (Tier 1)	Retail: \$15 <u>copay</u> Mail Order: \$30 <u>copay</u>	Retail: Not covered	Retail – 31-day supply limit. Mail Order – 90-day supply limit. <u>Plan</u> only covers cost of generic for brand drug with generic equivalent. <u>Deductible</u> waived-refer to OptumRx Preventive Drug List.
	Preferred brand drugs (Tier 2)	Retail: 20% <u>coinsurance deductible</u> does not apply Mail Order: 20% <u>coinsurance deductible</u> does not apply	Retail: Not covered	Retail – Up to \$250 per prescription with 31-day supply limit. Mail Order – Up to \$500 per prescription with 90-day supply limit. <u>Deductible</u> does not apply. <u>Plan</u> only covers cost of generic for brand drug with generic equivalent.
	Non-preferred brand drugs (Tier 3)	Retail: 30% <u>coinsurance deductible</u> does not apply Mail Order: 30% <u>coinsurance deductible</u> does not apply	Retail: Not covered	Retail – Up to \$500 per prescription with 31-day supply limit. Mail Order – Up to \$1,000 per prescription with 90-day supply limit. <u>Deductible</u> does not apply. <u>Plan</u> only covers cost of generic for brand drug with generic equivalent.
	<u>Fertility drugs</u> (Tier 4)	Retail: 50% <u>coinsurance deductible</u> does not apply Mail Order: 50% <u>coinsurance deductible</u> does not apply	Retail: Not covered	Fertility: 50% <u>coinsurance</u> after the <u>deductible</u> . Retail and Mail Order have a \$35,000 lifetime max combined with medical.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	10% <u>coinsurance</u>	50% <u>coinsurance</u>	Premier <u>network</u> – 10% <u>coinsurance</u> after <u>deductible</u> . Non- <u>network advanced notification</u> requested for certain services.

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)	
	Physician/surgeon fees	10% <u>coinsurance</u>	50% <u>coinsurance</u>	Premier <u>network</u> – 10% <u>coinsurance</u> after <u>deductible</u> .
If you need immediate medical attention	Emergency room care	10% <u>coinsurance</u>	10% <u>coinsurance</u>	Premier <u>network</u> – 10% <u>coinsurance</u> after <u>deductible</u> . Non- <u>network</u> notification requested within 48 hours of admission.
	Emergency medical transportation	10% <u>coinsurance</u>	10% <u>coinsurance</u>	Premier <u>network</u> – 10% <u>coinsurance</u> after <u>deductible</u> .
	Urgent care	10% <u>coinsurance</u>	50% <u>coinsurance</u>	Premier <u>network</u> – 10% <u>coinsurance</u> after <u>deductible</u> .
If you have a hospital stay	Facility fee (e.g., hospital room)	10% <u>coinsurance</u>	50% <u>coinsurance</u>	Premier <u>network</u> – 10% <u>coinsurance</u> after <u>deductible</u> . Non- <u>network</u> <u>advanced notification</u> requested.
	Physician/surgeon fees	10% <u>coinsurance</u>	50% <u>coinsurance</u>	Premier <u>network</u> – 10% <u>coinsurance</u> after <u>deductible</u> .
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Office: \$35 <u>copay</u> /visit Outpatient: 10% <u>coinsurance</u>	Office: \$35 <u>copay</u> /visit Outpatient: 10% <u>coinsurance</u>	Premier <u>network</u> & non- <u>network</u> office visits – \$35 <u>copay</u> , no <u>deductible</u> . Premier <u>network</u> & non- <u>network</u> outpatient services – 10% <u>coinsurance</u> after <u>deductible</u> . Neurobiological Disorders – Non- <u>network</u> <u>advanced notification</u> is required for Benefits provided for Applied Behavioral Analysis (ABA).
	Inpatient services	10% <u>coinsurance</u>	10% <u>coinsurance</u>	Non- <u>network</u> <u>advanced notification</u> required.
If you are pregnant	Office visits	\$35 <u>copay</u> /initial visit only	50% <u>coinsurance</u>	
	Childbirth/delivery professional services	10% <u>coinsurance</u>	50% <u>coinsurance</u>	

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		<u>Network Provider</u> (You will pay the least)	<u>Out-of-Network Provider</u> (You will pay the most)	
	Childbirth/delivery facility services	10% <u>coinsurance</u>	50% <u>coinsurance</u>	<p>Premier <u>network</u> office visits – \$35 <u>copay</u>. Premier <u>network</u> professional and facility services – 10% <u>coinsurance</u> after <u>deductible</u>.</p> <p>Non-<u>network</u> <u>advanced notification</u> requested for Inpatient Stays that exceed normal 48 hours for natural delivery or 96 hours for cesarean. <u>Cost sharing</u> does not apply for <u>preventive services</u>. Depending on the type of service, a <u>copayment</u>, <u>coinsurance</u> or <u>deductible</u> may apply. Maternity care may include tests and services described elsewhere in the SBC. (i.e., ultrasound)Benefits include Doula services and limited to \$3,000 per pregnancy.</p>
If you need help recovering or have other special health needs	Home health care	10% <u>coinsurance</u>	50% <u>coinsurance</u>	<p>Premier <u>network</u> – 10% <u>coinsurance</u> after <u>deductible</u>. Limited to 100 visits per calendar year for <u>Home health care</u> and 120 visits per calendar year for Outpatient Private Duty Nursing. Non-<u>network</u> <u>advanced notification</u> requested for certain services (skilled nursing by RN or LPN) and Outpatient Private Duty Nursing.</p>
	Rehabilitation services	\$60 <u>copay</u> /visit	50% <u>coinsurance</u>	<p>Premier <u>network</u> – \$60 <u>copay</u>, <u>deductible</u> does not apply.</p>
	Habilitation services	\$60 <u>copay</u> /visit	50% <u>coinsurance</u>	<p>Premier <u>network</u> – \$60 <u>copay</u>, <u>deductible</u> does not apply.</p>

