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 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. Prescription drugs, preventive care, mental health services, substance abuse services, vision, hearing and services subject to a copayment 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?	Yes. **$50**/individual, **$100**/family for dental (not applicable to preventive services). There are no other specific deductibles.	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?	Medical: Network providers: **$300**/individual, **$600**/family;Medical: Out-of-network providers: **$1,500**/individual, **$3,000**/family. Prescription drug: **$7,950**/individual, **$15,900**/family	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, penalties for failure to obtain preauthorization, vision expenses, coinsurance for chiropractic services, health care this plan 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 out-of-pocket limit.
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 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

Important Questions	Answers	Why This Matters:
		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	No charge	25% coinsurance	In-network telehealth/virtual visits available through MDLive.
	Specialist visit	No charge	25% coinsurance	None.
	Preventive care/screening/ immunization	No charge; deductible does not apply	25% coinsurance; deductible does not apply	Age and frequency limits apply. You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	No charge	25% coinsurance	None.
	Imaging (CT/PET scans, MRIs)	No charge	25% coinsurance	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 **prescription drug coverage** is available at www.express-scripts.com	Generic drugs	Retail: 20% coinsurance, $5 minimum copay, $40 maximum copay/ prescription drug; Home Delivery: $10 copay/ prescription drug	Retail: 20% coinsurance, $5 minimum copay, $40 maximum copay/ prescription drug plus balance-billing charges; Home Delivery: Not available	Deductible 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 out-of-network prescription drugs, you pay the pharmacy and file a claim with Express Scripts. Certain drugs require preauthorization or no benefits provided. Certain drugs have quantity limits. The Plan may not cover certain prescription drugs removed from the Express Scripts formulary. Your cost sharing does not count toward the out-of-pocket limit. If you receive a brand drug when a generic drug is available, you pay the coinsurance/copay, 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).
	Preferred brand drugs	Retail: 20% coinsurance, $15 minimum copay, $40 maximum copay/ prescription drug; Home Delivery: $30 copay/ prescription drug	Retail: 20% coinsurance, $15 minimum copay, $40 maximum copay/ prescription drug plus balance-billing charges; Home Delivery: Not available	
	Non-preferred brand drugs	Retail: 20% coinsurance, $30 minimum copay, $40 maximum copay/ prescription drug; Home Delivery: $50 copay/ prescription drug	Retail: 20% coinsurance, $30 minimum copay, $40 maximum copay/ prescription plus balance-billing charges; Home Delivery: Not available	
	Specialty drugs	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	Deductible does not apply. Preauthorization required or no benefits provided. The Plan may not cover certain prescription drugs removed from the Express Scripts formulary. Your cost sharing does not count toward the out-of-pocket limit. Includes a specialty pharmacy copay assistance program. The cost of certain specialty drugs 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% coinsurance	Preauthorization required or no benefits provided.
	Physician/surgeon fees	No charge	25% coinsurance	None.
If you need immediate medical attention	Emergency room care	$50 copay per emergency room visit	$50 copay per emergency room visit	Copay waived if immediately admitted to hospital. Services that are not for an emergency medical condition are not covered. Professional/physician charges may be billed separately.
	Emergency medical transportation	No charge	No charge for air ambulance services; 25% coinsurance for all other forms of emergency medical transportation	Limited to transportation to nearest available facility for immediate treatment.
	Urgent care	No charge	25% coinsurance	None.
If you have a hospital stay	Facility fee (e.g., hospital room)	No charge after deductible	$200 copay per admission, then 25% coinsurance	Preauthorization 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 deductible	25% coinsurance	None.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	No charge; deductible does not apply	25% coinsurance; deductible does not apply	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; deductible does not apply	25% coinsurance; deductible does not apply	Preauthorization 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 deductible	25% coinsurance	Cost sharing does not apply for preventive services. Maternity care may include tests and services described somewhere else in the SBC (e.g., ultrasound).
	Childbirth/delivery professional services	No charge after deductible	25% coinsurance	
	Childbirth/delivery facility services	No charge after deductible	25% coinsurance	Preauthorization 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	Home health care	No charge after deductible	25% coinsurance	Preauthorization required or no benefits provided. Limited to 80 visits per year. Treatment must begin within one week of hospital stay.
	Rehabilitation services	No charge after deductible	25% coinsurance	Preauthorization required or no benefits provided. Limited to 70 days per confinement.
	Habilitation services	No charge after deductible	25% coinsurance	Speech therapy limited to 30 visits per year. Only specific conditions are covered.
	Skilled nursing care	No charge after deductible	25% coinsurance	Covered only when prescribed by a physician.
	Durable medical equipment	No charge after deductible	25% coinsurance	Must be prescribed by a physician and used for a medical purpose.
	Hospice services	No charge after deductible	25% coinsurance	None.
If your child needs dental or eye care	Children's eye exam	No charge; deductible does not apply.	No charge; deductible does not apply.	Retirees must elect vision coverage. These benefits are administered separately from the medical plan 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% coinsurance; deductible does not apply.	No charge up to allowed amount; deductible does not apply.	Out-of-network allowed amounts: $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 plan by EyeMed. Your cost sharing does not count toward the out-of-pocket limit.
	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 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.)

- 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 deductible** **$300**
- **Specialist copay** **$0**
- **Hospital (facility) copay** **$0**
- **Other copays** **$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	$300
Copayments	$0
Coinsurance	$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 deductible** **$300**
- **Specialist copay** **$0**
- **Hospital (facility) copay** **$0**
- **Other copays** **$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	$300
Copayments	$0
Coinsurance	$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 deductible** **$300**
- **Specialist copay** **$0**
- **Hospital ER (facility) copay** **$50**
- **Other copays** **$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	$300
Copayments	$50
Coinsurance	$10
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$360**

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