Joint Welfare Fund Local Union 164, I.B.E.W.: Plan B

Summary of Benefits and Coverage: What this Plan Covers & What it Costs

Coverage Period: 01/01/2023 - 12/31/2023
Coverage for: Family
Plan Type: Direct Access

This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at www.ibew164.org or by calling 1-877-228-4202.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	**$500** per person Applies only to non-participating providers.	You must pay all the costs up to the **deductible** amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the **deductible** starts over (usually, but not always, January 1st). See the chart starting on page 2 for how much you pay for covered services after you meet the **deductible.**
Are there other deductibles for specific services?	No	You don't have to meet **deductibles** for specific services, but see the chart starting on page 2 for other costs for services this plan covers.
Is there an out-of -pocket limit on my expenses?	Yes, **$2,000** per person	The **out-of-pocket limit** is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.
What is not included in the out-of-pocket limit?	Premiums, balance billed charges, co-pays, out-of-network copays and coinsurances for facilities, in-network copays and coinsurances, deductibles, penalties for failure to obtain pre-authorization for services and health care that this plan does not cover.	Even though you pay these expenses, they don't count toward the **out-of-pocket limit**.
Is there an overall annual limit on what the plan pays?	No	The chart starting on page 2 describes any limits on what the plan will pay for *specific* covered services, such as office visits.
Does this plan use a network of providers?	Yes. For a list of preferred providers see www.horizonblue.com or call 1-800-810-2583	If you use an in-network doctor or other health care **provider**, this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network **provider** for some services. Plans use the term in-network, **preferred**, or participating for **providers** in their **network**. See the chart starting on page 2 for how this plan pays different kinds of **providers**.
Do I need a referral to see a specialist?	No	You can see the **specialist** you choose without permission from this plan.
Are there services this plan doesn't cover?	Yes	Some of the services this plan doesn't cover are listed on page 7. See your policy or plan document for additional information about **excluded services**.

Questions: Call 1-877-228-4202 or visit us at www.ibew164.org
If you aren't clear about any of the underlined terms used in this form, see the Glossary.
You can view the Glossary at **www.ibew164.org** or call 1-877-228-4202 to request a copy.

- **Copayments** are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.
- **Coinsurance** is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is $1,000, your **coinsurance** payment of 20% would be $200. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges $1,500 for an overnight stay and the **allowed amount** is $1,000, you may have to pay the $500 difference. (This is called **balance billing**.)
- This plan may encourage you to use participating **providers** by charging you lower **deductibles**, **copayments** and **coinsurance** amounts.

Common Medical Event	Services You May Need	Your Cost If You Use a Participating Provider	Your Cost If You Use a Non- Participating Provider	Limitations & Exceptions
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$25 co-pay/visit	50% coinsurance after deductible	No coverage for workmen's compensation, motorcycle or auto accidents. No out of network coverage for pain management services.
	Specialist visit	$25 co-pay/visit	50% coinsurance after deductible	
	Other practitioner office visit	$25 co-pay /visit (excluding the chiropractic/ acupuncture combined benefit.)	50% coinsurance after deductible (excluding the chiropractic/acupuncture combined benefit.) For out of network physical therapy, 50% co-insurance using in-network allowables, after the deductible.	Coverage is limited to $50/day for the combined chiropractic/acupuncture benefit. Coverage is limited to 40 visits/calendar year. No out of network coverage for pain management services.
	Preventive care/screening/ immunization	No charge	50% coinsurance after deductible	Coverage is limited to one routine physical per calendar year.
If you have a test	Diagnostic test (x-ray, blood work)	No charge	50% coinsurance after deductible	All testing and outpatient care is subject to a $25 co-pay if services are rendered in a facility. Drug testing is not covered. No out of network coverage for pain management services.
	Imaging (CT/PET scans, MRIs)	No charge	50% coinsurance after deductible	

