SIHRTE Welfare Trust: Indemnity Plan A

Coverage Period: 07/01/2015 – 6/30/2016

Summary of Benefits and Coverage: What this Plan Covers & What it Costs **Coverage for:** Employees & Dependents | **Plan Type:** PPO

This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document by calling 1-800-562-9383 until March 1, 2016. Effective March 1, 2016, the Plan will have a new Trust Fund Administrator.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	**Per person $100 PPO $250 Non-PPO; Per family $250 PPO $500 Non-PPO** Doesn't apply to preventive care, doctor office visits, prescription drugs, outpatient mental health/substance abuse services, and x-ray & lab.	You must pay all the costs up to the **deductible** amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the **deductible** starts over (usually, but not always, January 1st). See the chart starting on page 2 for how much you pay for covered services after you meet the **deductible**.
Are there other deductibles for specific services?	No.	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.
Is there an out–of–pocket limit on my expenses?	Yes. For Medical benefits, PPO **$1,500** person / **$3,000** family and non-PPO **$7,000** person / **$14,000** family. For Prescription drugs benefits, PPO **$5,100 person/$10,200** family and non-PPO **No Limit.**	The **out-of-pocket limit** is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.
What is not included in the out–of–pocket limit?	Balance-billed charges, co-pays, 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**.
Is there an overall annual limit on what the plan pays?	No.	The chart starting on page 2 describes any limits on what the plan will pay for *specific* covered services, such as office visits.
Does this plan use a network of providers?	For a list of participating providers, please visit **www.aetna.com or call 1-866-694-3258**.	If you use an in-network doctor or other health care **provider**, this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network **provider** for some services. Plans use the term in-network, **preferred**, or participating for **providers** in their **network**. See the chart starting on page 2 for how this plan pays different kinds of **providers**.

Questions: Call 1-800-562-9383.
If you aren't clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary at www.dol.gov/ebsa/healthreform or call 1-800-562-9383 to request a copy.

Do I need a referral to see a specialist?	No. You don't need a referral to see a specialist.	You can see the **specialist** you choose without permission from this plan.
Are there services this plan doesn't cover?	Yes.	Some of the services this plan doesn't cover are listed on page 4. See your policy or plan document for additional information about **excluded services**.

- **Copayments** are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.
- **Coinsurance** is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is $1,000, your **coinsurance** payment of 20% would be $200. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges $1,500 for an overnight stay and the **allowed amount** is $1,000, you may have to pay the $500 difference. (This is called **balance billing**.)
- This plan may encourage you to use participating **providers** by charging you lower **deductibles**, **copayments** and **coinsurance** amounts.

Common Medical Event	Services You May Need	Your Cost If You Use a Participating Provider	Your Cost If You Use a Non-Participating Provider	Limitations & Exceptions
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$15 copay/visit; No Charge if preventive care	30% coinsurance	Deductible waived for PPO Provider.
	Specialist visit	$15 copay/visit	30% coinsurance	Deductible waived for PPO Provider.
	Other practitioner office visit	$15/copay/visit for chiropractor and acupuncture	50% coinsurance for chiropractor and acupuncture	Deductible waived for PPO Provider. PPO Chiropractor limited to 30 visits per Plan Year; non-PPO Chiropractor limited to 20 visits per Plan Year. Chiropractor copay and coinsurance do not apply to out-of-pocket limit.
	Family Planning, Speech Therapy and Physical Therapy office visit	$15 copay/visit	Not Covered but physical therapy covered at 30% coinsurance after deductible	Deductible waived for PPO Provider

Common Medical Event	Services You May Need	Your Cost If You Use a Participating Provider	Your Cost If You Use a Non-Participating Provider	Limitations & Exceptions
	Preventive care/screening/immunization	No charge	$25 copay and 30% coinsurance for charges in excess of $250.	——————none——————
If you have a test	Diagnostic test (x-ray, blood work)	$10 copay/test	30% coinsurance	Deductible waived for PPO Provider.
	Imaging (CT/PET scans, MRIs)	$10 copay/test	30% coinsurance	Deductible waived for PPO Provider.
	Hearing Test	$15 copay/test	Not Covered	Deductible waived, one test per year.
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available through Magellan Rx at www.magellanhealth.com.	Generic drugs	$10 copay/drug retail and $15/drug mail order	Not Covered	Deductible waived. Covers up to a 30-day supply (retail prescription); 31-90 day supply (mail order prescription).
	Brand drugs	$25 copay/drug retail and $15/drug mail order	Not Covered	Deductible waived. Covers up to a 30-day supply (retail prescription); 31-90 day supply (mail order prescription).
	Specialty drugs	$25 copay/drug retail and $15/drug mail order	Not Covered	Deductible waived. Covers up to a 30-day supply (retail prescription); 31-90 day supply (mail order prescription).
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	5% coinsurance	40% coinsurance	——————none——————
	Physician/surgeon fees	5% coinsurance	30% coinsurance	——————none——————
If you need immediate medical attention	Emergency room services	$150 copay plus 10% coinsurance ($150 copay/40% coinsurance if not for emergency care)	$150 copay plus 10% coinsurance ($150 copay/40% coinsurance if not for emergency care)	$150 copay will be waived if admitted as an in-patient. If you use a non-PPO facility, you must transfer to a PPO facility as soon as medically feasible.
	Emergency medical transportation	5% coinsurance	20% coinsurance	——————none——————
	Urgent care	5% coinsurance	40% coinsurance	Deductible waived for PPO Provider.

