
 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 1-800-765-4239. 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 1-800-765-4239 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	\$600 Individual/ \$1,800 Family <i>Certain <u>out-of-network claims</u> are treated as <u>in-network claims</u> (see page 2).</i>	Generally, you must pay all of the costs from <u>providers</u> up to the <u>deductible</u> amount before this <u>plan</u> begins to pay. If you have other family members on the <u>plan</u> , each family member must meet their own individual <u>deductible</u> until the total amount of <u>deductible</u> expenses paid by all family members meets the overall family <u>deductible</u> .
Are there services covered before you meet your deductible?	Yes. MD Live visits are covered before you meet your <u>deductible</u> .	This <u>plan</u> covers some items and services even if you haven't yet met the <u>deductible</u> amount. But a <u>copayment</u> or <u>coinsurance</u> may apply.
Are there other deductibles for specific services?	Yes. \$60 <u>prescription drug deductible</u> per individual and \$60 non-accident emergency room <u>deductible</u> per visit after first 2 visits. There are no other specific deductibles.	You must pay all of the costs for these specific services up to the specific <u>deductible</u> amount before this <u>plan</u> begins to pay for these services.
What is the out-of-pocket limit for this plan?	\$1,900 Individual/ \$3,800 Family <i>Certain <u>out-of-network claims</u> are treated as <u>in-network claims</u> (see page 2).</i>	The <u>out-of-pocket limit</u> is the most you could pay in a year for covered services. If you have other family members in this <u>plan</u> , they have to meet their own <u>out-of-pocket limits</u> until the overall family <u>out-of-pocket limit</u> has been met.
What is not included in the out-of-pocket limit?	Premiums, <u>balance-billing</u> charges, <u>deductibles</u> , office visit <u>copayments</u> , <u>prescription drugs</u> , non-accident emergency room <u>deductible</u> , chiropractic services, <u>coinsurance</u> for Non-Centers of Excellence transplant benefits, <u>cost sharing</u> for hearing aids, and health care this <u>plan</u> does not cover.	Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u> .

Important Questions	Answers	Why This Matters:
Will you pay less if you use a network provider ?	Yes.* See www.bcbs.com/find-a-doctor or call 1-800-810-2583 for a list of PPO providers. * Out-of-network providers may be treated as network providers for cost-sharing purposes for out-of-network emergency services , out-of-network providers at in-network facilities , and out-of-network air ambulance costs for emergencies .	This <u>plan</u> uses a <u>provider network</u> . You will pay less if you use a <u>provider</u> in the <u>plan's network</u> . You will pay the most if you use an <u>out-of-network provider</u> , and you might receive a bill from a <u>provider</u> for the difference between the <u>provider's</u> charge and what your <u>plan</u> pays (<u>balance billing</u>). Be aware your <u>network provider</u> might use an <u>out-of-network provider</u> for some services (such as lab work). Check with your <u>provider</u> before you get services.
Do you need a referral to see a specialist ?	No.	You can see the <u>specialist</u> you choose without a <u>referral</u> .

 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
		PPO <u>Provider</u> (You will pay the least)	Non-PPO <u>Provider</u> (You will pay the most)	
If you visit a health care <u>provider's</u> office or clinic	Primary care visit to treat an injury or illness	\$15 <u>copayment</u> /visit	\$15 <u>copayment</u> /visit	Office visit <u>copayments</u> do not count toward the <u>out-of-pocket limit</u> . Certain services are available through MD Live. There is no <u>copayment</u> , <u>deductible</u> , or <u>coinsurance</u> for a virtual visit through MD Live.
	<u>Specialist</u> visit	\$15 <u>copayment</u> /visit. 50% <u>coinsurance</u> for chiropractic care.	\$15 <u>copayment</u> /visit. 50% <u>coinsurance</u> for chiropractic care.	Chiropractic care limited to 48 visits per individual per calendar year. Office visit <u>copayments</u> do not count toward the <u>out-of-pocket limit</u> . Certain services are available through MD Live. There is no <u>copayment</u> , <u>deductible</u> , or <u>coinsurance</u> for a virtual visit through MD Live.
	<u>Preventive care/screening/immunization</u>	10% <u>coinsurance</u>	25% <u>coinsurance</u>	Certain services are available through MD Live. There is no <u>copayment</u> , <u>deductible</u> , or <u>coinsurance</u> for a virtual visit through MD Live.
If you have a test	<u>Diagnostic test</u> (x-ray, blood work)	10% <u>coinsurance</u>	25% <u>coinsurance</u>	None
	Imaging (CT/PET scans, MRIs)	10% <u>coinsurance</u>	25% <u>coinsurance</u>	None

