



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 <u>deductible</u>? | \$0 | See the Common Medical Events chart below for your costs for services this <u>plan</u> covers. |
| Are there services covered before you meet your <u>deductible</u>? | Not applicable | This <u>plan</u> does not have a <u>deductible</u> . |
| Are there other <u>deductibles</u> for specific services? | Yes. \$50/individual, \$100/family for dental (not applicable to <u>preventive services</u>). 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 <u>out-of-pocket limit</u> for this <u>plan</u>? | For prescription drugs: \$2,000 | The out-of-pocket limit is the most you could pay in a year for covered prescription drugs. 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 <u>out-of-pocket limit</u>? | Medical expenses | Even though you pay these medical expenses, they do not count toward the out-of-pocket limit. |
| Will you pay less if you use a <u>network provider</u>? | Yes, for <u>prescription drugs</u> , dental and vision only. For a list of <u>network providers</u> , see www.express-scripts.com or call 1-866-830-3890 (<u>prescription drugs</u>); see www.guardianlife.com or call 1-888-600-9200 (dental); or see www.eyemedvisioncare.com or call 1-877-226-1115 (vision) | 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 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> . |

| 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 | No charge | No charge | <u>Plan</u> pays secondary to Medicare. <u>In-network</u> telehealth/virtual visits available through MDLive. |
| | <u>Specialist</u> visit | No charge | No charge | <u>Plan</u> pays secondary to Medicare. |
| | <u>Preventive care/screening/immunization</u> | No charge | No charge | <u>Plan</u> pays secondary to Medicare. Age and frequency limits apply. |
| If you have a test | <u>Diagnostic test</u> (x-ray, blood work) | No charge | No charge | <u>Plan</u> pays secondary to Medicare. |
| | Imaging (CT/PET scans, MRIs) | No charge | No charge | <u>Plan</u> pays secondary to Medicare. |

| 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.express-scripts.com | Generic drugs | Retail one-month supply: 20% <u>coinsurance</u> , \$5 minimum <u>copay</u> , \$40 maximum <u>copay/prescription drug</u> ; Retail three-month supply or Express Scripts Pharmacy Home Delivery three-month supply: \$10 <u>copay/prescription drug</u> . | See "Limitations, Exceptions, & Other Important Information" | The Plan is enrolled in an Employer Group Waiver Plan (EGWP) called Express Scripts Medicare Prescription Drug Plan. If you opt-out of the EGWP no prescription drug coverage is available under the Plan. There is a \$35 maximum charge for a one-month supply of each insulin product covered by the Express Scripts Medicare Prescription Drug Plan, regardless of cost-sharing tier. |
| | Preferred brand drugs | Retail one-month supply: 20% <u>coinsurance</u> , \$15 minimum <u>copay</u> , \$40 maximum <u>copay/prescription drug</u> ; Retail three-month supply or Express Scripts Pharmacy Home Delivery three-month supply \$30 <u>copay/prescription drug</u> . | See "Limitations, Exceptions, & Other Important Information" | Certain drugs require <u>preauthorization</u> or no benefits are provided. Certain drugs have quantity limits. The <u>Plan</u> may not cover certain <u>prescription drugs</u> removed from the EGWP <u>formulary</u> . You must use Express Scripts Medicare network pharmacies to fill your prescriptions. Covered Medicare Part D drugs are available at out-of-network pharmacies only in special circumstances, such as illness while traveling outside of the Express Scripts Medicare PDP's service area where there is no network pharmacy. |
| | Non-preferred brand drugs | Retail one month supply: 20% <u>coinsurance</u> , \$30 minimum <u>copay</u> , \$40 maximum <u>copay/prescription drug</u> ; Retail three-month supply or Express Scripts Pharmacy Home Delivery three-month supply: \$50 <u>copay/prescription drug</u> . | See "Limitations, Exceptions, & Other Important Information" | Prescription drug coverage for residents of long-term care facilities is charged the same as for a Network Provider. |
| | <u>Specialty drugs</u> | Covered as generic, preferred brand or non-preferred brand drugs, as shown above | See "Limitations, Exceptions, & Other Important Information" | <u>Preauthorization</u> required or no benefits provided. The <u>Plan</u> may not cover certain <u>prescription drugs</u> removed from the EGWP <u>formulary</u> . |
| If you have outpatient surgery | Facility fee (e.g., ambulatory surgery center) | No charge | No charge | <u>Plan</u> pays secondary to Medicare. <u>Preauthorization</u> required or no benefits provided. |
| | Physician/surgeon fees | No charge | No charge | <u>Plan</u> pays secondary to Medicare. |
| If you need immediate medical attention | <u>Emergency room care</u> | No charge | No charge | <u>Plan</u> pays secondary to Medicare. Services that are not for an <u>emergency medical condition</u> are |

