


SIHRTE Welfare Trust: Self-Funded Indemnity Plan A

Coverage for: Employees & Dependents | Plan Type: Indemnity



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, call the Trust Fund Office at 1-925-398-7044 or toll free at 1-877-893-1500. 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.https://www.healthcare.gov/sbc-glossary](https://www.healthcare.gov/sbc-glossary) or call 1-925-398-7044 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible ?	For network providers , \$100/Individual or \$250/family. For out-of-network providers , \$250/Individual or \$500/family.	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 .
Are there services covered before you meet your deductible ?	Yes. Preventive care , doctor office visits, prescription drugs, outpatient mental health/substance abuse services, and x-ray & lab are covered before you meet your deductible .	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/ .
Are there other deductibles for specific services?	No.	You don't have to meet for deductibles specific services.
What is the out-of-pocket limit for this plan ?	For network providers , medical benefits \$1,500/Individual or \$3,000/Family and prescription drug benefits \$5,100/Individual or \$10,200/Family. For out-of-network providers , medical benefits \$7,000/Individual or \$14,000/Family and prescription drug benefits No Limit .	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 ?	Copayments for certain services, premiums , balance-billing charges, out-of-pocket expenses for DME, chiropractors and acupuncture, 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.aetna.com or call Aetna at 1-866-694-3258 or the Trust Fund Office at 1-925-398-7044 for a list of PPO network providers .	This plan uses a provider network through Aetna . You will pay less if you use a provider in the plan's PPO network . You will pay the most if you use an Non-PPO 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.
Do you need a 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
		PPO Network Provider (You will pay the least)	Non-PPO 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	\$15 copay /office visit; deductible does not apply; No Charge if preventive service or COVID-19 test (Until December 31, 2023 unless extended further)	30% coinsurance ; No charge COVID-19 test (Until December 31, 2023 unless extended further)	Deductible waived if PPO Network Provider. Until December 31, 2023 unless extended further, if in-person or telehealth visit results in an order for COVID-19 test, covered at no cost. If receive test non-PPO network, cash price of test must be posted on providers public website. Until December 31, 2023 unless extended further COVID-19 treatment is covered at no cost (Network provider) but 30% coinsurance (Non-PPO Network).
	Specialist visit	\$15 copay /visit	30% coinsurance but 50% coinsurance for chiropractor & acupuncture.	Deductible waived if PPO Network Provider. 30 visits/year (PPO chiropractor). 20 visits/year (Non-PPO chiropractor). Chiropractor copay and coinsurance do not apply to out-of-pocket limit .
	Preventive care/screening /immunization	No Charge (including COVID-19 vaccination).	\$25 copay and 30% coinsurance for charges in excess of \$250. (No Charge for COVID-19 vaccination Until December 31, 2023 unless extended further).	You may have to pay for services that aren't preventive . Ask your provider if the services you need are preventive. Then check what your plan will pay for. Until December 31, 2023 unless extended further, no Prior Auth. for COVID-19 vaccination including booster shots and will be covered at no cost at PPO, Non-PPO and participating pharmacies through Magellan Rx. After December 31, 2023 cost-sharing may be implemented for Non-PPO COVID-19 vaccines but COVID-19 vaccines at PPO remain at no cost as preventive service.
If you have a test	Diagnostic test (x-ray, blood work)	\$10 copay /per facility or location; deductible does not apply. (No charge COVID-19 test until December 31, 2023 unless extended further).	30% coinsurance . (No charge COVID-19 test until December 31, 2023 unless extended further).	Deductible waived if PPO Network Provider. Until December 31, 2023 unless extended further, COVID-19 testing and screening is covered at no cost per federal guidance.
	Imaging (CT/PET scans, MRIs)			