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		PPO <u>Provider</u> (You will pay the least)	Non-PPO <u>Provider</u> (You will pay the most)	
<p>If you need drugs to treat your illness or condition More information about <u>prescription drug coverage</u> is available at www.caremark.com</p>	Generic drugs	<p>\$15 <u>copayment/fill</u> (retail) and \$25 <u>copayment/fill</u> (mail order) after \$60 <u>prescription drug deductible</u>. Medical <u>deductible</u> does not apply.</p>	<p>50% <u>coinsurance</u> (retail) after \$60 <u>prescription drug deductible</u>. Medical <u>deductible</u> does not apply.</p>	<p>34-day supply (retail); 90-day supply (mail order) Maintenance medications limited to 3 fills at a retail pharmacy, then must be filled through mail order. 90-day supply for maintenance drugs is available through CVS Maintenance Choice (retail and mail order).</p>
	Brand drugs	<p>\$20 <u>copayment/fill</u> (retail) and \$35 <u>copayment/fill</u> (mail order) after \$60 <u>prescription drug deductible</u>, plus the difference between generic and brand when generic is available. Medical <u>deductible</u> does not apply.</p>	<p>50% <u>coinsurance</u> (retail) after \$60 <u>prescription drug deductible</u>. Medical <u>deductible</u> does not apply.</p>	<p>Your <u>cost sharing</u> does not count toward the <u>out-of-pocket limit</u>. Individuals age 19 and younger subject to opioid utilization program, which includes limiting members new to therapy to a 3-day supply. Vaccines for flu, pneumococcal, shingles and TDAP will be subject to \$0 <u>copayment</u> when obtained from a CVS pharmacy.</p>
	Specialty drugs through <u>prescription drug program</u>	<p>10% <u>coinsurance</u> (retail and mail order) after \$60 <u>prescription drug deductible</u> up to \$125 maximum/fill. Medical <u>deductible</u> does not apply.</p>	<p>50% <u>coinsurance</u> (retail) after \$60 <u>prescription drug deductible</u>. Medical <u>deductible</u> does not apply.</p>	<p>Specialty Medications included on the Select Drugs and Products List that are administered by a healthcare provider in a hospital, clinic or facility and those self-administered are subject to precertification for medical necessity and participation in the Select Drugs and Products Program. All covered persons receiving specialty medications included on the Select Drugs and Products List must enroll in the Select Drugs and Products Program. Specialty medications are subject to prior authorization, step-therapy, and administrative review that may require specific drug distribution channels be used. Failure to obtain medical necessity may result in a cost containment penalty equal to 100% reduction in benefits payable.</p>

