Sheet Metal Workers Local 104: Indemnity Health Plan

Coverage Period: 07/01/2023 – 06/30/2024

Summary of Benefits and Coverage: What this Plan Covers & What it Costs **Coverage for:** Members and Dependents | **Plan Type:** 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 www.sheet104fringe.org or call 1-800-548-1771. 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.dol.gov/ebsa/healthreform or call 1-800-548-1771 to request a copy.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	**$300** for a Member or **$600** for an entire Family Unit	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**. 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 services covered before you meet your deductible?	**Yes.** **Preventive care** is covered before you meet your **deductible.**	This **plan** covers some items and services even if you haven't yet met the deducible amount. For example, this **plan** covers certain **preventive services** without **cost sharing** and before you meet your **deducible**. See a list of covered **preventive services** at https://www.healthcare.gov/coverage/preventive-care-beenfits/.
Are there other deductibles for specific services?	**Yes. $200** for each elective non-contract hospital admission. There are no other specific **deductibles**.	You must pay all of the costs for these services up to the specific **deductible** amount before this **plan** begins to pay for these services.
- What is the **out–of–pocket limit** for this **plan?**	**$2,500** per individual/ **$5,000** per family	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?	Premiums, balance-billed charges, health care this plan doesn't cover, expenses relating to the use of non-PPO providers.	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.blueshieldca.com, or call the Trust Fund Office at 1-800-548-1771 for a list of **network providers**.	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 **network provider** may use an **out-of-network provider** for some services (such as lab work). Check with your **provider** before you get services. Plans use the term in-network, preferred, or participating for providers in

		their network. See the chart starting at page 2 for how this plan pays different kinds of providers.
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.
- * means that the percentages are based on Usual, Customary and Reasonable (UCR) charges.

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)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	20% coinsurance	35 % coinsurance*	——————none——————
	Specialist visit	20% coinsurance	35 % coinsurance*	——————none——————
	Other practitioner office visit	Acupuncture: 20% coinsurance* Chiropractic: plan pays $60/visit	Acupuncture: 20% coinsurance* Chiropractic: plan pays $60/visit	Acupuncture: maximum of $60/visit and $600/calendar year Chiropractic: maximum of 26 visits and $1,560/calendar year Does not apply to out-of-pocket limit.
	Preventive care/**screening**/immunization	No charge	35 % coinsurance*	You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for.
If you have a test	**Diagnostic test** (x-ray, blood work)	20% coinsurance	35 % coinsurance*	——————none——————
	Imaging (CT/PET scans, MRIs)	20% coinsurance	35 % coinsurance*	——————none——————

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)	
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.optumrx.com.	Generic drugs	Retail: $15/Rx Mail: $30/Rx	Reimbursement available	Retail is for a 30-day supply; Mail is for a 90-day supply
	Preferred brand drugs	Retail: 25% per Rx Mail: 50% per Rx	Reimbursement available	Retail: minimum $15 copay and a maximum $50 copay; Mail: minimum $30 copay and a maximum $100 copay
	Non-preferred brand drugs	Retail: 25% per Rx Mail: 50% per Rx	Reimbursement available	Retail: minimum $15 copay, but no maximum; Mail: minimum $30 copay, but no maximum. Does not count toward the out-of-pocket limit
	Specialty drugs	Retail: 20% per Rx Mail: 20% per Rx	Reimbursement available	Retail: minimum $15 copay; Mail: minimum $15 copay Retail & Mail: If Formulary, $50 copay maximum. If Non-Formulary, no copay maximum and your copayment does not apply to your out of pocket limit
	Brand drugs (if Generic available)	Retail: $15 plus cost difference between the Brand price and Generic price Mail: $30 plus cost difference between the Brand price and Generic Price	Reimbursement available	Does not count toward the out-of-pocket limit
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance	35 % coinsurance*	20% coinsurance* if the services were rendered in an emergency, regardless of whether the provider or hospital is an out-of-network provider.

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	20% coinsurance	35 % coinsurance*	20% coinsurance* if the services were rendered in an emergency, regardless of whether the provider or hospital is an out-of-network provider.
If you need immediate medical attention	**Emergency room care**	20% coinsurance	35% coinsurance*	20% coinsurance* if the services were rendered in an emergency, regardless of whether the provider or hospital is an out-of-network provider.
	Emergency medical transportation	20% coinsurance	20% coinsurance*	——————none——————
	Urgent care	20% coinsurance	35% coinsurance*	——————none——————
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance	35% coinsurance*	If you use an out-of-network hospital there is also a $200/person hospital deductible for each non-emergency admission. 20% coinsurance* if the services were rendered in an emergency, regardless of whether the provider or hospital is an out-of-network provider.
	Physician/surgeon fee	20% coinsurance	35% coinsurance*	20% coinsurance* if the services were rendered in an emergency, regardless of whether the provider or hospital is an out-of-network provider.

