SIHRTE Welfare Trust: Self-Funded Indemnity Plan C

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-glossaryor call 1-925-398-7044 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	For network providers, **$5,000** Individual or **$10,000** family. For out-of-network providers, **$10,000**/Individual or **$20,000**/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 and prescription drug expenses 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 **$6,000**/Individual or **$12,000**/Family and prescription drug benefits **$600**/Individual or **$1,200**/Family. For out-of-network providers, medical & prescription drug benefits Individual or Family **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 at1-866-694-3258 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	50% coinsurance; deductible does not apply; No Charge if preventive service	50% coinsurance	None.
	Specialist visit	50% coinsurance	50% coinsurance	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	50% coinsurance	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.
If you have a test	Diagnostic test (x-ray, blood work)	50% coinsurance	50% coinsurance	None.
	Imaging (CT/PET scans, MRIs)			
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.
	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)	50% coinsurance	50% coinsurance	None.
	Physician/surgeon fees	50% coinsurance	50% coinsurance	None.
If you need immediate medical attention	Emergency room care	50% coinsurance but $150 copay/50% coinsurance if not for emergency care.	50% coinsurance after deductible but $150 copay/50% coinsurance if not for emergency care.	$150 copay will be waived if admitted as in-patient. If you use a non-PPO facility, must transfer to PPO facility as soon as medically feasible.
	Emergency medical transportation	50% coinsurance	50% coinsurance	None.

[* For more information about limitations and exceptions, see the plan or policy document at www.SIHRTEbenefits.org

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)	
	Urgent care	50% coinsurance	50% coinsurance	None.
If you have a hospital stay	Facility fee (e.g., hospital room)	50% coinsurance	50% coinsurance	None.
	Physician/surgeon fees	50% coinsurance	50% coinsurance	None.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	50% coinsurance	50% coinsurance	None.
	Inpatient services	50% coinsurance	50% coinsurance	None.
If you are pregnant	Office visits	50% coinsurance; No Charge if preventive service	50% 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).
	Childbirth/delivery professional services	50% coinsurance	50% coinsurance	
	Childbirth/delivery facility services	50% coinsurance	50% coinsurance after deductible	
If you need help recovering or have other special health needs	Home health care	50% coinsurance	50% coinsurance	None.
	Rehabilitation services	50% coinsurance	50% coinsurance	None. Includes speech therapy (PPO) and physical therapy (PPO & Non-PPO). Speech therapy (non-PPO) not covered.
	Habilitation services	50% coinsurance	50% coinsurance	
	Skilled nursing care	50% coinsurance	50% coinsurance	None.
	Durable medical equipment	50% coinsurance	50% coinsurance	Deductible waived if PPO Network Provider. Coinsurance not included in the out-of-pocket limit.
	Hospice services	50% coinsurance	50% 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.)

- Bariatric Surgery
- Cosmetic Surgery
- Dental Care (ADULT & DEPENDENTS)
- Hearing Aids
- Infertility Treatment
- Long-Term Care
- Non-emergency care when traveling outside the U.S.
- Pregnancy for Dependent Children unless covered routine pre-natal service.
- Private Duty Nursing
- Routine Eye Care (ADULT) but covered under VSP.
- Routine Foot Care
- Weight Loss Programs

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

- Acupuncture (if prescribed for rehabilitation purposes)
- Chiropractic Care (limited to 30/visits year for PPO)
- Most coverage provided outside of the United States. Contact 1-925-398-7044 for information.

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

If you don't have Minimum Essential Coverage for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

Does this plan meet the Minimum Value Standards? Yes

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

Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al 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.

[* For more information about limitations and exceptions, see the plan or policy document at www.SIHRTEbenefits.org

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	$5,000
Specialist coinsurance	50%
Hospital (facility) coinsurance	50%
Other coinsurance	50%

This EXAMPLE event includes services like:
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	**$12,800**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$1,763
Copayments	$0
Coinsurance	$4,237
What isn't covered	
Limits or exclusions	$0
The total Peg would pay is	**$6,000**

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

The plan's overall deductible	$5,000
Specialist coinsurance	50%
Hospital (facility) coinsurance	50%
Other coinsurance	50%

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	**$7,400**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$4,182
Copayments	$478
Coinsurance	$1,340
What isn't covered	
Limits or exclusions	$0
The total Joe would pay is	**$6,000**

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

The plan's overall deductible	$5,000
Specialist coinsurance	50%
Hospital (facility) coinsurance	50%
Other coinsurance	50%

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	**$1,900**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$963
Copayments	$0
Coinsurance	$963
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,900**

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