IBEW Local 22/NECA Health and Welfare Plan

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, visit www.22benefits.aibpa.com or call (402) 592-3753 or toll-free (855) 330-3242. 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 (402) 592-3753 or toll-free (855) 330-3242 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	In-Network: $700 Individual / $2,100 Family Out-of-Network: $700 Individual / $2,100 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. Most preventive care, nurse practitioner clinics, In-Network telehealth, and Prescription Drug Benefits are covered before you meet your deductible. If eligible, the HRA may be used to offset all or a portion of 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. For example, this plan covers certain preventive services without cost-sharing and before you meet your deductible. See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/.
Are there other deductibles for specific services?	No.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	Medical (excludes prescription drug copayments) In-Network: $4,500 Ind'l / $9,000 Family Out-of-Network: No out-of-pocket limit Prescription (applies only to prescription drug copayments) In-Network: $2,650 Ind'l / $5,300 Family Out-of-Network: No out-of-pocket limit	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, the overall family out-of-pocket limit must be met.
What is not included in the out-of-pocket limit?	Premiums, balance billing charges and health care this plan doesn't cover. The amount of any coupon, rebate, or other financial assistance applied directly towards a specialty drugs copayment at the time of purchase.	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.umr.com or call (800) 207-3172 for a list of network providers.	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
		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	$20 copayment / visit and 20% coinsurance	$20 copayment / visit and 30% coinsurance	In-Network Telehealth visits covered at no cost. In-Network Retail Nurse Practitioner Clinics paid at 100% after $5 copayment with no deductible. Out-of-Network covered at 30% coinsurance. Some office services are subject to the deductible or coinsurance.
	Specialist visit	$20 copayment / visit and 20% coinsurance	$20 copayment / visit and 30% coinsurance	Some office services are subject to the deductible or coinsurance.
	Preventive care/screening/ immunization	No charge for federally mandated services.	30% coinsurance For immunizations for children up to age 7, the deductible is waived.	Age, gender and frequency limits may apply to some preventive services. 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.
If you have a test	Diagnostic test (x-ray, blood work)	20% coinsurance	30% coinsurance	Benefits will vary based on the place of service and provider type.
	Imaging (CT/PET scans, MRIs)	20% coinsurance	30% coinsurance	Prior certification may apply. Failure to preauthorize may result in a denial of the claim.

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 need drugs to treat your illness or condition More information about prescription drug coverage is available at www.castiarx.com or by calling (866) 516-3121.	Generic drugs	Retail: greater of $10 copayment or 10% coinsurance Mail Order: $20 copayment	Retail: greater of $10 copayment or 10% coinsurance	Retail: 30 day supply; 90 day supply of maintenance medications at Walgreens. Mail Order: 90 day supply. For Out-of-Network claims must submit claim form from pharmacy to CastiaRx for reimbursement. If a generic equivalent is available for a brand name prescription drug, you will be required to pay the applicable copayment plus the price difference between the generic drug and the brand name drug. Prescription drugs that are considered preventive services under the Affordable Care Act are covered at 100% by the plan and are not subject to the deductible or copayments. Please see the SMM dated July 2015 for additional information. Maintenance medication only covered if filled by CastiaRx mail order or at Walgreens retail pharmacies. Specialty drugs only covered if medically necessary and filled through CastiaRx mail order. Alternate copayments may apply to certain specialty drugs eligible for manufacturer discount coupon applied by CastiaRx at time of purchase.
	Preferred brand drugs	Retail: greater of $25 copayment or 20% coinsurance Mail Order: greater of $50 copayment or 20% coinsurance	Retail: greater of $25 copayment or 20% coinsurance	
	Non-preferred brand drugs	Retail: greater of $40 copayment or 40% coinsurance Mail Order: greater of $80 copayment or 40% coinsurance	Retail: greater of $40 copayment or 40% coinsurance	
	Specialty drugs	Retail: greater of $40 copayment or 40% coinsurance Mail Order: greater of $80 copayment or 40% coinsurance	Retail: greater of $40 copayment or 40% coinsurance	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance	30% coinsurance	----------none----------
	Physician/surgeon fees	20% coinsurance	30% coinsurance	----------none----------