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		PPO <u>Provider</u> (You will pay the least)	Non-PPO <u>Provider</u> (You will pay the most)	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	10% <u>coinsurance</u>	25% <u>coinsurance</u>	Certain <u>out-of-network</u> costs are treated as <u>in-network</u> costs as described on page 2.
	Physician/surgeon fees	10% <u>coinsurance</u>	25% <u>coinsurance</u>	<u>Provider</u> charges for co-surgeons are limited to 50% of <u>allowed amount</u> . <u>Provider</u> charges for assistant surgeons are limited to 20% of <u>allowed amount</u> . No coverage for organ transplants without precertification. Certain <u>out-of-network</u> costs are treated as <u>in-network</u> costs as described on page 2.
If you need immediate medical attention	<u>Emergency room care</u>	10% <u>coinsurance</u> ; \$60 non-accident emergency room <u>deductible</u> applies after first 2 visits per calendar year. Medical <u>deductible</u> does not apply.	25% <u>coinsurance</u> ; \$60 non-accident emergency room <u>deductible</u> applies after first 2 visits per calendar year. Medical <u>deductible</u> does not apply.	\$60 non-accident emergency room <u>deductible</u> does not count toward the <u>out-of-pocket limit</u> .
	<u>Emergency medical transportation</u>	10% <u>coinsurance</u>	10% <u>coinsurance</u> for ground ambulance transportation; 25% <u>coinsurance</u> for all other transportation	<u>Out-of-network</u> air ambulance costs may be treated as <u>in-network</u> costs as described on page 2.
	<u>Urgent care</u>	10% <u>coinsurance</u>	25% <u>coinsurance</u>	None
If you have a hospital stay	Facility fee (e.g., hospital room)	10% <u>coinsurance</u>	25% <u>coinsurance</u>	Charges based on semi-private room rates. Certain <u>out-of-network</u> costs are treated as <u>in-network</u> costs as described on page 2.
	Physician/surgeon fees	10% <u>coinsurance</u>	25% <u>coinsurance</u>	<u>Provider</u> charges for co-surgeons are limited to 50% of <u>allowed amount</u> . <u>Provider</u> charges for assistant surgeons are limited to 20% of <u>allowed amount</u> . No coverage for organ transplants without precertification. Certain <u>out-of-network</u> costs are treated as <u>in-network</u> costs as described on page 2.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		PPO <u>Provider</u> (You will pay the least)	Non-PPO <u>Provider</u> (You will pay the most)	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	\$15 <u>copayment</u> /office visit; 10% <u>coinsurance</u> for all other services.	\$15 <u>copayment</u> /office visit; 25% <u>coinsurance</u> for all other services.	Certain services are available through MD Live. There is no <u>copayment</u> , <u>deductible</u> , or <u>coinsurance</u> for a virtual visit through MD Live. Dependents must be 12 years old to use this service and dependents under age 18 require a parent/guardian present. Certain <u>out-of-network</u> costs are treated as <u>in-network</u> costs as described on page 2.
	Inpatient services	10% <u>coinsurance</u>	25% <u>coinsurance</u>	Charges based on semi-private room rates. Certain <u>out-of-network</u> costs are treated as <u>in-network</u> costs as described on page 2.
if you are pregnant	Office visits	10% <u>coinsurance</u>	25% <u>coinsurance</u>	Plan does not cover the pregnancy of a dependent child. Certain <u>out-of-network</u> costs are treated as <u>in-network</u> costs as described on page 2.
	Childbirth/ delivery professional services	10% <u>coinsurance</u>	25% <u>coinsurance</u>	
	Childbirth/ delivery facility services	10% <u>coinsurance</u>	25% <u>coinsurance</u>	
If you need help recovering or have other special health needs	<u>Home health care</u>	10% <u>coinsurance</u>	25% <u>coinsurance</u>	60-day maximum per occurrence.
	<u>Rehabilitation services</u>	10% <u>coinsurance</u>	25% <u>coinsurance</u>	Limited to 12 weeks per calendar year for cardiac rehab. Limited to 48 visits per individual per calendar year combined for physical/massage therapy/acupuncture. Limited to 48 visits per individual per calendar year for speech therapy. Limited to 48 visits per individual per calendar year for occupational therapy. Physical/massage/speech/occupational therapy limits apply to individuals age six and older. There are no limits for dependents under age six if the dependent is making ongoing therapeutic progress.
	<u>Habilitation services</u>	10% <u>coinsurance</u>	25% <u>coinsurance</u>	Coverage is limited to ABA therapy.
	<u>Skilled nursing care</u>	10% <u>coinsurance</u>	25% <u>coinsurance</u>	None
	<u>Durable medical equipment</u>	10% <u>coinsurance</u>	25% <u>coinsurance</u>	Equipment cannot exceed 130% of its wholesale cost.
	<u>Hospice services</u>	10% <u>coinsurance</u>	25% <u>coinsurance</u>	None