Common Medical Event	Services You May Need	Your Cost If You Use a Participating Provider	Your Cost If You Use a Non- Participating Provider	Limitations & Exceptions
If you need drugs to treat your illness or prescription More information is available by calling the Global Pharmaceutical Benefits helpdesk at 800 341-2234. If you are interested in obtaining drugs with a $0 co-pay and/or a 90 day supply for maintenance drugs call Global Pharmaceutical Benefits for further information on Horizon Health Center.	Generic drugs	$15 co-pay	$15 co-pay plus excess UCR.	30-day supply on all medications available at most pharmacies. Under the prescription benefit all proton pump inhibitors (PPI) and prescriptions available over-the counter (OTC) are excluded from coverage. For scripts purchased at Walgreens/Duane Reade pharmacy network there is a $5/script surcharge. CVS/Caremark pharmacy does not participate with Global Pharmaceutical Benefits, LLC. No payment will be made to the pharmacy. Diabetic supplies are payable at 90% or applicable co-pay (whichever is higher). Utilization management programs may apply.
	Preferred brand drugs	$25 co-pay	$25 co-pay plus excess UCR.	
	Non-preferred brand drugs	$25 co-pay	$25 co-pay plus excess UCR.	
	Specialty drugs	$25 co-pay	$25 co-pay plus excess UCR.	
Prescription coverage for Medicare primary members is provided by Express Scripts Medicare®PDP. More information about this Medicare Part D Plan is available from Labor First at 201 298-9308.	Generic drugs	$15 co-pay	N/A	This plan allows a 90-day supply to be picked up at a retail pharmacy. The co-pay for the 90-day supply will be up to a $45 co-pay for generic drugs and up to a $75 copay for preferred, non-preferred and specialty drugs. Maintenance medications are available through mail order and a 90-day supply will have a $15 co-pay for generic drugs and a $25 co-pay for preferred, non-preferred and specialty drugs.
	Preferred brand drugs	$25 co-pay	N/A	
	Non-preferred brand drugs	$25 co-pay	N/A	
	Specialty drugs	$25 co-pay	N/A	

Common Medical Event	Services You May Need	Your Cost If You Use a Participating Provider	Your Cost If You Use a Non-Participating Provider	Limitations & Exceptions
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	$25 co-pay	$25 co-pay plus 50% coinsurance after deductible 100% cost to member for all out of network pain management services	Out of network pain management services are not covered.
	Physician/surgeon charges	No charge	50% coinsurance after deductible	
If you need immediate medical attention	Emergency room services	$200 co-pay	$200 co-pay plus excess UCR	Workman's compensation, motorcycle and auto accidents are not covered.
	Emergency medical transportation	10% coinsurance	10% coinsurance	Workman's compensation, motorcycle and auto accidents are not covered. Ambulance service for medical emergency only. Water ambulance is not covered.
	Urgent care	$25 co-pay/visit	50% coinsurance after deductible	Workman's compensation, motorcycle and auto accidents are not covered.
If you have a hospital stay Must be pre-authorized through Horizon BCBS at 800 664-2583	Facility fee (e.g., hospital room)	$200 co-pay	$200 co-pay plus 50% coinsurance after deductible	Coverage is limited to 100 inpatient days/confinement. Failure to pre-authorize will result in up to a $500 reduction for admissions **approved** as Medically Necessary. Admissions **not approved** as Medically Necessary will not be covered and the covered person will be responsible for 100% of the charges.
	Physician/surgeon fee	No charge	50% coinsurance after deductible	

Common Medical Event	Services You May Need	Your Cost If You Use a Participating Provider	Your Cost If You Use a Non-Participating Provider	Limitations & Exceptions
If you have mental health, behavioral health or substance abuse needs	Mental/behavioral health outpatient services	$25 co-pay/visit	50% coinsurance after deductible	Contact Intervention Strategies at 800 663-0404 for participating providers. Pre-authorization recommended for all outpatient services. Claims filed with BCBS will be denied. All claims must be filed with Intervention Strategies. **Drug testing or psychological testing is not covered. ABA therapy is not covered.**
	Substance use disorder outpatient services	$25 co-pay/visit	50% coinsurance after deductible	
	Mental/behavioral health inpatient services	$200 co-pay	$200 co-pay and 50% coinsurance after deductible	Coverage is limited to 100 inpatient days per confinement. Contact Intervention Strategies for participating providers. Pre-authorization required through Intervention Strategies at 800 663-0404. Claims filed with BCBS will be denied. All claims must be filed with: Intervention Strategies 351 Evelyn Street, 3rd floor Paramus, NJ 07652 Drug testing or psychological testing is not covered.
	Substance use disorder inpatient services	$200 co-pay	$200 co-pay and 50% coinsurance after deductible	
If you are pregnant	Prenatal and postnatal care	$25 co-pay	50% coinsurance after deductible	No coverage for pregnancy related charges and complications of pregnancy for dependent children.
	Delivery and all inpatient services	$200 co-pay each for both mother and baby	$200 co-pay each for both mother and baby 50% coinsurance after deductible	
If your child needs dental or eye care	Eye exam	Balance remaining after $85 benefit	Balance remaining after $85 benefit	The annual routine vision benefit is $85 for the exam and $300 for glasses, contact lens fitting or contacts per person, per calendar year.
	Glasses	Balance remaining after $300 benefit	Balance remaining after $300 benefit	
	Dental check –up	Not covered	Not covered	Coverage provided by Horizon Dental 1-800 433-6825

