District Council 37 Local 95 Head Start Employees Welfare Fund

Summary of Benefits and Coverage: What this Plan Covers & What You Pay For Covered Services

Coverage Period: 08/01/2022-07/31/2023
Coverage for: Individual or Family | Plan Type: EPO

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 1-212-343-1660. 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.healthcare.gov/sbc-glossary or call 1-800-633-5568 to request a copy. If you want more detail about your coverage and costs, you can get the complete terms in the Summary Plan Description or by calling the Fund office at 1-212-343-1660.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	$500 / individual or $1,000 / family	Generally, you must pay all 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 primary care services 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. There are no other specific **deductibles**	You do not have to meet deductibles for specific services, but see the chart on page 2 for other costs for services this Plan covers.
What is the out-of-pocket limit for this plan?	Yes, there are 2 separate out-of-pocket limits under this plan: Medical and a separate one for the Prescription benefit. Each benefit's out-of-pocket limit is $5,000 Individual, $10,000 Family.	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?	Premiums and Healthcare expenses that this Plan does not 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?		
Do you 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 provided that they are in the network.

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
		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	$25 co-pay / visit	Not Covered	Outpatient facility visits; $200 co-pay plus 12% coinsurance
	Specialist visit	$25 co-pay / visit	Not Covered	Outpatient facility visits; $200 co-pay plus 12% coinsurance
	Preventive care/screening/ immunization	No Charge	Not Covered	---------- none ----------
If you have a test	Diagnostic test (x-ray, blood work)	$25 co-pay / test	Not Covered	Outpatient facility visits; $200 co-pay plus 12% coinsurance
	Imaging (CT/PET scans, MRIs)	$25 co-pay / test	Not Covered	Outpatient facility visits; $200 co-pay plus 12% coinsurance
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.Navitus.com	Generic drugs	$10 co-pay	Covered up to the Navitus discount rate.	Up to 90 day retail supply available co-pay $30
	Preferred brand drugs	The greater of $25 co-pay or 25% of the cost of the medication.	Covered up to the Navitus discount rate.	If there is a Generic equivalent available in addition to the co-pay, the member will pay the difference in the cost between the Generic vs Preferred Brand cost.
	Non-preferred brand drugs	The greater of $50 co-pay or 25% of the cost of the medication.	Covered up to the Navitus discount rate.	If there is a Generic equivalent available in addition to the co-pay, the member will pay the difference in the cost between the Generic vs Non Preferred Brand cost.
	Specialty drugs	Same as above	Not Covered	Mandatory Specialty Program contact 1-855-847-3553
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	12% Coinsurance	Not Covered	Outpatient facility visits; $200 co-pay plus 12% coinsurance
	Physician/surgeon fees	12% Coinsurance	Not Covered	Outpatient facility visits; $200 co-pay plus 12% coinsurance
If you need immediate medical attention	Emergency room care	$150 co-pay	$150 co-pay	Waived if admitted.
	Emergency medical transportation	12% Coinsurance	12% Coinsurance	Maximum allowance ALS $1,290 BLS $704 plus $12 per mile transport.
	Urgent care	$50 co-pay	Not Covered	---------- 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 have a hospital stay	Facility fee (e.g., hospital room)	12% Coinsurance	Not Covered	---------- none ----------
	Physician/surgeon fees	12% Coinsurance	Not Covered	Allowed one visit per day.
If you need mental health, behavioral health, or substance abuse services	Outpatient services office visit.	$25 co-pay	Not Covered	Outpatient facility visit; $200 co-pay plus 12% coinsurance
	Inpatient services	12% Coinsurance	Not Covered	Precertification required
	Substance use disorder outpatient services office visit.	$25 co-pay	Not Covered	Outpatient facility visit; $200 co-pay plus 12% coinsurance
	Substance use disorder inpatient services	12% Coinsurance	Not Covered	Residential Care Programs not covered.
If you are pregnant	Office visits	$25 co-pay	Not Covered	Outpatient facility visit; $200 co-pay plus 12% coinsurance
	Childbirth/delivery professional services	12% Coinsurance	Not Covered	
	Childbirth/delivery facility services	Outpatient facility visit; $200 co-pay plus 12% coinsurance	Not Covered	Outpatient facility visit; $200 co-pay plus 12% coinsurance
If you need help recovering or have other special health needs	Home health care	20% Coinsurance	Not Covered	Maximum 60 visits per year requires re-authorization.
	Rehabilitation services	12% Coinsurance	Not Covered	Outpatient facility visit; $200 co-pay plus 12% coinsurance
	Habilitation services	12% Coinsurance	Not Covered	Outpatient facility visit; $200 co-pay plus 12% coinsurance
	Skilled nursing care	12% Coinsurance	Not Covered	Outpatient facility visit; $200 co-pay plus 12% coinsurance
	Durable medical equipment	12% Coinsurance	Not Covered	Pre-cert required when amount is greater than $2,000.
	Hospice services	12% Coinsurance	Not Covered	Pre-cert required up to 210 days per lifetime.
If your child needs dental or eye care	Children's eye exam	Not Covered	Not Covered	---------- none ----------
	Children's glasses	Not Covered	Not Covered	---------- none ----------
	Children's dental check-up	Not Covered	Not Covered	If enrolled in Dental Benefit.

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.)

- Cosmetic Surgery
- Long-term care
- Hearing aids
- Motor vehicle related expenses
- Non-emergency care when traveling outside the U.S.
- Routine foot care
- Private-duty nursing

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

- Acupuncture
- Chiropractic care
- Routine medical checkup
- Dialysis (in-network only)
- Dental Care
- Chemotherapy
- Organ transplants

Your Rights to Continue Coverage:

**** Individual health insurance sample -**

Federal and State laws may provide protections that allow you to keep this health insurance coverage as long as you or your employer pay the **premium**. There are exceptions, however, such as if:

- You commit fraud
- The Fund Stops offering services
- you move outside the coverage area

For more information on your rights to continue coverage, contact the Fund at 1-212-343-1660. You may also contact your state insurance department.

Group health 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 1-212-343-1660. You may also contact 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 x 61565 or www.cciio.cms.gov.

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: [insert applicable contact information from instructions].

Does this plan provide Minimum Essential Coverage? [Yes/No]
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/No]
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 [insert telephone number].]
[Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa [insert telephone number].]
[Chinese (中文): 如果需要中文的帮助，请拨打这个号码 [insert telephone number].]
[Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' [insert telephone number].]

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	$500
Specialist *[cost sharing]*	$25
Hospital (facility) *[cost sharing]*	$200
Other *[cost sharing]*	12%

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	$500
Copayments	$225
Coinsurance	$1,536
What isn't covered	
Limits or exclusions	$100
The total Peg would pay is	**$2,361**

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

The plan's overall deductible	$500
Specialist *[cost sharing]*	$25
Hospital (facility) *[cost sharing]*	$200
Other *[cost sharing]*	12%

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	$500
Copayments	$225
Coinsurance	$888
What isn't covered	
Limits or exclusions	$100
The total Joe would pay is	**$1,713**

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

The plan's overall deductible	$500
Specialist *[cost sharing]*	$25
Hospital (facility) *[cost sharing]*	$200
Other *[cost sharing]*	12%

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	$500
Copayments	$225
Coinsurance	$228
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$953**

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**, **co-payments**, and **co-insurance** 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 received 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 Example to compare plans?

✓ **Yes.** When you look at the Summary of the 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 **co-payments**, **deductibles**, and **co-insurance**. 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.