IBEW-NECA SW Health & Benefit Fund: Sub-Plan B2

Coverage Period: 09/01/2015 - 08/31/2016

Summary of Benefits and Coverage: What this Plan Covers & What it Costs

Coverage for: Individual + Family | **Plan Type:** PPO

This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document by calling **1-800-527-0320**.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	**$300** person/**$600** family. Doesn't apply to vision. Balance billing and excluded services do not count toward the **deductible**.	You must pay all the costs up to the **deductible** amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the **deductible** starts over (usually, but not always, January 1st). See the chart starting on page 2 for how much you pay for covered services after you meet the **deductible**.
Are there other deductibles for specific services?	Yes. **$200** non-PPO hospital deductible. There are no other specific **deductibles**.	You must pay all of the costs for these services up to the specific **deductible** amount before this plan begins to pay for these services.
Is there an out–of–pocket limit on my expenses?	No.	There's no limit on how much you could pay during a coverage period for your share of the cost of covered services.
What is not included in the out–of–pocket limit?	This plan has no **out-of-pocket limit**.	Not applicable because there's no **out-of-pocket limit** on your expenses.
Is there an overall annual limit on what the plan pays?	No.	The chart starting on page 2 describes any limits on what the plan will pay for *specific* covered services, such as office visits.
Does this plan use a network of providers?	Yes. For a list of **providers**, see **www.bcbsil.com**.	If you use an in-network doctor or other health care **provider**, this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network **provider** for some services. Plans use the term in-network, **preferred**, or participating for **providers** in their **network**. See the chart starting on page 2 for how this plan pays different kinds of **providers**.
Do I need a referral to see a specialist?	No.	You can see the **specialist** you choose without permission from this plan.

Questions: Call **1-800-527-0320**.

If you aren't clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary at **www.dol.gov/ebsa/healthreform** or call **1-800-527-0320** to request a copy.

Important Questions	Answers	Why this Matters:
Are there services this plan doesn't cover?	Yes.	Some of the services this plan doesn't cover are listed on page 6. See your policy or plan document for additional information about **excluded services**.

- **Copayments** are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.
- **Coinsurance** is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is $1,000, your **coinsurance** payment of 20% would be $200. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount.** If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges $1,500 for an overnight stay and the **allowed amount** is $1,000, you may have to pay the $500 difference. (This is called **balance billing**.)
- This plan may encourage you to use in-network **providers** by charging you lower **deductibles**, **copayments** and **coinsurance** amounts.

Common Medical Event	Service You May Need	Your Cost if You Use an In-Network Provider	Your Cost if You Use an Out-of-Network Provider	Limitations & Exceptions
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	20% coinsurance	50% coinsurance	-- None --
	Specialist visit	20% coinsurance	50% coinsurance	-- None --
	Other practitioner office visit	Chiropractic and acupuncture not covered	Chiropractic and acupuncture not covered	You must pay 100% of these expenses, even in-network.
	Preventive care/ screening/immunization	Not covered	Not covered	You must pay 100% of these expenses, even in-network.
If you have a test	Diagnostic test (x-ray, blood work)	20% coinsurance	50% coinsurance	-- None --
	Imaging (CT/PET scans, MRIs)	20% coinsurance	50% coinsurance	-- None --

Common Medical Event	Service You May Need	Your Cost if You Use an In-Network Provider	Your Cost if You Use an Out-of-Network Provider	Limitations & Exceptions
If you need drugs to treat your illness or condition	Generic drugs	10% coinsurance	10% coinsurance	-- None --
	Preferred brand drugs	25% coinsurance	25% coinsurance	No benefits are available for a brand name drug for which a generic equivalent is available. This applies even if your physician prescribes a brand name drug for which there is a generic equivalent available and indicates "dispense as written."
	Specialty drugs	Not covered, except as noted under "Limitations & Exceptions" column	Not covered, except as noted under "Limitations & Exceptions" column	Specialty drugs administered in a physician's office will be covered up to a maximum of two times for each newly prescribed specialty drug.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance	50% coinsurance	Coverage limited to lesser of 20 hospital days (inpatient or outpatient), or two surgeries or admissions per calendar year.
	Physician/surgeon fees	20% coinsurance	50% coinsurance	-- None --
If you need immediate medical attention	Emergency room services	20% coinsurance	50% coinsurance	Must be in connection with bona fide emergency.
	Emergency medical transportation	20% coinsurance	50% coinsurance	Limited to ground or commercial air transportation to/from nearest facility able to provide necessary treatment. Must be in connection with bona fide emergency.
	Urgent care	20% coinsurance	50% coinsurance	-- None --
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance	50% coinsurance	Coverage limited to lesser of 20 hospital days (inpatient or outpatient), or two surgeries or admissions per calendar year. Precertification required or benefits reduced 50% up to maximum reduction of $250.
	Physician/surgeon fee	20% coinsurance	50% coinsurance	-- None --

