

Summary of Benefits and Coverage: What this Plan Covers & What You Pay For Covered Services
Southern Illinois Laborers & Employers Health & Welfare Fund:
Plan E – Active Participants

Coverage Period: 01/01/2018 – 12/31/2018

Coverage for: Employees & Dependents


Plan Type: HMO/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, go to www.silchw.org or call (618) 998-1300. 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 <https://www.healthcare.gov/sbc-glossary/> or call (618) 998-1300 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible ?	In-Network: \$850 per Individual/\$2,550 per Family Out-of-Network: \$4,000 per Individual/\$12,000 per 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. In-Network Preventive, Hearing, Smoking Cessation and Prescription Benefits 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.
Are there other deductibles for specific services?	Yes. \$50 Dental deductible ,	You must pay all 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 ?	Medical In-Network: \$5,250 per Individual/\$10,500 per Family Pharmacy In-Network: \$1,900 per Individual/\$3,800 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 the family out-of-pocket limit has been met.
What is not included in the out-of-pocket limit ?	Premiums , balance billing charges 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.healthlink.com or call (800) 624-2356 for a list of network providers .	You pay the least if you use a provider in Tier 1 Healthlink network . You will pay more if you use a provider in Tier 2 Healthlink network . You will pay the most if you use an 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 .
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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
		Tier 1 Healthlink Provider (You will pay the least)	Tier 2 Healthlink Provider	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	25% coinsurance	55% coinsurance	-----none----- Tier 1 or 2 – No deductible . Limited to 1 physical exam (including, but not limited to, pap smear, gynecological exam and prostate exam) per calendar year. 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. For specific benefits and limitations, see the SPD.*
	Specialist visit			55% coinsurance	
	Preventive care/screening/immunization	No charge		55% coinsurance	
If you have a test	Diagnostic test (x-ray, blood work)	20% coinsurance	25% coinsurance	55% coinsurance	-----none-----
	Imaging (CT/PET scans, MRIs)				

*For more information about limitations and exceptions, see summary plan description (SPD).

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Tier 1 Healthlink Provider (You will pay the least)	Tier 2 Healthlink Provider	Out-of-Network Provider (You will pay the most)	
<p>If you need drugs to treat your illness or condition</p> <p>More information about prescription drug coverage is available by calling the Fund Office at (800) 553-9032.</p>	Generic drugs	Retail (30 days) – Greater of \$10 or 25% coinsurance , \$20 max Mail order (90 days) - Greater of \$20 or 25% coinsurance , \$50 max		Not covered	<p>No deductible on Prescription Benefits.</p> <p>If a participant chooses to utilize a brand drug when a generic equivalent is available, the participant will be required to pay the applicable \$40 or \$75 copayment plus the difference in cost between the brand drug and generic.</p> <p>Cancer related drugs are excluded from the 30% coinsurance. The first dialysis treatment of each month that includes bio-injectable or specialty medications is subject to \$225 copayment.</p>
	Preferred brand drugs	Retail (30 days) – Greater of \$35 or 30% coinsurance , \$40 max Mail order (90 days) - Greater of \$70 or 30% coinsurance , \$75 max			
	Non-preferred brand drugs	Retail (30 days) – Greater of \$45 or 35% coinsurance , \$70 max Mail order (90 days) - Greater of \$90 or 35% coinsurance , \$100 max			
	Specialty drugs	SPECIALTY PHARMACY 30% coinsurance , \$225 max per prescription PHYSICIAN OR FACILITY 30% coinsurance , \$225 max per course of treatment, subject to deductible .			
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center) Physician/surgeon fees	20% coinsurance	25% coinsurance	55% coinsurance	-----none-----
If you need immediate medical attention	Emergency room care	20% coinsurance after \$175 copayment for non-accidents			\$175 copayment waived if patient is immediately admitted to hospital.
	Emergency medical transportation	20% coinsurance			-----none-----
	Urgent care	20% coinsurance	25% coinsurance	55% coinsurance	-----none-----
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance	25% coinsurance	55% coinsurance	Semi-private room only.
	Physician/surgeon fees				-----none-----

