


# District Council 37 Local 95 Head Start Employees Welfare Fund

Coverage Period: 04/01/2025-03/31/2026

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

Coverage for: Individual or Member/Dependent | 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](http://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 <a href="#">deductible</a> ?	\$1,000 / individual or \$2,000 / member/child(ren)	Generally, you must pay all the costs from <a href="#">providers</a> up to the <a href="#">deductible</a> amount before this <a href="#">plan</a> begins to pay. If you have other family members on the <a href="#">plan</a> , each family member must meet their own individual <a href="#">deductible</a> until the total amount of <a href="#">deductible</a> expenses paid by all family members meets the overall family <a href="#">deductible</a> .
Are there services covered before you meet your <a href="#">deductible</a> ?	Yes. <a href="#">Preventive care</a> and primary care services are covered before you meet your <a href="#">deductible</a> .	This <a href="#">plan</a> covers some items and services even if you haven't yet met the <a href="#">deductible</a> amount. But a <a href="#">copayment</a> or <a href="#">coinsurance</a> may apply. For example, this <a href="#">plan</a> covers certain <a href="#">preventive services</a> without <a href="#">cost sharing</a> and before you meet your <a href="#">deductible</a> . See a list of covered <a href="#">preventive services</a> at <a href="https://www.healthcare.gov/coverage/preventive-care-benefits/">https://www.healthcare.gov/coverage/preventive-care-benefits/</a> .
Are there other <a href="#">deductibles</a> for specific services?	No. There are no other specific <a href="#">deductibles</a>	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 <a href="#">out-of-pocket limit</a> for this <a href="#">plan</a> ?	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 Member/Child(ren).	The <b>Out-of-pocket</b> 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 <a href="#">out-of-pocket limit</a> ?	Premiums and Healthcare expenses that this Plan does not cover.	Even though you pay these expenses, they don't count toward the <b>out-of-pocket limit</b> .
Will you pay less if you use a <a href="#">network provider</a> ?	Yes go to <a href="http://www.magnacare">www.magnacare</a> for providers. You may use any hospital or facility.	This <a href="#">plan</a> uses a <a href="#">provider network</a> . You will pay less if you use a <a href="#">provider</a> in the <a href="#">plan's network</a> . You will pay the most if you use an <a href="#">out-of-network provider</a> , and you might receive a bill from a <a href="#">provider</a> for the difference between the <a href="#">provider's</a> charge and what your plan pays ( <a href="#">balance billing</a> ). Be aware your <a href="#">network provider</a> might use an <a href="#">out of network provider</a> for some services (such as lab work). Check with your <a href="#">provider</a> before you get services.
Do you need a <a href="#">referral</a> to see a <a href="#">specialist</a> ?	No. You don't need a referral to see a specialist.	You can see the <b>Specialist</b> you choose without permission from this plan provided that they are in the network.