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|---|---|--|--|--|
| | | Network Provider (You will pay the least) | Out-of-Network Provider (You will pay the most) | |
| | | | | not covered. Professional/physician charges may be billed separately. |
| | <u>Emergency medical transportation</u> | No charge | No charge | <u>Plan</u> pays secondary to Medicare. Limited to transportation to nearest available facility for immediate treatment. |
| | <u>Urgent care</u> | No charge | No charge | <u>Plan</u> pays secondary to Medicare. |
| If you have a hospital stay | Facility fee (e.g., hospital room) | No charge | No charge | <u>Plan</u> pays secondary to Medicare. <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 | No charge | <u>Plan</u> pays secondary to Medicare. |
| If you need mental health, behavioral health, or substance abuse services | Outpatient services | No charge | No charge | <u>Plan</u> pays secondary to Medicare. In-network 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 | No charge | <u>Plan</u> pays secondary to Medicare. <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 | No charge | Plan pays secondary to Medicare. Maternity care may include tests and services described somewhere else in the SBC (e.g., ultrasound). |
| | Childbirth/delivery professional services | No charge | No charge | |
| | Childbirth/delivery facility services | No charge | No charge | Plan pays secondary to Medicare. <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. |
| If you need help recovering or have other special health needs | <u>Home health care</u> | No charge | No charge | Plan pays secondary to Medicare. <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 | No charge | Plan pays secondary to Medicare. <u>Preauthorization</u> required or no benefits provided. Limited to 70 days per confinement. |
| | <u>Habilitation services</u> | No charge | No charge | Plan pays secondary to Medicare. Speech therapy limited to 30 visits per year. Only specific conditions are covered. |
| | <u>Skilled nursing care</u> | No charge | No charge | Plan pays secondary to Medicare. Covered only when prescribed by a physician. |
| | <u>Durable medical equipment</u> | No charge | No charge | Plan pays secondary to Medicare. Must be prescribed by a physician and used for a medical purpose. |
| | <u>Hospice services</u> | No charge | No charge | Plan pays secondary to Medicare. |

| 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 your child needs dental or eye care | Children's eye exam | No charge | No charge | 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 <u>providers</u>), then 80% <u>coinsurance</u> . | No charge up to <u>allowed amount</u> | <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 cost sharing 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 excluded services.)

- Cosmetic surgery
- Long-term care
- Routine foot care
- Weight loss programs (except 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.)

- Acupuncture
- Bariatric surgery (preauthorization required or no benefits provided; subject to clinical criteria)
- Chiropractic care (your coinsurance increases beginning with the 13th visit)
- 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
- 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> | \$0 |
| ■ <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 |
|---------------------------|-----------------|

In this example, Peg would pay:

| Cost Sharing | |
|-----------------------------------|-------------|
| <u>Deductibles</u> | \$0 |
| <u>Copayments</u> | \$0 |
| <u>Coinsurance</u> | \$10 |
| What isn't covered | |
| Limits or exclusions | \$60 |
| The total Peg would pay is | \$70 |

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> | \$0 |
| ■ <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 |
|---------------------------|----------------|

In this example, Joe would pay:

| Cost Sharing | |
|-----------------------------------|--------------|
| <u>Deductibles</u> | \$0 |
| <u>Copayments</u> | \$0 |
| <u>Coinsurance</u> | \$670 |
| What isn't covered | |
| Limits or exclusions | \$20 |
| The total Joe would pay is | \$690 |

Mia's Simple Fracture

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

| | |
|--|-----|
| ■ The plan's overall <u>deductible</u> | \$0 |
| ■ <u>Specialist copay</u> | \$0 |
| ■ Hospital (facility) <u>copay</u> | \$0 |
| ■ 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 |
|---------------------------|----------------|

In this example, Mia would pay:

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