




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, see www.neibenefits.org or call the plan at 1-800-CLAIM11. 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.dol.gov/ebsa/healthreform or call 1-800-CLAIM11 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	\$300/individual, \$600/family	Generally, you must pay all of the costs from <u>providers</u> up to the <u>deductible</u> amount before this <u>plan</u> begins to pay. If you have other family members on the <u>plan</u> , each family member must meet their own individual <u>deductible</u> until the total amount of <u>deductible</u> expenses paid by all family members meets the overall family <u>deductible</u> .
Are there services covered before you meet your deductible?	Yes. <u>Prescription drugs</u> , <u>preventive care</u> , mental health services, substance abuse services, vision, hearing and services subject to a <u>copayment</u> are covered before you meet your <u>deductible</u> .	This <u>plan</u> covers some items and services even if you haven't yet met the <u>deductible</u> amount. But a <u>copayment</u> or <u>coinsurance</u> may apply. For example, this <u>plan</u> covers certain <u>preventive services</u> without <u>cost sharing</u> and before you meet your <u>deductible</u> . See a list of covered <u>preventive services</u> at https://www.healthcare.gov/coverage/preventive-care-benefits/ .
Are there other deductibles for specific services?	Yes. \$50/individual, \$100/family for dental (not applicable to preventive services). There are no other specific <u>deductibles</u> .	You must pay all of the costs for these services up to the specific <u>deductible</u> amount before this <u>plan</u> begins to pay for these services.
What is the out-of-pocket limit for this plan?	Medical: <u>Network providers</u> : \$300/individual, \$600/family ; Medical: <u>Out-of-network providers</u> : \$1,500/individual, \$3,000/family . Prescription drug: \$7,950/individual, \$15,900/family	The <u>out-of-pocket limit</u> is the most you could pay in a year for covered services. If you have other family members in this <u>plan</u> , they have to meet their own <u>out-of-pocket limits</u> until the overall family <u>out-of-pocket limit</u> has been met.
What is not included in the out-of-pocket limit?	<u>Premiums</u> , <u>balance-billing</u> charges, penalties for failure to obtain <u>preauthorization</u> , <u>vision expenses</u> , <u>coinsurance</u> for chiropractic services, health care this <u>plan</u> doesn't cover, and certain specialty pharmacy drugs that are considered non-essential health benefits (these are generally reimbursed by the manufacturer at no cost to you).	Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u> .
Will you pay less if you use a network provider?	Yes. See www.bcbs.com or call 1-800-810-BLUE for a list of <u>network providers</u> .	This <u>plan</u> uses a <u>provider network</u> . You will pay less if you use a <u>provider</u> in the <u>plan's network</u> . You will pay the most if you use an <u>out-of-network provider</u> , and you might receive a bill from a <u>provider</u> for the difference between the <u>provider's charge</u> and what your <u>plan</u> pays (<u>balance billing</u>). Be aware your <u>network provider</u> might use

Important Questions	Answers	Why This Matters:
		an <u>out-of-network provider</u> for some services (such as lab work). Check with your <u>provider</u> before you get services.
Do you need a <u>referral</u> to see a <u>specialist</u> ?	No	You can see the <u>specialist</u> you choose without a <u>referral</u> .