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 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	\$30 <a href="#">copayment</a> after <a href="#">deductible</a> / visit	Not Covered	Outpatient facility visits; \$200 <a href="#">copayment</a> plus 20% <a href="#">coinsurance</a> after <a href="#">deductible</a>
	<a href="#">Specialist</a> visit	\$30 <a href="#">copayment</a> after <a href="#">deductible</a> / visit	Not Covered	Outpatient facility visits; \$200 <a href="#">copayment</a> plus 20% <a href="#">coinsurance</a> after <a href="#">deductible</a>
	<a href="#">Preventive care/screening/immunization</a>	No Charge	Not Covered	----- none -----
If you have a test	<a href="#">Diagnostic test</a> (x-ray, blood work)	\$30 <a href="#">copayment</a> after <a href="#">deductible</a> / test freestanding facility	Not Covered	Outpatient facility visits; \$200 <a href="#">copayment</a> plus 20% <a href="#">coinsurance</a> after <a href="#">deductible</a>
	Imaging (CT/PET scans, MRIs)	\$30 <a href="#">copayment</a> after <a href="#">deductible</a> / test freestanding facility	Not Covered	Outpatient facility visits; \$200 <a href="#">copayment</a> plus 20% <a href="#">coinsurance</a> after <a href="#">deductible</a>
If you need drugs to treat your illness or condition More information about <a href="#">prescription drug coverage</a> is available at <a href="http://www.Navitus.com">www.Navitus.com</a>	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 \$30 <a href="#">copayment</a> 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 <a href="#">copayment</a> 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.
	<a href="#">Specialty drugs</a>	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)	\$200 <a href="#">copayment</a> plus 20% <a href="#">coinsurance</a> after <a href="#">deductible</a>	Not Covered	Outpatient facility visits; \$200 <a href="#">copayment</a> plus 20% <a href="#">coinsurance</a> after <a href="#">deductible</a>
	Physician/surgeon fees	20% <a href="#">coinsurance</a> after <a href="#">deductible</a>	Not Covered	Outpatient hospital facility 20% <a href="#">coinsurance</a> after <a href="#">deductible</a>
If you need immediate medical attention	<a href="#">Emergency room care</a>	\$300 <a href="#">copayment</a> after <a href="#">deductible</a>	\$300 <a href="#">copayment</a> after <a href="#">deductible</a>	Waived if admitted.
	<a href="#">Emergency medical transportation</a>	20% <a href="#">coinsurance</a> after <a href="#">deductible</a>	20% <a href="#">coinsurance</a> after <a href="#">deductible</a>	Maximum allowance ALS \$1,290 BLS \$704 plus \$12 per mile transport.
	<a href="#">Urgent care</a>	\$50 <a href="#">copayment</a> after <a href="#">deductible</a>	Not Covered	----- none -----
If you have a hospital stay	Facility fee (e.g., hospital room)	\$100 <a href="#">copayment</a> ; then 20% <a href="#">coinsurance</a> after <a href="#">deductible</a>	Not Covered	----- none -----
	Physician/surgeon fees	20% <a href="#">coinsurance</a> after <a href="#">deductible</a>	Not Covered	Allowed one visit per day.

For more information about limitations and exceptions, see the [plan](#) or policy document at [www.dc1707195wf.net](http://www.dc1707195wf.net) by calling, DC 37 Local 95 HSEWF at 1-212-343-1660

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		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 office visit.	\$30 <a href="#">copayment</a> after <a href="#">deductible</a>	Not Covered	Outpatient facility visit; \$200 <a href="#">copayment</a> plus 20% <a href="#">coinsurance</a> after <a href="#">deductible</a>
	Inpatient services	\$100 <a href="#">copayment</a> ; 20% <a href="#">coinsurance</a> after <a href="#">deductible</a>	Not Covered	Precertification required
	Substance use disorder outpatient services office visit.	\$30 <a href="#">copayment</a> after <a href="#">deductible</a>	Not Covered	Outpatient facility visit; \$200 <a href="#">copayment</a> plus 20% <a href="#">coinsurance</a> after <a href="#">deductible</a>
	Substance use disorder inpatient services	\$100 <a href="#">copayment</a> ; 20% <a href="#">coinsurance</a> after <a href="#">deductible</a>	Not Covered	Residential Care Programs not covered.
If you are pregnant	Office visits	\$30 <a href="#">copayment</a> after <a href="#">deductible</a>	Not Covered	Outpatient facility visit; \$200 <a href="#">copayment</a> plus 20% <a href="#">coinsurance</a> after <a href="#">deductible</a>
	Childbirth/delivery professional services	20% <a href="#">coinsurance</a> after <a href="#">deductible</a>	Not Covered	
	Childbirth/delivery facility services	20% <a href="#">coinsurance</a> after <a href="#">deductible</a>	Not Covered	Outpatient facility visit; \$200 <a href="#">copayment</a> plus 20% <a href="#">coinsurance</a> after <a href="#">deductible</a>
If you need help recovering or have other special health needs	<a href="#">Home health care</a>	20% <a href="#">coinsurance</a> after <a href="#">deductible</a>	Not Covered	Maximum 60 visits per year requires re-authorization.
	<a href="#">Rehabilitation services</a>	120% <a href="#">coinsurance</a> after <a href="#">deductible</a>	Not Covered	Inpatient \$100 <a href="#">copayment</a> ; Outpatient facility - \$200 <a href="#">copayment</a> plus 20% <a href="#">coinsurance</a> after <a href="#">deductible</a>
	<a href="#">Habilitation services</a>	20% <a href="#">coinsurance</a> after <a href="#">deductible</a>	Not Covered	Outpatient facility visit; \$200 <a href="#">copayment</a> plus 20% <a href="#">coinsurance</a> after <a href="#">deductible</a>
	<a href="#">Skilled nursing care</a>	20% <a href="#">coinsurance</a> after <a href="#">deductible</a>	Not Covered	Inpatient \$100 <a href="#">copayment</a> ; Outpatient facility - \$200 <a href="#">copayment</a> plus 20% <a href="#">coinsurance</a> after <a href="#">deductible</a>
	<a href="#">Durable medical equipment</a>	20% <a href="#">coinsurance</a> after <a href="#">deductible</a>	Not Covered	Pre-cert required when amount is greater than \$2,000.
	<a href="#">Hospice services</a>	20% <a href="#">coinsurance</a> after <a href="#">deductible</a>	Not Covered	Pre-cert required up to 210 days per lifetime.
If your child needs dental or eye care	Children's eye exam	Child Eye Exam under ACA Only	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.