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Tier 1 Healthlink Provider (You will pay the least)	Tier 2 Healthlink Provider	Out-of-Network Provider (You will pay the most)	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	20% coinsurance	25% coinsurance	55% coinsurance	-----none-----
	Inpatient services				
If you are pregnant	Office visits	20% coinsurance	25% coinsurance	55% coinsurance	Post-natal services, delivery and inpatient services for Employee and Spouse only. Cost sharing does not apply to Tier 1 or Tier 2 preventive services . Maternity care may include tests and services described elsewhere in this document (i.e. ultrasound).
	Childbirth/delivery professional services				
	Childbirth/delivery facility services				
If you need help recovering or have other special health needs	Home health care	20% coinsurance	25% coinsurance	55% coinsurance	Limit of 100 visits per calendar year. Up to 4 hours = 1 visit.
	Rehabilitation services				Limit of 50 visits per year. Speech therapy covered only for certain conditions. See SPD Section 2.22 for more information.*
	Habilitation services				Limit of 50 visits per year. See SPD for other exclusions and limitations.*
	Skilled nursing care				Limit of 30 days per year.
	Durable medical equipment				Wheelchair paid at 50% up to \$1,000. All other equipment rental covered up to the purchase price. See SPD Section 2.09 for criteria.*
	Hospice services				Limit of 185 days per year. Must submit a Hospice Care Plan

*For more information about limitations and exceptions, see summary plan description (SPD).

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Tier 1 Healthlink Provider (You will pay the least)	Tier 2 Healthlink Provider	Out-of-Network Provider (You will pay the most)	
If your child needs dental or eye care	Children's eye exam	Not covered			-----none-----
	Children's glasses	Not covered			-----none-----
	Children's dental check-up	No charge			One exam and cleaning every 6 months.

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 .)		
<ul style="list-style-type: none"> • Acupuncture • Bariatric surgery • Cosmetic surgery (unless necessary as a result of an accident) 	<ul style="list-style-type: none"> • Infertility treatment • Long-term care • Non-emergency care when traveling outside the U.S. 	<ul style="list-style-type: none"> • 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.)		
<ul style="list-style-type: none"> • Chiropractic care (up to 20 visits/year) • Dental care (adult) 	<ul style="list-style-type: none"> • Hearing aids • Routine eye care (adult) 	<ul style="list-style-type: none"> • 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: 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 (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: the Fund Office at (618) 998-1300 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:

Para obtener asistencia en Español, llame al (618) 998-1300.

-----*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	\$850
■ Specialist coinsurance	20%
■ Hospital (facility) coinsurance	20%
■ Other coinsurance	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	\$12,800
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In this example, Peg would pay:

Cost Sharing	
Deductibles	\$850
Copayments	\$0
Coinsurance	\$2,500
<i>What isn't covered</i>	
Limits or exclusions	\$60
The total Peg would pay is	\$3,400

Managing Joe's type 2 Diabetes

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

■ The plan's overall deductible	\$850
■ Specialist coinsurance	20%
■ Hospital (facility) coinsurance	20%
■ Other coinsurance	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	\$7,500
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In this example, Joe would pay:

Cost Sharing	
Deductibles	\$850
Copayments	\$0
Coinsurance	\$1,800
<i>What isn't covered</i>	
Limits or exclusions	\$60
The total Joe would pay is	\$2,700

Mia's Simple Fracture

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

■ The plan's overall deductible	\$850
■ Specialist coinsurance	20%
■ Hospital (facility) coinsurance	20%
■ Other coinsurance	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	\$2,000
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In this example, Mia would pay:

Cost Sharing	
Deductibles	\$850
Copayments	\$0
Coinsurance	\$400
<i>What isn't covered</i>	
Limits or exclusions	\$0
The total Mia would pay is	\$1,200