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		PPO <u>Provider</u> (You will pay the least)	Non-PPO <u>Provider</u> (You will pay the most)	
If your child needs dental or eye care	Children's eye exam	No charge	No charge	None
	Children's glasses	No charge	No charge	Calendar year maximum of one set of lenses and one pair of frames, or one 12-month supply of contacts, or one frame and one 12-month supply of contacts. One 12-month supply of contacts must be purchased at one time.
	Children's dental check-up	10% <u>coinsurance</u>	10% <u>coinsurance</u>	None

Excluded Services & Other Covered Services:

Services Your <u>Plan</u> Generally Does NOT Cover (Check your policy or <u>plan</u> document for more information and a list of any other <u>excluded services</u>.)		
<ul style="list-style-type: none"> • Cosmetic surgery (except for injury, sickness, disease, or <u>reconstructive surgery</u> following mastectomy) 	<ul style="list-style-type: none"> • <u>Habilitation services</u> (except for ABA therapy) • Long-term care • Non-emergency care when traveling outside the U.S. 	<ul style="list-style-type: none"> • Private-duty nursing (except for Hospice care) • Weight loss programs

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your <u>plan</u> document.)		
<ul style="list-style-type: none"> • Acupuncture (48 visits per individual per calendar year combined with physical therapy and massage therapy) • Bariatric surgery • Chiropractic care (up to 48 visits per individual per calendar year) 	<ul style="list-style-type: none"> • Dental care (Adult) (up to \$1,500 per individual per calendar year) • Hearing aids (up to \$1,250 per ear every 5 years, except for individuals under age 18) • Infertility treatment (artificial means of treatment are excluded) 	<ul style="list-style-type: none"> • Routine eye care (Adult) (up to \$400 per individual per calendar year) • 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 the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or <https://www.dol.gov/agencies/ebsa>. 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 1-800-318-2596.

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 on how 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 Administrator, NECA-IBEW Welfare Trust Fund, 2120 Hubbard Avenue, Decatur, IL 62526-2871, Telephone 1-800-765-4239. You may also contact the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or <https://www.dol.gov/agencies/ebsa>.

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:

Para obtener asistencia en Español, llame al 1-800-765-4239.

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 PPO pre-natal care and a hospital delivery)

■ The <u>plan's</u> overall medical <u>deductible</u>	\$600
■ <u>Specialist copayment</u>	\$15
■ <u>Hospital (facility) coinsurance</u>	10%
■ <u>Other coinsurance</u>	10%

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
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In this example, Peg would pay:

<i>Cost Sharing</i>	
<u>Deductibles*</u>	\$610
<u>Copayments</u>	\$0
<u>Coinsurance</u>	\$1,200
<i>What isn't covered</i>	
Limits or exclusions	\$60
The total Peg would pay is	\$1,870

Managing Joe's type 2 Diabetes

(a year of routine PPO care of a well-controlled condition)

■ The <u>plan's</u> overall medical <u>deductible</u>	\$600
■ <u>Specialist copayment</u>	\$15
■ <u>Hospital (facility) coinsurance</u>	10%
■ <u>Other coinsurance</u>	10%

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
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In this example, Joe would pay:

<i>Cost Sharing</i>	
<u>Deductibles*</u>	\$660
<u>Copayments</u>	\$810
<u>Coinsurance</u>	\$20
<i>What isn't covered</i>	
Limits or exclusions	\$120
The total Joe would pay is	\$1,610

Mia's Simple Fracture

(PPO emergency room visit and follow up care)

■ The <u>plan's</u> overall medical <u>deductible</u>	\$600
■ <u>Specialist copayment</u>	\$15
■ <u>Hospital (facility) coinsurance</u>	10%
■ <u>Other coinsurance</u>	10%

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
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In this example, Mia would pay:

<i>Cost Sharing</i>	
<u>Deductibles*</u>	\$610
<u>Copayments</u>	\$60
<u>Coinsurance</u>	\$180
<i>What isn't covered</i>	
Limits or exclusions	\$0
The total Mia would pay is	\$850

*NOTE: This plan has other deductibles for specific services included in this coverage example. See "Are there other deductibles for specific services?" row above.