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)	
If you need mental health, behavioral health, or substance abuse services	outpatient services	20% coinsurance	35% coinsurance*	——————none——————
	inpatient services	20% coinsurance	35% coinsurance*	——————none——————
	Substance use disorder outpatient services	No charge	35% coinsurance*	——————none——————
	Substance use disorder inpatient services	20% coinsurance	35% coinsurance*	Requires preauthorization by Beat It. If a covered participant fails to use the Inpatient Review Program, all benefits otherwise payable in connection with the confinement may be reduced by 20%; and benefit payment will be based on the length of stay that would have been authorized if the Utilization Review Program had been used.
If you are pregnant	Prenatal and postnatal care	No charge	35% coinsurance*	——————none——————
	Delivery and all inpatient services	20% coinsurance	35% coinsurance*	——————none——————

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)	
If you need help recovering or have other special health needs	**Home health care**	20% coinsurance*	20% coinsurance*	The Plan pays for up to 100 home health care visits/calendar year, up to 30 days per plan year.
	Rehabilitation services	Physical/Occupational Therapy: 20% coinsurance Speech Therapy: 20% coinsurance*	Physical/Occupational Therapy: 20% coinsurance* Speech Therapy: 20% coinsurance*	Physical/Occupational Therapy: Maximum 20 visits/calendar year. Out-of-network charges will not count toward the out-of-pocket maximum. Speech Therapy: every case extending beyond a 30-day period of treatment will be reappraised by the Utilization Review Organization.
	Habilitation services	See Rehabilitation Services	See Rehabilitation Services	See Rehabilitation Services
	Skilled nursing care	20% coinsurance	35% coinsurance*	The Plan will pay if Blue Shield certifies medical necessity, up to 100 days/calendar year
	Durable medical equipment	20% coinsurance*	20% coinsurance*	These expenses do not count toward the out-of pocket maximum.
	Hospice service	20% coinsurance*	20% coinsurance*	Limited to $10,000/patient, and requires certification from a physician that the life expectancy is less than six months.
If you need dental or eye care	Eye exam	No charge	Not covered	Provided by VSP
	Glasses	Not covered	Not covered	——————none——————
	Dental check-up	Plan covers 2 cleanings per year at 100%	Not covered	Provided by Delta Dental Maximum calendar year benefit is $3,500/individual and $7,000/family

Excluded Services & Other Covered Services:

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

- Cosmetic surgery
- Infertility treatment
- Long term care
- Non-emergency care when traveling outside the U.S.
- Private duty nursing
- Weight loss programs

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

- Acupuncture
- Bariatric surgery
- *Chiropractic care
- Dental Care
- Hearing aids
- Routine eye care
- 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: 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.com.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 plan at 1-800-548-1771 or www.sheet104fringe.org. You may also contact the U.S. 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 1-800-548-1771.

Chinese (中文): 如果需要中文的帮助，请拨打这个号码 1-800-548-1771.

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 $300**
- **Specialist [cost sharing] 20%**
- **Hospital (facility) [cost sharing] 20%**
- **Other [cost sharing] 20%**

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	**$12,700**
In this example, Peg would pay:	
Cost Sharing	
Deductibles	$300
Copayments	$0
Coinsurance	$2,480
What isn't covered	
Limits or exclusions	$0
The total Peg would pay is	**$2,780**

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

- **The plan's overall deductible $300**
- **Specialist [cost sharing] 20%**
- **Hospital (facility) [cost sharing] 20%**
- **Other [cost sharing] 20%**

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**
In this example, Joe would pay:	
Cost Sharing	
Deductibles	$300
Copayments	$0
Coinsurance	$1,060
What isn't covered	
Limits or exclusions	$0
The total Joe would pay is	**$1,360**

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

- **The plan's overall deductible $300**
- **Specialist [cost sharing] 20%**
- **Hospital (facility) [cost sharing] 20%**
- **Other [cost sharing] 20%**

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**
In this example, Mia would pay:	
Cost Sharing	
Deductibles	$300
Copayments	$0
Coinsurance	$500
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$800**

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