 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 <u>provider's</u> office or clinic	Primary care visit to treat an injury or illness	No charge	25% <u>coinsurance</u>	<u>In-network</u> telehealth/virtual visits available through MDLive.
	<u>Specialist</u> visit	No charge	25% <u>coinsurance</u>	None.
	<u>Preventive care/screening/immunization</u>	No charge; <u>deductible</u> does not apply	25% <u>coinsurance</u> ; <u>deductible</u> does not apply	Age and frequency limits apply. You may have to pay for services that aren't preventive. Ask your <u>provider</u> if the services needed are preventive. Then check what your <u>plan</u> will pay for.
If you have a test	<u>Diagnostic test</u> (x-ray, blood work)	No charge	25% <u>coinsurance</u>	None.
	Imaging (CT/PET scans, MRIs)	No charge	25% <u>coinsurance</u>	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 drugs to treat your illness or condition More information about <u>prescription drug coverage</u> is available at www.express-scripts.com	Generic drugs	Retail: 20% <u>coinsurance</u> , \$5 minimum <u>copay</u> , \$40 maximum <u>copay</u> / <u>prescription drug</u> ; Home Delivery: \$10 <u>copay</u> / <u>prescription drug</u>	Retail: 20% <u>coinsurance</u> , \$5 minimum <u>copay</u> , \$40 maximum <u>copay</u> / <u>prescription drug</u> plus <u>balance-billing</u> charges; Home Delivery: Not available	<u>Deductible</u> does not apply. Retail: Limited to up to a 30-day supply. Home Delivery and Walgreens Retail: Limited to up to a 90-day supply. For <u>out-of-network prescription drugs</u> , you pay the pharmacy and file a claim with Express Scripts. Certain drugs require <u>preauthorization</u> or no benefits provided.
	Preferred brand drugs	Retail: 20% <u>coinsurance</u> , \$15 minimum <u>copay</u> , \$40 maximum <u>copay</u> / <u>prescription drug</u> ; Home Delivery: \$30 <u>copay</u> / <u>prescription drug</u>	Retail: 20% <u>coinsurance</u> , \$15 minimum <u>copay</u> , \$40 maximum <u>copay</u> / <u>prescription drug</u> plus <u>balance-billing</u> charges; Home Delivery: Not available	Certain drugs have quantity limits. The <u>Plan</u> may not cover certain <u>prescription drugs</u> removed from the Express Scripts <u>formulary</u> . Your <u>cost sharing</u> does not count toward the <u>out-of-pocket limit</u> .
	Non-preferred brand drugs	Retail: 20% <u>coinsurance</u> , \$30 minimum <u>copay</u> , \$40 maximum <u>copay</u> / <u>prescription drug</u> ; Home Delivery: \$50 <u>copay</u> / <u>prescription drug</u>	Retail: 20% <u>coinsurance</u> , \$30 minimum <u>copay</u> , \$40 maximum <u>copay</u> / <u>prescription</u> plus <u>balance-billing</u> charges; Home Delivery: Not available	If you receive a brand drug when a generic drug is available, you pay the <u>coinsurance/copay</u> , plus the difference in cost between the brand and generic drug. No charge for FDA-approved generic contraceptives (or brand name contraceptives if a generic is medically inappropriate).
	<u>Specialty drugs</u>	Covered as generic, preferred brand or non-preferred brand drugs, as shown above	Covered as generic, preferred brand or non-preferred brand drugs, as shown above	<u>Deductible</u> does not apply. <u>Preauthorization</u> required or no benefits provided. The <u>Plan</u> may not cover certain <u>prescription drugs</u> removed from the Express Scripts <u>formulary</u> . Your <u>cost sharing</u> does not count toward the <u>out-of-pocket limit</u> . Includes a specialty pharmacy copay assistance program. The cost of certain <u>specialty drugs</u> will be reimbursed by the manufacturer at no cost to you. You must participate in the SaveonSP program to receive your medications at no cost.

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)	No charge	25% <u>coinsurance</u>	<u>Preauthorization</u> required or no benefits provided.
	Physician/surgeon fees	No charge	25% <u>coinsurance</u>	None.
If you need immediate medical attention	<u>Emergency room care</u>	\$100 <u>copay</u> per emergency room visit	\$100 <u>copay</u> per emergency room visit	<u>Copay</u> waived if immediately admitted to hospital. Services that are not for an <u>emergency medical condition</u> are not covered. Professional/physician charges may be billed separately.
	<u>Emergency medical transportation</u>	No charge	No charge for air ambulance services; 25% <u>coinsurance</u> for all other forms of <u>emergency medical transportation</u>	Limited to transportation to nearest available facility for immediate treatment.
	<u>Urgent care</u>	No charge	25% <u>coinsurance</u>	None.
If you have a hospital stay	Facility fee (e.g., hospital room)	No charge after <u>deductible</u>	\$200 <u>copay</u> per admission, then 25% <u>coinsurance</u>	<u>Preauthorization</u> required or no benefits provided. Contact Acentra at 1-800-634-4832. Limited to coverage for a semi-private room.
	Physician/surgeon fees	No charge after <u>deductible</u>	25% <u>coinsurance</u>	None.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	No charge; <u>deductible</u> does not apply	25% <u>coinsurance</u> ; <u>deductible</u> does not apply	In- <u>network</u> telehealth/virtual visits available through MDLive. Includes up to 16 free mental health coaching/therapy sessions per individual per calendar year through Lyra Member Assistance Program (MAP).
	Inpatient services	No charge; <u>deductible</u> does not apply	25% <u>coinsurance</u> ; <u>deductible</u> does not apply	<u>Preauthorization</u> required or no benefits provided. Contact Acentra at 1-800-634-4832. Limited to coverage for a semi-private room.