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)	
	Skilled nursing care	10% <u>coinsurance</u>	50% <u>coinsurance</u>	Premier <u>network</u> – 10% <u>coinsurance</u> after <u>deductible</u> . 120-day visit limit per calendar year. Non- <u>network</u> <u>advanced notification</u> requested.
	Durable medical equipment	10% <u>coinsurance</u>	50% <u>coinsurance</u>	Premier <u>network</u> – 10% <u>coinsurance</u> after <u>deductible</u> . Foot orthotics excluded. Non- <u>network</u> <u>advanced notification</u> requested for DME over \$1,000.
	Hospice services	10% <u>coinsurance</u>	50% <u>coinsurance</u>	Premier <u>network</u> – 10% <u>coinsurance</u> after <u>deductible</u> . Non- <u>network</u> <u>advanced notification</u> requested before admission for an Inpatient Stay in a hospice facility.
If your child needs dental or eye care	Children’s eye exam	Not covered	Not covered	Child routine vision exam is not covered.
	Children’s glasses	Not covered	Not covered	Child glasses are not covered.
	Children’s dental check-up	Not covered	Not covered	Child dental check-up is not covered.

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or <u>plan</u> document for more information and a list of any other excluded services.)		
<ul style="list-style-type: none"> • Adult routine vision exam (i.e. refraction) • Cosmetic Surgery 	<ul style="list-style-type: none"> • Dental Care (Adult) • Long-term care 	<ul style="list-style-type: none"> • Weight loss programs
Other Covered Services (Limitations may apply to these services. This isn’t a complete list. Please see your plan document.)		
<ul style="list-style-type: none"> • Acupuncture – 25 visits per calendar year (no limit at QHC) • Bariatric Surgery • Chiropractic care – 25 visits per calendar year (no limit at QHC) 	<ul style="list-style-type: none"> • Hearing aids – 1 per ear every 3 calendar years • Fertility treatment - \$35,000 lifetime maximum • Non-emergency care when traveling outside the U.S. 	<ul style="list-style-type: none"> • Private-duty nursing – 120 visits per calendar year • Routine foot 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: Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or <https://www.dol.gov/ebsa/healthreform>. Other coverage options may be available to you too, including buying individual insurance coverage through the [Health Insurance Marketplace](#). For more information about the [Marketplace](#), visit www.HealthCare.gov/ or call 1-800-318-2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your plan for a denial of a [claim](#). This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information on how to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact: 1-800-861-8417 or visit www.myuhc.com or the Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa/healthreform.

Does this plan provide Minimum Essential Coverage? Yes

Minimum Essential Coverage generally includes [plans](#), [health insurance](#) available through the [Marketplace](#) or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of Minimum Essential Coverage, you may not be eligible for the [premium tax credit](#).

Does this plan meet the Minimum Value Standards? Yes

If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the [Marketplace](#).

Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al 1-800-861-8417.

Traditional Chinese (中文): 如果需要中文的帮助, 请拨打这个号码 1-800-861-8417.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijigo holne' 1-800-861-8417.

Pennsylvania Dutch (Deutsch): Fer Hilf griegie in Deutsch, ruf 1-800-861-8417 uff.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-861-8417.

Samoan (Gagana Samoa): Mo se fesoasoani i le Gagana Samoa, vala'au mai i le numera telefoni 1-800-861-8417.

Carolinian (Kapasal Falawasch): ngere aukke ghut alillis reel kapasal Falawasch au fafaingi tilifon ye 1-800-861-8417.

Chamorro (Chamoru): Para un ma ayuda gi finu Chamoru, a'gang 1-800-861-8417.

—————*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 plan's overall deductible	\$550
■ Specialist <u>copayment</u>	\$60
■ Hospital (facility) <u>coinsurance</u>	10%
■ Other <u>coinsurance</u>	10%

This EXAMPLE event includes services like:

Specialist office visits (*pre-natal care*)
 Childbirth/Delivery Professional Services
 Childbirth/Delivery Facility Services
Diagnostic tests (*ultrasounds and blood work*)
 Specialist visit (*anesthesia*)

Total Example Cost	\$12,700
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In this example, Peg would pay:

<u>Cost Sharing</u>	
<u>Deductibles</u>	\$550
<u>Copayments</u>	\$60
<u>Coinsurance</u>	\$1,200
<i>What isn't covered</i>	
Limits or exclusions	\$60
The total Peg would pay is	\$1,870

Managing Joe's type 2 Diabetes

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

■ The plan's overall deductible	\$550
■ Specialist <u>copayment</u>	\$60
■ Hospital (facility) <u>coinsurance</u>	10%
■ Other <u>coinsurance</u>	10%

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	\$5,600
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In this example, Joe would pay:

<u>Cost Sharing</u>	
<u>Deductibles</u>	\$100
<u>Copayments</u>	\$900
<u>Coinsurance</u>	\$600
<i>What isn't covered</i>	
Limits or exclusions	\$20
The total Joe would pay is	\$1,620

Mia's Simple Fracture

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

■ The plan's overall deductible	\$550
■ Specialist <u>copayment</u>	\$60
■ Hospital (facility) <u>coinsurance</u>	10%
■ Other <u>coinsurance</u>	10%

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	\$2,800
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In this example, Mia would pay:

<u>Cost Sharing</u>	
<u>Deductibles</u>	\$550
<u>Copayments</u>	\$400
<u>Coinsurance</u>	\$100
<i>What isn't covered</i>	
Limits or exclusions	\$0
The total Mia would pay is	\$1,050