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		PPO Network Provider (You will pay the least)	Non-PPO Out-of-Network Provider (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.magellanhealth.com .	Generic drugs	\$10 copay (retail); \$15 copay (mail)	Not Covered.	Deductible waived. Covers up to a 30-day supply (retail subscription); 31-90 day supply (mail order prescription). Pharmacy copayments are not included in the out-of-pocket limit . For Specialty Drugs, voluntary drug coupon program is available to save costs. Please contact Magellan Rx or log into www.magellanrx.com for more information.
	Preferred brand drugs	\$25 copay (retail); \$15 copay (mail)	Not Covered.	
	Non-preferred brand drugs	\$25 copay (retail); \$15 copay (mail)	Not Covered.	
	Specialty drugs	\$25 copay (retail); \$15 copay (mail)	Not Covered.	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	5% coinsurance	40% coinsurance except for <u>No Surprise Act covered services same as PPO Network provider.</u>	Certain non-emergency services & ancillary services (ex. emergency medicine, anesthesia, pathology, radiology, lab, neonatology, assistant surgeon, hospitalist or intensivist services) received by out-of-network provider at ambulatory surgery center you cannot be billed more than the plan's network contract rate. However, there are certain other non-emergency services and post-stabilization services at these network facilities, you can give written consent to be balance billed . Contact the Trust Fund Office for more information. None.
	Physician/surgeon fees	5% coinsurance	30% coinsurance except for <u>No Surprise Act covered services same as PPO Network provider.</u>	
If you need immediate medical attention	Emergency room care	\$150 copay (waived if admitted) plus 10% coinsurance but \$150 copay /40% coinsurance if not for emergency care.	Per No Surprise Act, same as PPO Network provider ; \$150 copay (waived if admitted) plus 10% coinsurance but \$150 copay /40% coinsurance if not for emergency care.	No Pre-authorization required & No balance billing . Any Non-PPO emergency cost-sharing will count towards any Plan applicable deductible or out-of-pocket limit similar to PPO network emergency care. \$150 copay will be waived if admitted as in-patient. until December 31, 2023 unless extended further, emergency COVID-19 treatment covered at no cost (both Network Provider & Non-PPO network). Emergency includes treatment received in Independent Free standing emergency department. After December 31, 2023 cost-sharing may be implemented for COVID-19 treatment For covered air ambulance, any cost-sharing will count towards any Plan applicable deductible or out-of-pocket limit & No balance billing . Deductible waived if PPO & Non-PPO Network
	Emergency medical transportation	5% coinsurance	5% coinsurance Per No Surprise Act	
	Urgent care	5% coinsurance	Per No Surprise Act 5%	

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		PPO Network Provider (You will pay the least)	Non-PPO Out-of-Network Provider (You will pay the most)	
			coinsurance	Provider. Any Non-PPO emergency cost-sharing will count towards any Plan applicable deductible or out-of-pocket limit similar to PPO network urgent care. No Pre-authorization required & No balance billing .
If you have a hospital stay	Facility fee (e.g., hospital room)	5% coinsurance	\$150 copay plus 40% coinsurance except for No Surprise Act covered services same as PPO Network provider.	During public health emergency, COVID-19 treatment hospital admission is covered at no cost (Network provider) but \$150 copay plus 40% coinsurance (Non-PPO Network). Certain non-emergency services & ancillary services (ex. emergency medicine, anesthesia, pathology, radiology, lab, neonatology, assistant surgeon, hospitalist or intensivist services) received by out-of-network provider at network hospital you cannot be billed more than the plan's network contract rate. However, there are certain other non-emergency services and post-stabilization services at these network facilities, you can give written consent to be balance billed . Contact the Trust Fund Office for more information
	Physician/surgeon fees	5% coinsurance	\$150 copay plus 40% coinsurance except for No Surprise Act covered services same as PPO Network provider.	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	\$15 copay /office visit; deductible does not apply.	30% coinsurance except for No Surprise Act covered services same as PPO Network provider.	Deductible waived if PPO Network Provider. Non-PPO Network emergency services covered same as PPO network provider.
	Inpatient services	5% coinsurance	40% coinsurance except for No Surprise Act covered services same as PPO Network provider.	Non-PPO Network emergency services covered same as PPO network provider.
If you are pregnant	Office visits	5% coinsurance ; No Charge if preventive service	30% coinsurance	Cost sharing does not apply to certain preventive services . Depending on the type of services, coinsurance may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound). Non-PPO Network emergency services covered same as PPO network provider.
	Childbirth/delivery professional services	5% coinsurance	30% coinsurance except for No Surprise Act covered services same as PPO Network provider.	
	Childbirth/delivery facility services	5% coinsurance	30% coinsurance except for No Surprise Act covered services same as PPO	