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 need immediate medical attention	Emergency room care	$20 copayment / visit and 20% coinsurance	$20 copayment / visit and 20% coinsurance	Copayment waived if admitted.
	Emergency medical transportation	20% coinsurance	20% coinsurance	Limitations may apply to air ambulance.
	Urgent care	$20 copayment / visit and 20% coinsurance	$20 copayment / visit and 20% coinsurance	In-Network Telehealth visits covered at no cost. In-Network Retail Nurse Practitioner Clinics paid at 100% after $5 copayment with no deductible. Out-of-Network covered at 30% coinsurance. Copayment applies to urgent care facilities. Some urgent care services are subject to deductible and coinsurance.
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance	30% coinsurance	Prior certification required. If you have a private room, benefits will be based on the allowable charge for a semiprivate room.
	Physician/surgeon fees	20% coinsurance	30% coinsurance	----------none----------
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Office visit: $20 copayment / visit and 20% coinsurance Other outpatient services: 20% coinsurance	Office visit: $20 copayment / visit and 30% coinsurance Other outpatient services: 30% coinsurance	Some office services are subject to the deductible and coinsurance.
	Inpatient services	20% coinsurance	30% coinsurance	Prior certification required. Failure to preauthorize may result in denial of the claim. No coverage for claims incurred at an Out-of-Network residential treatment facility.
If you are pregnant	Office visits	$20 copayment / visit and 20% coinsurance	$20 copayment / visit and 30% coinsurance	Cost sharing does not apply to preventive services. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound). No coverage for services in connection with a pregnancy of a Dependent child except in limited circumstances when considered preventive under the ACA.
	Childbirth/delivery professional services	20% coinsurance	30% coinsurance	
	Childbirth/delivery facility services	20% coinsurance	30% coinsurance	

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 need help recovering or have other special health needs	Home health care	20% coinsurance	30% coinsurance	Limitations apply. Must be medically necessary and preauthorized. Failure to preauthorize may result in a denial of the claim.
	Rehabilitation services	20% coinsurance	Outpatient: 30% coinsurance Inpatient: Not covered	Outpatient physical, occupational, speech, physiotherapy: Combined 60 sessions/year. Outpatient cardiac or pulmonary rehabilitation: Combined 18 session limit per diagnoses for certain cardiac diagnoses. Inpatient physical rehabilitation: Must follow within 90 days of discharge from acute hospitalization. Some services require prior certification. Failure to preauthorize may result in a denial of the claim.
	Habilitation services	20% coinsurance	30% coinsurance	See the "Rehabilitation services" and "If you have a hospital stay" sections. Educational services are not covered.
	Skilled nursing care	20% coinsurance	Not covered	Limited to 60 days per calendar year. Prior certification is required. Failure to preauthorize may result in a denial of the claim.
	Durable medical equipment	20% coinsurance	30% coinsurance	Rental or purchase, whichever is least costly. Must be prescribed by a physician. Prior certification is required for subsequent purchases. Failure to preauthorize may result in a denial of the claim.
	Hospice services	20% coinsurance	30% coinsurance	Limited to 180 days per calendar year inpatient/outpatient, combined. Prior certification is required. Failure to preauthorize may result in a denial of the claim. Additional limits may apply.
If your child needs dental or eye care	Children's eye exam	Not covered	Not covered	No coverage for eye exams.
	Children's glasses	Not covered	Not covered	No coverage for glasses.
	Children's dental check-up	Not covered	Not covered	No coverage for dental check-ups.

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.)

- Acupuncture
- Bariatric surgery
- Cosmetic surgery
- Dental care (adult and child – except in limited circumstances; refer to SPD for complete benefit information)*
- Glasses (except as a result of covered intraocular surgery or ocular injury)
- Hearing aids
- Infertility treatment
- Long-term care
- Private duty nursing
- Routine eye care (adult and child)
- Routine foot care
- Weight loss programs (except those covered under ACA preventive care guidelines)

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

- Chiropractic care
- Non-emergency care when traveling outside the U.S.

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 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 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 (402) 592-3753 or toll-free (855) 330-3242 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:

Spanish (Español): Para obtener asistencia en Español, llame al (402) 592-3753.

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

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

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	$700
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	$12,840

In this example, Peg would pay:

Cost Sharing	
Deductibles	$700
Copayments	$20
Coinsurance	$2,520
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	$3,300

Managing Joe's type 2 Diabetes
(a year of routine In-network care of a well-controlled condition)

The plan's overall deductible	$700
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	$7,460

In this example, Joe would pay:

Cost Sharing	
Deductibles	$700
Copayments	$40
Coinsurance	$1,370
What isn't covered	
Limits or exclusions	$60
The total Joe would pay is	$2,170

Mia's Simple Fracture
(In-network emergency room visit and follow up care)

The plan's overall deductible	$700
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	$2,010

In this example, Mia would pay:

Cost Sharing	
Deductibles	$700
Copayments	$20
Coinsurance	$390
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	$1,110

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