Common Medical Event	Service You May Need	Your Cost if You Use an In-Network Provider	Your Cost if You Use an Out-of-Network Provider	Limitations & Exceptions
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	20% coinsurance	50% coinsurance	-- None --
	Mental/Behavioral health inpatient services	20% coinsurance	50% coinsurance	Coverage limited to lesser of 20 hospital days (inpatient or outpatient), or two surgeries or admissions per calendar year. Precertification required or benefits reduced 50% up to maximum reduction of $250.
	Substance use disorder outpatient services	20% coinsurance	50% coinsurance	-- None --
	Substance use disorder inpatient services	20% coinsurance	50% coinsurance	Coverage limited to lesser of 20 hospital days (inpatient or outpatient), or two surgeries or admissions per calendar year. Precertification required or benefits reduced 50% up to maximum reduction of $250.
If you are pregnant	Prenatal and postnatal care	20% coinsurance	50% coinsurance	Not covered for any dependent other than the employee's spouse.
	Delivery and all inpatient services	20% coinsurance	50% coinsurance	Not covered for any dependent other than the employee's spouse.

Common Medical Event	Service You May Need	Your Cost if You Use an In-Network Provider	Your Cost if You Use an Out-of-Network Provider	Limitations & Exceptions
If you need help recovering or have other special health needs	Home health care	20% coinsurance	50% coinsurance	-- None --
	Rehabilitation services	20% coinsurance	50% coinsurance	Physical therapy limited to 20 visits per calendar year. Speech therapy must be to restore speech loss, or correct impairment, due to (1) a congenital defect for which corrective surgery has been performed, or (2) an injury or sickness. Occupational therapy not covered.
	Habilitation services	20% coinsurance	50% coinsurance	
	Skilled nursing care	20% coinsurance	50% coinsurance	-- None --
	Durable medical equipment	20% coinsurance	50% coinsurance	Limited to least expensive of appropriate treatment or equipment.
	Hospice service	Not covered	Not covered	You must pay 100% of these expenses, even in-network.
If your child needs dental or eye care	Eye exam	$50 copay with purchase of complete pair of prescription glasses; 20% discount without purchase of complete pair of prescription glasses.	Not covered	Limited to one eye exam per calendar year.
	Glasses	Lenses: $40 copay for single vision lenses with purchase of complete pair of prescription glasses; Frames: 25% discount with purchase of complete pair of prescription glasses	Not covered	-- None --
	Dental check-up	Not covered	Not covered	You must pay 100% of these expenses, even in-network.

Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover **(This isn't a complete list. Check your policy or plan document for other excluded services.)**

- Acupuncture
- Bariatric surgery
- Chiropractic care
- Cosmetic surgery (except for treatment of an accidental injury where treatment is begun within six months after the accident, treatment of a congenital anomaly in a child or in connection with a mastectomy)
- Dental care
- Hearing aids
- Hospice service
- Infertility treatment
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Preventive care/screening/immunization
- Private-duty nursing
- Routine foot care
- Weight loss programs

Other Covered Services **(This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)**

- Routine eye care (Adult)

Your Rights to Continue 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 1-800-527-0320. You may also contact your state insurance department, 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 x61565 or www.cciio.cms.gov.

Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to **appeal** or file a **grievance**. For questions about your rights, this notice, or assistance, you can contact the plan at 1-800-527-0320. You may also contact the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform.

Does this Coverage Provide Minimum Essential Coverage?

The Affordable Care Act requires most people to have health care coverage that qualifies as "minimum essential coverage." **This plan or policy does provide minimum essential coverage.**

Does this Coverage Meet the Minimum Value Standard?

The Affordable Care Act establishes a minimum value standard of benefits of a health plan. The minimum value standard is 60% (actuarial value). **This health coverage does meet the minimum value standard for the benefits it provides.**

Language Access Services: SPANISH (Español): Para obtener asistencia en Español, llame al 1-800-527-0320.

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

About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.

This is not a cost estimator.

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

Having a baby
(normal delivery)

- **Amount owed to providers:** $7,540
- **Plan pays** $5,660
- **Patient pays** $1,880

Sample care costs:

Hospital charges (mother)	$2,700
Routine obstetric care	$2,100
Hospital charges (baby)	$900
Anesthesia	$900
Laboratory tests	$500
Prescriptions	$200
Radiology	$200
Vaccines, other preventive	$40
Total	**$7,540**

Patient pays:

Deductibles	$300
Copays	$0
Coinsurance	$1,390
Limits or exclusions	$190
Total	**$1,880**

Managing type 2 diabetes
(routine maintenance of a well-controlled condition)

- **Amount owed to providers:** $5,400
- **Plan pays** $4,160
- **Patient pays** $1,240

Sample care costs:

Prescriptions	$2,900
Medical Equipment and Supplies	$1,300
Office Visits and Procedures	$700
Education	$300
Laboratory tests	$100
Vaccines, other preventive	$100
Total	**$5,400**

Patient pays:

Deductibles	$300
Copays	$0
Coinsurance	$860
Limits or exclusions	$80
Total	**$1,240**

Questions and answers about the Coverage Examples:

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**, **copayments**, and **coinsurance** 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 Examples to compare plans?

✓ **Yes.** When you look at the Summary of 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 **copayments**, **deductibles**, and **coinsurance**. 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.

Questions: Call **1-800-527-0320**.
If you aren't clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary at **www.dol.gov/ebsa/healthreform** or call **1-800-527-0320** to request a copy.