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		PPO Network Provider (You will pay the least)	Non-PPO Out-of-Network Provider (You will pay the most)	
			Network provider.	
If you need help recovering or have other special health needs	Home health care	5% coinsurance	40% coinsurance	See Article IX, Section C.7 Page 35 of the SPD/Plan Document for more details.
	Rehabilitation services	\$15 copay /office visit	30% coinsurance	None. Includes speech therapy (PPO) and physical therapy (PPO & Non-PPO). Speech therapy (non-PPO) not covered. Deductible waived if PPO for speech therapy & physical therapy. Medically necessary Autism Spectrum Disorder diagnosis and treatment (PPO & Non-PPO) covered pursuant to the Plan rules.
	Habilitation services	\$15 copay /office visit	30% coinsurance	
	Skilled nursing care	5% coinsurance	40% coinsurance	None.
	Durable medical equipment	\$15 copay ; 20% coinsurance	50% coinsurance	Deductible waived if PPO Network Provider. Coinsurance not included in the out-of-pocket limit .
	Hospice services	5% coinsurance	40% coinsurance	None.
If your child needs dental or eye care	Children's eye exam (VSP)	\$10 copay /visit	\$50 copay /visit	Coverage limited to one exam/year.
	Children's glasses (VSP)	Up to \$150 allowance	Up to \$70 allowance	Coverage limited to one pair of lenses/year and one frame/every 24 months. Contact 1-925-398-7044 or see VSP booklet.
	Children's dental check-up	Not Covered	Not Covered	None.

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](#).)

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|---|---|---|
| <ul style="list-style-type: none"> • Bariatric Surgery • Cosmetic Surgery • Dental Care (DEPENDENTS) • Hearing Aids | <ul style="list-style-type: none"> • Long-Term Care • Infertility Treatment • Non-emergency care when traveling outside the U.S. | <ul style="list-style-type: none"> • Private Duty Nursing • Routine Foot Care • Weight Loss Programs |
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Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your [plan](#) document.)

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| <ul style="list-style-type: none"> • Acupuncture (if prescribed for rehabilitation purposes) • Chiropractic Care (limited to 30/visits year for PPO) | <ul style="list-style-type: none"> • Dental Care (ADULT) (through Health Smart PPO) • Routine Eye Care (ADULT & DEPENDENTS) (through VSP) | <ul style="list-style-type: none"> • Most coverage provided outside of the United States. Contact 1-925-398-7044 for information. |
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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: **BeneSys Administrators** at 1-925-398-7044 or toll free at 1-877-893-1500 or 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

[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 1-925-398-7044 or toll free at 1-877-893-1500.

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	\$100
■ Specialist copayment	\$15
■ Hospital (facility) coinsurance	5%
■ Other coinsurance	5%

[Specialist](#) office visits (*prenatal 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:

Cost Sharing	
Deductibles	\$100
Copayments	\$200
Coinsurance	\$500
What isn't covered	
Limits or exclusions	\$60
The total Peg would pay is	\$860

Managing Joe's type 2 Diabetes

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

■ The plan's overall deductible	\$100
■ Specialist copayment	\$15
■ Hospital (facility) coinsurance	5%
■ Other coinsurance	5%

T 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:

Cost Sharing	
Deductibles	\$100
Copayments	\$500
Coinsurance	\$30
What isn't covered	
Limits or exclusions	\$20
The total Joe would pay is	\$650

Mia's Simple Fracture

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

■ The plan's overall deductible	\$100
■ Specialist copayment	\$15
■ Hospital (facility) coinsurance	10%
■ Other coinsurance	5%

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:

Cost Sharing	
Deductibles	\$265
Copayments	\$100
Coinsurance	\$200
What isn't covered	
Limits or exclusions	\$0
The total Mia would pay is	\$565