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 *Certain out-of-network claims are treated as in-network claims (see page 2).*	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. MD Live visits 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. **$60** prescription drug deductible per individual and **$60** non-accident emergency room deductible 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 deductible amount before this plan begins to pay for these services.
What is the out-of-pocket limit for this plan?	**$1,900** Individual/**$3,800** Family *Certain out-of-network claims are treated as in-network claims (see page 2).*	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-billing charges, deductibles, office visit copayments, prescription drugs, non-accident emergency room deductible, chiropractic services, coinsurance for Non-Centers of Excellence transplant benefits, cost sharing for hearing aids, and health care 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?	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 plan uses a provider network. You will pay less if you use a provider in the plan's 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.

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

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		PPO Provider (You will pay the least)	Non-PPO 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.caremark.com.	Generic drugs	$15 copayment/fill (retail) and $25 copayment/fill (mail order) after $60 prescription drug deductible. Medical deductible does not apply.	50% coinsurance (retail) after $60 prescription drug deductible. Medical deductible does not apply.	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 available through CVS Maintenance Choice (retail and mail order). Your cost sharing does not count toward the out-of-pocket limit. 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 copayment when obtained from a CVS pharmacy.
	Brand drugs	$20 copayment/fill (retail) and $35 copayment/fill (mail order) after $60 prescription drug deductible, plus the difference between generic and brand when generic is available. Medical deductible does not apply.	50% coinsurance (retail) after $60 prescription drug deductible. Medical deductible does not apply.	
	Specialty drugs through prescription drug program	10% coinsurance (retail and mail order) after $60 prescription drug deductible up to $125 maximum/fill. Medical deductible does not apply.	50% coinsurance (retail) after $60 prescription drug deductible. Medical deductible does not apply.	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.

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

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		PPO Provider (You will pay the least)	Non-PPO Provider (You will pay the most)	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$15 copayment/office visit; 10% coinsurance for all other services	$15 copayment/office visit; 25% coinsurance for all other services	Certain services are available through MD Live. There is no copayment, deductible, or coinsurance 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 out-of-network costs are treated as in-network costs as described on page 2.
	Inpatient services	10% coinsurance	25% coinsurance	Charges based on semi-private room rates. Certain out-of-network costs are treated as in-network costs as described on page 2.
If you are pregnant	Office visits	10% coinsurance	25% coinsurance	Plan does not cover the pregnancy of a dependent child. Certain out-of-network costs are treated as in-network costs as described on page 2.
	Childbirth/delivery professional services	10% coinsurance	25% coinsurance	
	Childbirth/delivery facility services	10% coinsurance	25% coinsurance	
If you need help recovering or have other special health needs	Home health care	10% coinsurance	25% coinsurance	60-day maximum per occurrence.
	Rehabilitation services	10% coinsurance	25% coinsurance	Limited to 12 weeks per individual 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.
	Habilitation services	10% coinsurance	25% coinsurance	Coverage is limited to ABA therapy.
	Skilled nursing care	10% coinsurance	25% coinsurance	None

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		PPO Provider (You will pay the least)	Non-PPO Provider (You will pay the most)	
	Durable medical equipment	10% coinsurance	25% coinsurance	Equipment cannot exceed 130% of its wholesale cost.
	Hospice services	10% coinsurance	25% coinsurance	None
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.
	Children's dental check-up	10% coinsurance	10% coinsurance	None

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 (except for injury, sickness, disease, or reconstructive surgery following mastectomy)
- Habilitation services (except for ABA therapy)
- Long-term care
- Non-emergency care when traveling outside the U.S.
- 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 plan document.)

- Acupuncture (up to 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)
- 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)
- 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 plan's overall medical deductible	**$600**
Specialist copayment	**$15**
Hospital (facility) coinsurance	**10%**
Other coinsurance	**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**

In this example, Peg would pay:

Cost Sharing	
Deductibles*	$640
Copayments	$0
Coinsurance	$1,200
What isn't covered	
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 plan's overall deductible	**$600**
Specialist copayment	**$15**
Hospital (facility) coinsurance	**10%**
Other coinsurance	**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**

In this example, Joe would pay:

Cost Sharing	
Deductibles*	$660
Copayments	$810
Coinsurance	$20
What isn't covered	
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 plan's overall deductible	**$600**
Specialist copayment	**$15**
Hospital (facility) coinsurance	**10%**
Other coinsurance	**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**

In this example, Mia would pay:

Cost Sharing	
Deductibles*	$610
Copayments	$60
Coinsurance	$180
What isn't covered	
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.

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