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 **1-800-499-1275** or visit us at www.excellusbcbs.com/IBEW910. 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.cciio.cms.gov or www.healthcare.gov/sbc-glossary or call 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 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?	No	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	For network providers and out-of-network providers **$1,000** per individual.	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.
What is not included in the out-of-pocket limit?	Deductibles, Copayments, premiums, balance-billing charges, 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.excellusbcbs.com/IBEW910 or call 1-800-499-1275 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% coinsurance	20% coinsurance, up to allowable amount.	Subject to deductible
	Specialist visit	20% coinsurance	20% coinsurance, up to allowable amount.	Subject to deductible
	Preventive care/screening/ immunization	No charge	20% coinsurance, up to allowable amount.	You may have to pay for services that aren't preventive. Ask your provider if the services you need are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	20% coinsurance	20% coinsurance, up to allowable amount.	Subject to deductible
	Imaging (CT/PET scans, MRIs)	20% coinsurance	20% coinsurance, up to allowable amount.	Subject to deductible
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at **www.savrx.com**.	Generic drugs	20% coinsurance (Retail & Mail order)	Not Covered	**Retail** prescriptions limited to 30-day supply. **Mail order** prescriptions limited to 90-day supply.
	Preferred brand drugs	20% coinsurance (Retail & Mail order)	Not Covered	
	Non-preferred brand drugs	20% coinsurance (Retail & Mail order)	Not Covered	
	Specialty drugs	20% coinsurance (Retail & Mail order)	Not Covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	No Charge	20% coinsurance, up to allowable amount.	None
	Physician/surgeon fees	No Charge	20% coinsurance, up to allowable amount.	None
If you need immediate medical attention	Emergency room care	No Charge	20% coinsurance, up to allowable amount.	None
	Emergency medical transportation	20% coinsurance	20% coinsurance, up to allowable amount.	Subject to deductible
	Urgent care	20% coinsurance	20% coinsurance, up to allowable amount.	Subject to deductible

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 a hospital stay	Facility fee (e.g., hospital room)	No Charge	20% coinsurance, up to allowable amount.	None
	Physician/surgeon fees	No Charge	20% coinsurance, up to allowable amount.	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	20% coinsurance	20% coinsurance, up to allowable amount.	**Outpatient mental/behavioral** services are subject to deductible. **Outpatient substance abuse** services are covered in full for a network provider.
	Inpatient services	No Charge	20% coinsurance, up to allowable amount.	None
If you are pregnant	Office visits	No Charge	20% coinsurance, up to allowable amount.	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).
	Childbirth/delivery professional services	No Charge	20% coinsurance, up to allowable amount.	
	Childbirth/delivery facility services	No Charge	20% coinsurance, up to allowable amount.	
If you need help recovering or have other special health needs	Home health care	No Charge	20% coinsurance, up to allowable amount.	None
	Rehabilitation services	20% coinsurance	20% coinsurance, up to allowable amount.	Subject to deductible. Limit: Physical, Occupational and Speech Therapy – 20 visits per calendar year, per therapy.
	Habilitation services	See Rehabilitation services	See Rehabilitation services	See Rehabilitation services
	Skilled nursing care	No Charge	20% coinsurance, up to allowable amount.	None
	Durable medical equipment	20% coinsurance	20% coinsurance, up to allowable amount.	Excludes vehicle modifications, home modifications, exercise, and bathroom equipment.
	Hospice services	No Charge	20% coinsurance, up to allowable amount.	Limited to 210 days per lifetime.
If your child needs dental or eye care	Children's eye exam	Not Covered	Not Covered	Not Covered
	Children's glasses	Not Covered	Not Covered	Not Covered
	Children's dental check-up	Not Covered	Not covered	Not Covered

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
- Dental Care
- Hearing Aids
- Infertility Treatment
- Long Term Care
- Routine eye care (Adult)
- 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.)

- Bariatric Surgery
- Chiropractic Care – Limited to 40 visits per calendar year
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing – Limited to 30 visits per calendar year

Your Rights to Continue Coverage: For more information on your rights to continue coverage, contact the IBEW Local 910 Fund Office at 1-800-801-2201. There are also 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 phone number on Your ID card or; Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform; New York State Department of Financial Services Consumer Assistance Unit at 1-800-342-3736 or www.dfs.ny.gov. Additionally a consumer assistance program can help you file your appeal. Contact the Consumer Assistance Program at 1-888-614-5400, or e-mail cha@cssny.org or www.communityhealthadvocates.org. A list of states with Consumer Assistance Programs is available at: www.dol.gov/ebsa/healthreform and www.cms.gov/CCIIO/Resources/Consumer-Assistance-Grants.

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 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.

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	$250
Specialist coinsurance	20%
Hospital (facility) coinsurance	0%
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	**$12,820**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$0
Copayments	$0
Coinsurance	$0
What isn't covered	
Limits or exclusions	$80
The total Peg would pay is	**$80**

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 coinsurance	20%
Hospital (facility) coinsurance	0%
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	$250
Copayments	$0
Coinsurance	$90
What isn't covered	
Limits or exclusions	$370
The total Joe would pay is	**$710**

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

The plan's overall deductible	$250
Specialist coinsurance	20%
Hospital (facility) coinsurance	0%
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	**$1,970**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$250
Copayments	$0
Coinsurance	$80
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$330**

Note: This plan is integrated with a Health Reimbursement Arrangement ("HRA"). Deductibles, copayments and other qualified out-of-pocket expenses may be reimbursable under the HRA.

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