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 are pregnant	Office visits	No charge after <u>deductible</u>	25% <u>coinsurance</u>	<u>Cost sharing</u> does not apply for <u>preventive services</u> . Maternity care may include tests and services described somewhere else in the SBC (e.g., ultrasound). <u>Preauthorization</u> required if hospital stay exceeds 48 hours following a vaginal delivery or 96 hours following a delivery by cesarean section, or no benefits provided. Limited to coverage for a semi-private room.
	Childbirth/delivery professional services	No charge after <u>deductible</u>	25% <u>coinsurance</u>	
	Childbirth/delivery facility services	No charge after <u>deductible</u>	25% <u>coinsurance</u>	
If you need help recovering or have other special health needs	<u>Home health care</u>	No charge after <u>deductible</u>	25% <u>coinsurance</u>	<u>Preauthorization</u> required or no benefits provided. Limited to 80 visits per year. Treatment must begin within one week of hospital stay.
	<u>Rehabilitation services</u>	No charge after <u>deductible</u>	25% <u>coinsurance</u>	<u>Preauthorization</u> required or no benefits provided. Limited to 70 days per confinement.
	<u>Habilitation services</u>	No charge after <u>deductible</u>	25% <u>coinsurance</u>	Speech therapy limited to 30 visits per year. Only specific conditions are covered.
	<u>Skilled nursing care</u>	No charge after <u>deductible</u>	25% <u>coinsurance</u>	Covered only when prescribed by a physician.
	<u>Durable medical equipment</u>	No charge after <u>deductible</u>	25% <u>coinsurance</u>	Must be prescribed by a physician and used for a medical purpose.
	<u>Hospice services</u>	No charge after <u>deductible</u>	25% <u>coinsurance</u>	None.
If your child needs dental or eye care	Children's eye exam	No charge; <u>deductible</u> does not apply.	No charge; <u>deductible</u> does not apply.	Retirees must elect vision coverage. These benefits are administered separately from the medical <u>plan</u> by EyeMed.
	Children's glasses	Lenses: no charge for standard lenses; Frames: no charge up to \$150 (up to \$200 at EyeMed PLUS providers), then 80% <u>coinsurance</u> ; <u>deductible</u> does not apply.	No charge up to <u>allowed amount</u> ; <u>deductible</u> does not apply.	<u>Out-of-network allowed amounts</u> : \$50 for frames; \$55 to \$140 for lenses; and \$50 for coatings. Retirees must elect vision coverage. These benefits are administered separately from the medical <u>plan</u> by EyeMed. Your <u>cost sharing</u> does not count toward the <u>out-of-pocket limit</u> .
	Children's dental check-up	No charge	No charge up to the UCR amount, then 100%	Limited to two oral exams per year. Retirees must elect dental coverage.

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 <u>excluded services</u> .)		
<ul style="list-style-type: none">• Cosmetic surgery• Long-term care	<ul style="list-style-type: none">• Routine foot care	<ul style="list-style-type: none">• Weight loss programs (except as required by the health reform law and/or as provided by Virta Health)
Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)		
<ul style="list-style-type: none">• Acupuncture• Bariatric surgery (<u>preauthorization</u> required or no benefits provided; subject to clinical criteria)• Chiropractic care (your <u>coinsurance</u> increases beginning with the 13th visit)	<ul style="list-style-type: none">• Dental care (Adult) (limited to \$2,000 annual limit, except Type I services not subject to annual limit)• Hearing aids (limited to one pair every 36 months)• Infertility treatment	<ul style="list-style-type: none">• Non-emergency care when traveling outside the U.S.• Private-duty nursing (limited to outpatient services only)• 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: the 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 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 plan at 1-800-CLAIM11. 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 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.

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 <u>deductible</u>	\$300
■ <u>Specialist copay</u>	\$0
■ Hospital (facility) <u>copay</u>	\$0
■ Other <u>copays</u>	\$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
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In this example, Peg would pay:

Cost Sharing	
<u>Deductibles</u>	\$300
<u>Copayments</u>	\$0
<u>Coinsurance</u>	\$10
What isn't covered	
Limits or exclusions	\$60
The total Peg would pay is	\$370

Managing Joe's Type 2 Diabetes

(a year of routine in-network care of a well-controlled condition)

■ The plan's overall <u>deductible</u>	\$300
■ <u>Specialist copay</u>	\$0
■ Hospital (facility) <u>copay</u>	\$0
■ Other <u>copays</u>	\$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
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In this example, Joe would pay:

Cost Sharing	
<u>Deductibles</u>	\$300
<u>Copayments</u>	\$0
<u>Coinsurance</u>	\$670
What isn't covered	
Limits or exclusions	\$20
The total Joe would pay is	\$990

Mia's Simple Fracture

(in-network emergency room visit and follow up care)

■ The plan's overall <u>deductible</u>	\$300
■ <u>Specialist copay</u>	\$0
■ Hospital ER (facility) <u>copay</u>	\$50
■ Other <u>copays</u>	\$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
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In this example, Mia would pay:

Cost Sharing	
<u>Deductibles</u>	\$300
<u>Copayments</u>	\$50
<u>Coinsurance</u>	\$10
What isn't covered	
Limits or exclusions	\$0
The total Mia would pay is	\$360