Common Medical Event	Services You May Need	Your Cost If You Use a Participating Provider	Your Cost If You Use a Non-Participating Provider	Limitations & Exceptions
If you need help recovering or have other special health needs	Home health care	$25 co-pay/visit	50% coinsurance after deductible	Coverage is limited to no more than 8 hours/day, and 240 hours per year for home care nursing. Pre-authorization required. Home health care aides are not covered. Authorization for in-network providers is through Horizon Care at Home at 855 243-3321. Authorization for out-of-network providers is through Horizon at 800 664-2583
	Rehabilitation services	$200 co-pay for inpatient claims	$200 co-pay for inpatient claims and 50% coinsurance after deductible	Coverage is limited to 100 inpatient days/confinement. Pre-authorization required. The allowance for out of network physical therapy is based on in network allowables and initial evaluations are not covered for out of network providers.
		$25 co-pay/visit for outpatient claims	50% coinsurance for outpatient claims after deductible	
	Habilitation services	Not covered	Not covered	----------none----------
	Skilled nursing care	$200 co-pay	$200 co-pay and 50% coinsurance after deductible	Coverage is limited to 100 inpatient days/confinement. Pre-authorization required. Combined with inpatient hospitalization benefit.
	Durable medical equipment	20% coinsurance	50% coinsurance after deductible	Pre-authorization is required for all charges exceeding $1,500. Authorization for in-network providers is through Horizon Care at Home at 855 243-3321. Authorization for out-of-network providers is through Horizon at 800 664-2583
	Hospice Service	No charge	50% coinsurance after deductible	Coverage is limited to 30 days. Pre-authorization required.

Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy or plan document for other excluded services.)

Workmen's Compensation injuries; Injuries from Motorcycle or Auto Accidents; Drug Testing; Psychological testing; ABA therapy; Pregnancy related charges for any dependent other than a spouse; All pain management services with an out of network provider including professional services (the doctor), facility (the surgery center or hospital), anesthesia and /or any other related charges including office visits and testing; Dental services including full bony impacted wisdom teeth; Massage Therapy; Cosmetic Surgery; Habilitation services; Long Term Care; Gym Memberships; Weight Loss Programs; Durable Medical Equipment prescribed by a Chiropractor; Water Ambulance Service; Non-Emergency Ambulance Services; Services that are deemed to be Investigational; Services that are not Medically Necessary; and Medical treatment outside the United States. Under the prescription benefit all proton pump inhibitors (PPI) and prescriptions available over-the counter (OTC) are excluded from coverage.

Other Covered Services (This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)