For more information about limitations and exceptions, see the [plan](#) or policy document at [www.dc1707195wf.net](http://www.dc1707195wf.net) by calling, DC 37 Local 95 HSEWF at 1-212-343-1660

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## 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 (for pain management or used for anesthesia)
- Chiropractic care (limited)
- Routine medical checkup
- Dialysis (in-network only)
- Dental Care (adult/child refer to standalone dental benefits)
- Chemotherapy
- Organ transplants

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## 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](http://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](http://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]

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 800-225-1345.]

[Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 800-225-1345]

[Chinese (中文): 如果需要中文的帮助, 请拨打这个号码 800-225-1345]

[Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijigo holne' 800-225-1345]

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

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## 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 <a href="#">plan's</a> overall <a href="#">deductible</a>	\$1000
■ <a href="#">Specialist</a> [ <i>cost sharing</i> ]	\$30
■ Hospital (facility) [ <i>cost sharing</i> ]	\$200
■ Other [ <i>cost sharing</i> ]	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*)

<b>Total Example Cost</b>	<b>\$12,700</b>
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In this example, Peg would pay:

<i>Cost Sharing</i>	
Deductibles	\$1,000
Copayments	\$230
Coinsurance	\$2,560
<i>What isn't covered</i>	
Limits or exclusions	\$100
<b>The total Peg would pay is</b>	<b>\$3,890</b>

### Managing Joe's type 2 Diabetes

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

■ The <a href="#">plan's</a> overall <a href="#">deductible</a>	\$1,000
■ <a href="#">Specialist</a> [ <i>cost sharing</i> ]	\$30
■ Hospital (facility) [ <i>cost sharing</i> ]	\$200
■ Other [ <i>cost sharing</i> ]	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*)

<b>Total Example Cost</b>	<b>\$5,600</b>
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In this example, Joe would pay:

<i>Cost Sharing</i>	
Deductibles	\$1,000
Copayments	\$230
Coinsurance	\$1,480
<i>What isn't covered</i>	
Limits or exclusions	\$100
<b>The total Joe would pay is</b>	<b>\$2,810</b>

### Mia's Simple Fracture

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

■ The <a href="#">plan's</a> overall <a href="#">deductible</a>	\$1,000
■ <a href="#">Specialist</a> [ <i>cost sharing</i> ]	\$30
■ Hospital (facility) [ <i>cost sharing</i> ]	\$200
■ Other [ <i>cost sharing</i> ]	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*)

<b>Total Example Cost</b>	<b>\$2,800</b>
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In this example, Mia would pay:

<i>Cost Sharing</i>	
Deductibles	\$1,000
Copayments	\$230
Coinsurance	\$380
<i>What isn't covered</i>	
Limits or exclusions	\$0
<b>The total Mia would pay is</b>	<b>\$1,610</b>

Note: These numbers assume the patient does not participate in the plan's wellness program. If you participate in the plan's wellness program, you may be able to reduce your costs. For more information about the wellness program, please contact: DC 37 Local 95 HSEWF by calling 1-212-343-1660.

### 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 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 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.