IBEW LOCAL NO. 9 LINE CLEARANCE HEALTH AND WELFARE BENEFIT FUND

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.ibew9lctt.org or call 1-877-423-9155. 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 1-855-756-4448 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	$250 / individual or $500 / 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. Preventive care and primary care services 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. 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?	Yes, for dental services.	For dental services there is a $25 individual and $75 family deductible.
What is the out-of-pocket limit for this plan?	For network providers $1,250 individual / $2,500 family; for out-of-network providers $2,250 individual / $4,500 family. Non-administrator provider no 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, 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?	Copayments, out-of-network balance-billing charges, deductible 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.bcbsil.com or call 1-800-367-8309 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 use 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	$10 copay/office visit. Deductible does not apply.	$10 copay then 20% coinsurance per office visit. Deductible does not apply.	$10 copay then 50% coinsurance for the non-administrator level of benefits. Out-of-network may balance bill.
	Specialist visit	$10 copay/office visit. Deductible does not apply.	$10 copay then 20% coinsurance per office visit. Deductible does not apply.	$10 copay then 50% coinsurance for the non-administrator level of benefits. Out-of-network may balance bill.
	Preventive care/screening/ immunization	No charge. Deductible does not apply.	No charge. Deductible does not apply.	Out-of-network may balance bill.
If you have a test	Diagnostic test (x-ray, blood work)	10% coinsurance after deductible.	20% coinsurance after deductible.	Non-administrator provider 50% coinsurance. Out-of-network may balance bill.
	Imaging (CT/PET scans, MRIs)	10% coinsurance after deductible.	20% coinsurance after deductible.	
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.[insert].com	Generic drugs	$5 copay for retail 30–day supply; $10 copay for mail order 90-day supply.	$5 copay plus an additional 25% of BCBS approved amount for the drug.	Mail order drugs are not covered out-of-network.
	Preferred brand drugs	$20 copay for retail 30–day supply; $40 copay for mail order 90-day supply.	$20 copay plus an additional 25% of BCBS approved amount for the drug.	
	Non-preferred brand drugs	$40 copay for retail 30–day supply; $80 copay for mail order 90-day supply.	$40 copay plus an additional 25% of BCBS approved amount for the drug.	
	Specialty drugs	Retail copay based on prescription tier.	Retail copay based on prescription tier plus 25% of total cost.	Required to use Prime Therapeutics Specialty Pharmacy to obtain coverage for all specialty medications.

* For more information about limitations and exceptions, see the plan or policy document at www.ibew9lctt.org.

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 have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	10% coinsurance after deductible.	20% coinsurance after deductible.	Non-administrator provider 50% coinsurance. Out-of-network may balance bill.
	Physician/surgeon fees	10% coinsurance after deductible.	20% coinsurance after deductible.	Non-administrator provider 50% coinsurance. Out-of-network may balance bill.
If you need immediate medical attention	Emergency room care	No charge. Deductible does not apply.	No charge. Deductible does not apply.	Non-administrator provider 50% coinsurance. Out-of-network may balance bill.
	Emergency medical transportation	20% coinsurance after deductible.	20% coinsurance after deductible.	
	Urgent care	10% coinsurance after deductible.	20% coinsurance after deductible.	
If you have a hospital stay	Facility fee (e.g., hospital room)	10% coinsurance after deductible.	20% coinsurance after deductible.	Non-administrator provider 50% coinsurance. Out-of-network may balance bill.
	Physician/surgeon fees	10% coinsurance after deductible.	20% coinsurance after deductible.	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	10% coinsurance after deductible.	20% coinsurance after deductible.	Must pre-authorize through MAP for serious mental illness or you will be responsible for the first $250 hospital charge. Out-of-network may balance bill. Non-administrator provider 50% coinsurance.
	Inpatient services	10% coinsurance after deductible.	20% coinsurance after deductible.	
If you are pregnant	Office visits, prenatal and postnatal care	$10 copay/office visit. 10% coinsurance after deductible.	$10 copay/office visit. 20% coinsurance after deductible.	Non-administrator provider 50% coinsurance. Out-of-network may balance bill.
	Childbirth/delivery professional services	10% coinsurance after deductible.	20% coinsurance after deductible.	
	Childbirth/delivery facility services	10% coinsurance after deductible.	20% coinsurance after deductible.	

* For more information about limitations and exceptions, see the plan or policy document at www.ibew9lctt.org.

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	10% coinsurance after deductible.	20% coinsurance after deductible.	Out-of-network may balance bill; must be medically necessary and provided and billed by a participating home health care agency. Up to 50 visits allowed.
	Rehabilitation services	10% coinsurance after deductible.	20% coinsurance after deductible.	Physical, Occupational, Speech therapy is limited to a maximum of 60 visits per individual per calendar year. Out-of-network may balance bill.
	Habilitation services	10% coinsurance after deductible.	20% coinsurance after deductible.	Out-of-network may balance bill.
	Skilled nursing care	10% coinsurance after deductible.	20% coinsurance after deductible.	Out-of-network may balance bill; must be in a participating skilled nursing facility; no limit on the number of days.
	Durable medical equipment	10% coinsurance after deductible.	20% coinsurance after deductible.	Non-participating providers may balance bill.
	Hospice services	10% coinsurance after deductible.	20% coinsurance after deductible.	Provided through a participating hospice program only; no lifetime maximum.
If your child needs dental or eye care	Children's eye exam	No charge	Covered up to $25	None.
	Children's glasses	No charge for lenses. Frames covered up to $175.	Single vision lenses covered up to $30. Frames covered up to $45.	None.
	Children's dental check-up	$25 individual / $75 family deductible.	$25 individual / $75 family deductible.	Maximum dental benefits of $1,500 per individual, per calendar year. The calendar year maximum benefit does not apply to covered individuals younger than age 18. Limited to one check-up per individual every 6 months.

* For more information about limitations and exceptions, see the plan or policy document at www.ibew9lctt.org.

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
- Cosmetic surgery (not medically necessary)
- Infertility treatment
- Long-term care
- Weight loss programs

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

- Chiropractic Care ($10 copay per visit maximum of $70 per visit and limit to 13 visits per calendar year)
- Dental care (Adult and Child)
- Hearing aids ($3,000 per every three years)
- Non-emergency care when traveling outside of the U.S.
- Private-duty nursing (maximum of $3,000 per month)
- Routine eye care (Adult & Child)
- Smoking cessation program
- Weight loss counseling

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, Employee Benefits Security Administration 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 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: www.ibew9lctt.org or 1-877-423-9155.

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:

[Spanish (Español): Para obtener asistencia en Español, llame al 1-877-423-9155.

[Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-877-423-9155.

[Chinese (中文): 如果需要中文的帮助，请拨打这个号码1-877-423-9155.

[Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-877-423-9155

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 the plan or policy document at www.ibew9lctt.org.

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	$250
Specialist copayment	$10
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	$250
Copayments	$100
Coinsurance	$700
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$1,110**

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

The plan's overall deductible	$250
Specialist copayment	$10
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*	$250
Copayments	$200
Coinsurance	$500
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$970**

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

The plan's overall deductible	$250
Specialist copayment	$10
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*	$250
Copayments	$100
Coinsurance	$300
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$650**

Note: These numbers assume the patient does not participate in the plan's wellness program. If you participate in the plan's wellness program, you may be able to reduce your costs. For more information about the wellness program, please contact: [insert].
*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.