Chiropractic/acupuncture benefit: Coverage is limited to $50/day, 40 visits/calendar year for the combined benefit. Physical therapy will not be covered on the same day at the same place of service if chiropractic/acupuncture benefits were provided;
Growth hormone benefit: Coverage is limited to $10,000 per calendar year, up to three years for growth hormones. Pre-certification is required;
Hearing aid benefit: $1500/ear every 3 years;
Infertility benefit: Only basic services are covered for infertility at a 50% benefit, non-participating infertility claims are subject to the deductible, and the $25 facility outpatient co-pay also applies to infertility claims. Infertility drugs will be covered at 50% with a letter of medical necessity, which must indicate that the infertility drugs are not to be used to prepare for in-vitro fertilization;
Laser vision correction benefit: $1000/eye/lifetime for members and dependents who have not already exhausted the lifetime benefit;
Nutritional counseling: Covered 3x/year with a $25 co-pay for participating providers and 50% of UCR after deductible for non-participating providers;
TMJ benefit: Medically necessary treatment of TMJ must be pre-authorized and follow Horizon's medical guidelines policy.
FOR MEDICARE PRIMARY MEMBERS ONLY
If your Medicare Plan is your primary coverage and the Joint Welfare Fund Local Union 164, IBEW is your secondary coverage; you should be seeking doctors and providers that accept Medicare assignment in order for you to arrive at your lowest out-of-pocket expense. If the provider accepts Medicare assignment and your JWF Local Union 164 Plan annual $500 deductible is satisfied, the Plan will pay the balance of the Medicare approved amount. Deductible waived if providers also participate with Blue Cross/ Blue Shield. Co-pays and coinsurances do not apply.
If you use Doctors or Providers who do not accept Medicare assignment and your JWF Local Union 164 Plan annual $500 deductible is satisfied, the Plan will pay you the balance after Medicare, up to the Medicare approved amount. Co-pays and coinsurances do not apply.
If Medicare does not allow a procedure or service or considers any benefit to be exhausted, then your JWF Local Union 164 Plan will process your claim as primary with applicable co-pays and coinsurances for covered services.

Your Rights to Continue Coverage:

If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a **premium**, which may be significantly higher than the premium you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply.

For more information on your rights to continue coverage, contact the plan at 1-877-228-4202. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cciio.cms.gov.

Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to **appeal** or file a **grievance**. For questions about your rights, this notice, or assistance, you can contact the plan at 1-877-228-4202.

For group health coverage subject to ERISA, contact the plan at 1-877-228-4202 or the Department of Labor's Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa/healthreform.

Language access Services:
Spanish: Para obtener asistencia en Espanol, llame al 1-877-228-4202

About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.

This is not a cost estimator.

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

Having a baby
(normal delivery)

- **Amount owed to providers: $7,540**
- **Plan pays $7,125**
- **Patient pays $415**

Sample care costs:	
Hospital charges (mother)	$2,700
Routine obstetric care	$2,100
Hospital charges (baby)	$900
Anesthesia	$900
Laboratory tests	$500
Prescriptions	$200
Radiology	$200
Vaccines, other preventive	$40
Total	**$7,540**

Patient pays:	$415
Deductibles	$0
Co-pays	$415
Coinsurance	$0
Limits or exclusions	$0
Total	**$415**

Managing type 2 diabetes
(routine maintenance of A well-controlled condition)

- **Amount owed to providers: $5,400**
- **Plan pays $5,075**
- **Patient pays $325**

Sample care costs:	
Prescriptions	$2,900
Medical Equipment and Supplies	$1,300
Office Visits and Procedures	$700
Education	$300
Laboratory tests	$100
Vaccines, other preventive	$100
Total	**$5,400**

Patient pays:	$325
Deductibles	$0
Co-pays	$65
Coinsurance	$260
Limits or exclusions	$0
Total	**$325**

Questions and answers about the Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

- Costs don't include **premiums**.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network **providers**. If the patient had received care from out-of-network **providers**, costs would have been higher.

What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how **deductibles**, **copayments**, and **coinsurance** can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

Does the Coverage Example predict my own care needs?

✗ **No.** Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

Does the Coverage Example predict my future expenses?

✗ **No.** Coverage Examples are **not** cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your **providers** charge, and the reimbursement your health plan allows.

Can I use Coverage Examples to compare plans?

✓ **Yes.** When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

Are there other costs I should consider when comparing plans?

✓ **Yes.** An important cost is the **premium** you pay. Generally, the lower your **premium**, the more you'll pay in out-of-pocket costs, such as **copayments**, **deductibles**, and **coinsurance**. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.

Questions: Call 1-877-228-4202 or visit us at www.ibew164.org
If you aren't clear about any of the underlined terms used in this form, see the Glossary.
You can view the Glossary at **www.ibew164.org** or call 1-877-228-4202 to request a copy.