



Healthcare Reform Experts.

BENEFITS OFFERING

2017 Member Plan



Northern California
Chapter
Benefit Trust

Your **HEALTH**
Your **LIFE**

January 1 - December 31, 2017



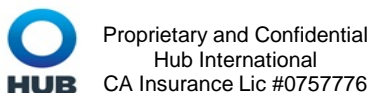
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Effective January 1, 2017

Medical - HMO Preferred	
MEDICAL	Blue Shield Access+HMO® Per Admit 20-500
Annual Deductible	
Individual	None
Family	None
Annual Out-of-Pocket Maximum	
Individual	\$2,000
Two-Party	\$4,000
Family	\$4,000
Professional Services	
Physician Office Visit	\$20
Specialist Office Visit	\$20
Physical Therapy	\$20
Hospitalization	
Outpatient Surgery	\$250 Copay / Surgery
Inpatient Admission	\$500 / Admission
Emergency Room	\$100
Other Services	
Lab and X-Ray	No Charge
Preventive Care	No Charge
Mental Health & Chemical Dependency	
Inpatient Admission	\$500 / Admission
Outpatient Office Visit	\$20 / Visit
PRESCRIPTION DRUGS	
Out-of-Pocket Maximum (Ind / Fam)	See Annual Medical Out-of-Pocket Maximum
Retail (30 days)	
Tier 1	\$15
Tier 2	\$30
Tier 3	\$45
Mail Order (90 days)	
Tier 1	\$30
Tier 2	\$60
Tier 3	\$90

This is a summary only. Consult the certificate of insurance to determine the exact terms and conditions of coverage.



Contact an ABC NORCAL Benefit Trust Consultant at 775-560-7006 to learn more.



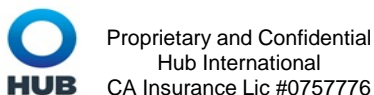
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Effective January 1, 2017

Medical - HMO Select	
MEDICAL	Blue Shield Access+HMO® Facility Coinsurance 40-40%
Annual Deductible	
Individual	None
Family	None
Annual Out-of-Pocket Maximum	
Individual	\$3,500
Two-Party	\$7,000
Family	\$7,000
Professional Services	
Physician Office Visit	\$40
Specialist Office Visit	\$40
Physical Therapy	\$40
Hospitalization	
Outpatient Surgery	40% Coinsurance
Inpatient Admission	\$100 / Admission + 40%
Emergency Room	\$100 / Visit
Other Services	
Lab and X-Ray	No Charge
Preventive Care	No Charge
Mental Health & Chemical Dependency	
Inpatient Admission	\$100 / Admission + 40%
Outpatient Office Visit	\$40 / Visit
PRESCRIPTION DRUGS	
Out-of-Pocket Maximum (Ind / Fam)	See Annual Medical Out-of-Pocket Maximum
Retail (30 days)	
Tier 1	\$15
Tier 2	\$30
Tier 3	\$45
Mail Order (90 days)	
Tier 1	\$30
Tier 2	\$60
Tier 3	\$90

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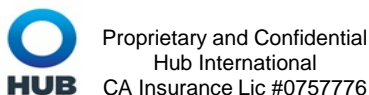
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Effective January 1, 2017

Medical - HMO Standard	
MEDICAL	Blue Shield Access+HMO® Facility 20-20%
Annual Deductible	
Individual	None
Family	None
Annual Out-of-Pocket Maximum	
Individual	\$2,000
Two-Party	\$4,000
Family	\$4,000
Professional Services	
Physician Office Visit	\$20
Specialist Office Visit	\$20
Physical Therapy	\$20
Hospitalization	
Outpatient Surgery	20%
Inpatient Admission	\$100 / Admission + 20%
Emergency Room	\$100 / Visit
Other Services	
Lab and X-Ray	No Charge
Preventive Care	No Charge
Mental Health & Chemical Dependency	
Inpatient Admission	\$100 / Admission + 20%
Outpatient Visit	\$20 / Visit
PRESCRIPTION DRUGS	
Out-of-Pocket Maximum (Ind / Fam)	See Annual Medical Out-of-Pocket Maximum
Retail (30 days)	
Tier 1	\$15
Tier 2	\$30
Tier 3	\$45
Mail Order (90 days)	
Tier 1	\$30
Tier 2	\$60
Tier 3	\$90

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Medical - PPO / OOS		
MEDICAL	Blue Shield Full PPO Split Deductible 20-500 80/60	
	In-Network	Out-of-Network
Annual Deductible		
Individual	\$500	\$1,000
Family	\$1,000	\$2,000
Annual Out-of-Pocket Maximum		
Individual	\$2,500	\$5,000
Two-Party	\$5,000	\$10,000
Family	\$5,000	\$10,000
Professional Services		
Physician Office Visit	\$20	40%*
Specialist Office Visit	\$20	40%*
Physical Therapy	\$20	40%*
Hospitalization		
Outpatient Surgery	20%*	40%* up to \$350 / Day
Inpatient Admission	\$100 / Admit + 20%*	40%* up to \$600 / Day
Emergency Room	\$100 / Visit + 20%	\$100 / Visit + 20%
Other Services		
Lab and X-Ray	\$20*	40%*
Preventive Care	No Charge	Not Covered
Mental Health & Chemical Dependency		
Inpatient Admission	\$100 / Admit + 20%*	40%* up to \$600 / Day
Outpatient Visit	\$20	40%*
PRESCRIPTION DRUGS		
Out-of-Pocket Maximum (Ind / Fam)	See Annual Medical Out-of-Pocket Maximum	
Retail (30 days)		
Tier 1	\$10	25% + \$10
Tier 2	\$25	25% + \$25
Tier 3	\$40	25% + \$40
Mail Order (90 days)		
Tier 1	\$20	Not Covered
Tier 2	\$50	Not Covered
Tier 3	\$80	Not Covered