Common Medical Event	Services You May Need	Your Cost If You Use a Participating Provider	Your Cost If You Use a Non-Participating Provider	Limitations & Exceptions
If you have a hospital stay	Facility fee (e.g., hospital room)	5% coinsurance	$150 copay plus 40% coinsurance	——————none——————
	Physician/surgeon fee	5% coinsurance	$150 copay plus 40% coinsurance	——————none——————
If you have mental health, behavioral health, or substance abuse needs	Mental Health outpatient services	$15 copay/visit	30% coinsurance	Deductible waived for PPO Provider.
	Mental Health inpatient services	5% coinsurance	40% coinsurance	——————none——————
	Chemical Substance Abuse outpatient services	$15 copay/visit	30% coinsurance	Deductible waived for PPO Provider.
	Chemical Substance Abuse inpatient services	5% coinsurance	40% coinsurance	——————none——————
If you are pregnant	Prenatal and postnatal care	5% coinsurance; No charge if preventive care.	30% coinsurance	——————none——————
	Delivery and all inpatient services	5% coinsurance	30% coinsurance	——————none——————
If you need help recovering or have other special health needs	Home health care	5% coinsurance	40% coinsurance	——————none——————
	Rehabilitation services outpatient	$15 copay/visit	30% coinsurance	——————none——————
	Habilitation services outpatient	$15 copay/visit	30% coinsurance	——————none——————
	Skilled nursing care	5% coinsurance	40% coinsurance	——————none——————
	Durable medical equipment	20% coinsurance	50% coinsurance	Deductible waived PPO Provider. 20% and 50% coinsurance amounts do not apply to the out-of-pocket limit.
	Hospice service	5% coinsurance	40% coinsurance	——————none——————
If your child needs dental or eye care	Eye exam	$10 copay (through VSP)	$50 copay (through VSP)	Limited to One Exam every 12 months. Please see Plan booklet for details on vision care benefits through VSP.
	Glasses	Covered Under VSP.	Covered Under VSP.	Limited to One Pair of Lenses every 12 months and One Frame every 24 months. Please see Plan booklet for payable allowance limits.

Common Medical Event	Services You May Need	Your Cost If You Use a Participating Provider	Your Cost If You Use a Non-Participating Provider	Limitations & Exceptions
	Dental check-up	Not Covered	Not Covered	————————none————————

Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy or plan document for other excluded services.)

- Bariatric surgery
- Cosmetic surgery
- Dental care (Adult) but eligible Active Employees separately covered under HealthSmart PPO.
- Hearing Aids
- Infertility treatment
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Pregnancy for Dependent Children (unless covered routine prenatal service).
- Private Duty Nursing
- Routine eye care but covered under VSP.
- Routine foot care
- Weight Loss programs

Other Covered Services (This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)

- Acupuncture (if prescribed for rehabilitation purposes)
- Chiropractic care
- Most coverage provided outside the United States. Contact 1-800-562-9383 for information.

Your Rights to Continue Coverage:

If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a **premium**, which may be significantly higher than the premium you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply.

For more information on your rights to continue coverage, contact the plan at 1-800-562-9383. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cciio.cms.gov.

Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to **appeal** or file a **grievance**. For questions about your rights, this notice, or assistance, you can contact the Administrator **1-800-562-9383** or the Department of Labor, Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform.

Does this Coverage Provide Minimum Essential Coverage?

The Affordable Care Act requires most people to have health care coverage that qualifies as "minimum essential coverage." **This plan or policy does provide minimum essential coverage.**

Does this Coverage Meet the Minimum Value Standard?

The Affordable Care Act establishes a minimum value standard of benefits of a health plan. The minimum value standard is 60% (actuarial value). **This health coverage does meet the minimum value standard for the benefits it provides.**

To see examples of how this plan might cover costs for a sample medical situation, see the next page.

About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.

This is not a cost estimator.

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

Having a baby
(normal delivery)

- **Amount owed to providers:** $7,540
- **Plan pays** $7,010
- **Patient pays** $530

Sample care costs:

Hospital charges (mother)	$2,700
Routine obstetric care	$2,100
Hospital charges (baby)	$900
Anesthesia	$900
Laboratory tests	$500
Prescriptions	$200
Radiology	$200
Vaccines, other preventive	$40
Total	**$7,540**

Patient pays:

Deductibles (for PPO)	$0
Copays (for PPO)	$200
Coinsurance (for PPO)	$300
Limits or exclusions	$30
Total	**$ 530**

Managing type 2 diabetes
(routine maintenance of a well-controlled condition)

- **Amount owed to providers:** $5,400
- **Plan pays** $4,250
- **Patient pays** $1,150

Sample care costs:

Prescriptions	$2,900
Medical Equipment and Supplies	$1,300
Office Visits and Procedures	$700
Education	$300
Laboratory tests	$100
Vaccines, other preventive	$100
Total	**$5,400**

Patient pays:

Deductibles	$0
Copays	$800
Coinsurance	$0
Limits or exclusions	$350
Total	**$1,150**

Questions and answers about the Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

- Costs don't include **premiums**.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network **providers**. If the patient had received care from out-of-network **providers**, costs would have been higher.

What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how **deductibles**, **copayments**, and **coinsurance** can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

Does the Coverage Example predict my own care needs?

✘ **No.** Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

Does the Coverage Example predict my future expenses?

✘ **No.** Coverage Examples are **not** cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your **providers** charge, and the reimbursement your health plan allows.

Can I use Coverage Examples to compare plans?

✓ **Yes.** When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

Are there other costs I should consider when comparing plans?

✓ **Yes.** An important cost is the **premium** you pay. Generally, the lower your **premium**, the more you'll pay in out-of-pocket costs, such as **copayments**, **deductibles**, and **coinsurance**. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.