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, you can go to www.nifmcp.com or call 1-877-937-9602. 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 1-877-937-9602 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	PPO **$200** per person/**$400** per family; Non-PPO **$400** per person/**$800** per 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 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.
Are there other deductibles for specific services?	Yes. $100 for emergency room services.	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.
What is the out-of-pocket limit for this plan?	For network providers **$1,400** per person/ **$2,800** per family, Non-PPO **$1,400** per person/ **$2,800** per family (medical); **$1,000** per person/**$2,000** per family (Rx).	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, expenses for out-of-network services, 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.nifmcp.com or call 1-800-810-2583 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	No.	You can see the specialist you choose without a referral.

Important Questions	Answers	Why This Matters:
see a specialist?		

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	20% coinsurance	None.
	Specialist visit	$20 copayment	20% coinsurance	None.
	Preventive care/screening/ immunization	No charge.	No charge.	You are responsible for any balance-billing charges.
If you have a test	Diagnostic test (x-ray, blood work)	No charge.	20% coinsurance	Precertification required unless an emergency. No charge for professional charges by an out-of-network radiologist, pathologist or anesthesiologist for services provided at a network hospital.
	Imaging (CT/PET scans, MRIs)	No charge.	20% coinsurance	Precertification required unless an emergency. No charge for professional charges by an out-of-network radiologist, pathologist or anesthesiologist for services provided at a network hospital.
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.savrx.com	Generic drugs	No charge.	Not covered.	If you decline a generic substitution, you must pay the cost difference between the brand and generic. The difference does not apply to your out-of-pocket limit.
	Preferred brand drugs	20% coinsurance	Not covered.	None.
	Non-preferred brand drugs	30% coinsurance	Not covered.	Minimum $40 retail, $80 mail.
	Specialty drugs	No charge, 20% or 30% coinsurance	Not covered.	Your coinsurance cost varies depending on the prescription drug. Certain drugs may require prior authorization under the Plan's Step Therapy Program.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	No charge.	Not covered.	No coverage for out-of-network ambulatory surgical centers.

[* For more information about limitations and exceptions, see the plan or policy document at www.nifmcp.com.

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)	
	Physician/surgeon fees	No charge.	20% coinsurance	None.
If you need immediate medical attention	Emergency room care	$100 emergency room deductible per occurrence.	$100 emergency room deductible per occurrence.	$100 emergency room deductible is waived if visit results in an inpatient admission.
	Emergency medical transportation	No charge.	20% coinsurance	None.
	Urgent care	$20 copayment	20% coinsurance	None.
If you have a hospital stay	Facility fee (e.g., hospital room)	No charge.	20% coinsurance	$250 benefit reduction for failure to pre-certify an inpatient hospitalization.
	Physician/surgeon fees	No charge.	20% coinsurance	$250 benefit reduction for failure to pre-certify an inpatient hospitalization.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	No charge.	20% coinsurance	None.
	Inpatient services	No charge.	20% coinsurance	None.
If you are pregnant	Office visits	No charge.	20% coinsurance	Cost sharing does not apply to certain preventive services. Depending on the type of services, coinsurance may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound). No maternity coverage for dependent children.
	Childbirth/delivery professional services	No charge.	20% coinsurance	Cost sharing does not apply to certain preventive services. Depending on the type of services, coinsurance may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound). No maternity coverage for dependent children.
	Childbirth/delivery facility services	No charge.	20% coinsurance	Cost sharing does not apply to certain preventive services. Depending on the type of services, coinsurance may apply. Maternity care may include tests and services described elsewhere in the SBC

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)	
				(i.e. ultrasound). No maternity coverage for dependent children.
If you need help recovering or have other special health needs	Home health care	No charge.	20% coinsurance	Maximum 120 visits per calendar year.
	Rehabilitation services	No charge.	20% coinsurance	Maximum 50 visits per calendar year for speech therapy to restore speech lost due to stroke or trauma. No coverage for services due to developmental delays/learning disorders.
	Habilitation services	Not covered.	Not covered.	No coverage for services due to developmental delays/learning disorders.
	Skilled nursing care	No charge.	20% coinsurance	60 maximum allowable days per calendar year.
	Durable medical equipment	No charge.	20% coinsurance	Pre-certification required.
	Hospice services	No charge.	20% coinsurance	None.
If your child needs dental or eye care	Children's eye exam	No charge.	$35 allowed per calendar year.	Maximum 1 exam per calendar year.
	Children's glasses	No charge for lenses; $180 allowed for frames.	$30-55 allowed per calendar year.	Maximum 1 pair of glasses per calendar year.
	Children's dental check-up	$25 deductible per person ($75 per family) then no charge.	$25 deductible per person ($75 per family) no charge.	$1,500 maximum benefit per calendar year; orthodontia covered at 50% up to $2,000 for children up to age 26.

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 (except for correction of defects incurred through traumatic injuries sustained as a result of an accident within one year of the accident; correction of congenital defects; or breast reconstruction following a mastectomy).
- Habilitation Services
- Infertility Treatment
- Long Term Care
- Private Duty Nursing
- Routine Foot Care
- Weight Loss Programs

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

[* For more information about limitations and exceptions, see the plan or policy document at www.nifmcp.com.

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)		
• Chiropractic Care (Maximum 30 visits per calendar year)	• Dental Care (Adult) • Hearing Aids (one per ear per lifetime)	• Non-emergency care when traveling outside U.S. See www.nifmcp.com • Routine Eye Care (Adult)

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 1-877-937-9602. 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 NECA/IBEW Family Medical Care Plan Benefit Office at 1-877-937-9602.

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 [insert telephone number].]

[Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa [insert telephone number].]

[Chinese (中文): 如果需要中文的帮助，请拨打这个号码[insert telephone number].]

[Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' [insert telephone number].]

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 in-network pre-natal care and a hospital delivery)

The plan's overall deductible	**$200**
Specialist copayment	**$20**
Hospital (facility) coinsurance	**0%**
Other coinsurance	**0%**

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	$200
Copayments	$0
Coinsurance	$0
What isn't covered	
Limits or exclusions	$600*
The total Peg would pay is	**$800**

**Genetic tests are excluded.*

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

The plan's overall deductible	**$200**
Specialist copayment	**$20**
Hospital (facility) coinsurance	**0%**
Other coinsurance	**0%**

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	$200
Copayments	$140
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Joe would pay is	**$340**

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

The plan's overall deductible	**$200**
Specialist copayment	**$20**
Hospital (facility) coinsurance	**0%**
Other coinsurance	**0%**

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	$200
Copayments	$100
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$300**

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