*benefit after deductible has been met

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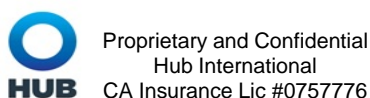


Effective January 1, 2017

Medical - PPO / HSA		
MEDICAL	Blue Shield Full PPO Savings Embedded Deductible HSA 2600	
	In-Network	Out-of-Network
Annual Deductible		
Individual	\$2,600	
Family	\$5,200	
Annual Out-of-Pocket Maximum		
Individual	\$5,000	\$10,000
Two-Party	\$10,000	\$20,000
Family	\$10,000	\$20,000
Professional Services		
Physician Office Visit	20%*	40%*
Specialist Office Visit	20%*	40%*
Physical Therapy	20%*	40%*
Hospitalization		
Outpatient Surgery	20%*	40%* up to \$350 / Day
Inpatient Admission	\$100 / Admit + 20%*	40%* up to \$600 / Day
Emergency Room	\$100 / Visit + 20%*	\$100 / Visit + 20%*
Other Services		
Lab and X-Ray	20%*	40%*
Preventive Care	No Charge	Not Covered
Mental Health & Chemical Dependency		
Inpatient Admission	\$100 / Admit + 20%*	40%* up to \$600 / Day
Outpatient Visit	20%*	40%*
PRESCRIPTION DRUGS		
Out-of-Pocket Maximum (Ind / Fam)	See Annual Medical Out-of-Pocket Maximum	
Pharmacy Deductible	Subject to Medical Deductible	
Retail (30 days)		
Tier 1	\$10	25% + \$10
Tier 2	\$25	25% + \$25
Tier 3	\$40	25% + \$40
Mail Order (90 days)		
Tier 1	\$20	Not Covered
Tier 2	\$50	Not Covered
Tier 3	\$80	Not Covered

*benefit after deductible has been met

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Effective January 1, 2017

Dental - Preferred		
Dental	United Concordia DPPO	
Calendar Year Maximum	In-Network	Out-of-Network
Per Member	\$1,500	
Calendar Year Deductible		
Individual	\$50 / \$150 Waived for Preventive	
Diagnostic and Preventive		
Oral Exam X-Rays Teeth Cleaning Flouride Treatment Sealants	No Charge	No Charge
Basic Services		
Anesthesia Periodontics Endodontics Simple and Surgical Extractions	10%	20%
Major Services		
Single Crowns Inlays and Onlays Dental Implants Bridges and Dentures	40%	50%
Orthodontia		
Benefit	Not Covered	
Out-of-Network Reimbursement		
Usual and Customary	N / A	90th Percentile

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INTERWEST
INSURANCE SERVICES, LLC

Effective January 1, 2017

Dental - Custom	
Dental	United Concordia DPPO
Calendar Year Maximum	In-Network Out-of-Network
Per Member	\$1,500
Calendar Year Deductible	
Individual	\$50 / \$150 Waived for Preventive
Diagnostic and Preventive	
Oral Exam X-Rays Teeth Cleaning Flouride Treatment Sealants	No Charge 20%
Basic Services	
Anesthesia Periodontics Endodontics Simple and Surgical Extractions	10% 20%
Major Services	
Single Crowns Inlays and Onlays Dental Implants Bridges and Dentures	40% 50%
Orthodontia	
Child-Only Benefit (Under 19 yrs)	50%
Lifetime Maximum	\$1,000
Out-of-Network Reimbursement	
Usual and Customary	N / A 90th Percentile

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Dental - Select		
Dental	United Concordia DPPO	
Calendar Year Maximum	In-Network	Out-of-Network
Per Member	\$1,000	
Calendar Year Deductible		
Individual	\$50 / \$150 Waived for Preventive	
Diagnostic and Preventive		
Oral Exam X-Rays Teeth Cleaning Flouride Treatment Sealants	No Charge	20%
Basic Services		
Anesthesia Periodontics Endodontics Simple and Surgical Extractions	20%	30%
Major Services		
Single Crowns Inlays and Onlays Dental Implants Bridges and Dentures	50%	60%
Orthodontia		
Benefit	Not Covered	
Out-of-Network Reimbursement		
Maximum Allowable Charge (MAC)	N / A	MAC

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Vision		
Vision	VSP Choice Plan	
	In-Network	Out-of-Network
Exam	\$10 Copay	Up to \$45
Materials	\$10 Copay	See Below
Lenses		
Single	Covered After Copay	Up to \$30
Bifocal		Up to \$50
Trifocal		Up to \$65
Contact Lenses		
Elective (in lieu of frames)	\$120 Allowance	Up to \$105
Frequency of Services		
Eye Exam	12 Months	
Lenses	12 Months	
Frames	24 Months	
Contact Lenses	12 Months	

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Life and AD&D	
	Mutual of Omaha Group Term Life and AD&D
Benefit Amount	
Group Term Life	\$25,000
AD&D	\$25,000
Benefit Reduction	
Age 65	65%
Age 70	50%
Retirement	None
Benefit Provisions	
Accelerated Death Benefit	75% of Life Benefit, Up to \$18,750
Waiver of Premium	Included
Conversion	Included
AD&D Benefits	Seat Belt, Airbag, Common Carrier, Paralysis
Additional Services	
Travel Assistance	Included
Employee Assistance Program	Included
Hearing Discount Program	Included
Will Preparation Services	Included

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