



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 1-800-765-4239. 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 <http://www.healthcare.gov/sbc-glossary> or call 1-800-765-4239 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall <a href="#">deductible</a> ?	\$0	See the Common Medical Events chart below for your costs for services this <a href="#">plan</a> covers. This is a Medicare Advantage Plan provided by Humana, please contact Retiree First at 855-433-1668 with any questions.
Are there services covered before you meet your <a href="#">deductible</a> ?	Not applicable.	This <a href="#">plan</a> does not have an overall <a href="#">deductible</a> . This is a Medicare Advantage Plan provided by Humana, please contact Retiree First at 855-433-1668 with any questions.
Are there other <a href="#">deductible</a> for specific services?	Yes. <b>\$1,000</b> per person for organ transplants. There are no other specific <a href="#">deductibles</a> .	You must pay all of the costs for these services up to the specific <a href="#">deductible</a> amount before this <a href="#">plan</a> begins to pay for these services. This is a Medicare Advantage Plan provided by Humana, please contact Retiree First at 855-433-1668 with any questions.
What is the <a href="#">out-of-pocket limit</a> for this <a href="#">plan</a> ?	Transplant Benefits: <b>\$3,000</b> per person at Center of Excellence Facility or with Medicare Provider and <b>No limit</b> at a Non-Center of Excellence Facility that is also a non-Medicare Provider. <i>Certain <a href="#">out-of-network claims</a> are treated as <a href="#">in-network claims</a>.</i>	The <a href="#">out-of-pocket limit</a> is the most you could pay in a year for covered transplant services.
What is not included in the <a href="#">out-of-pocket limit</a> ?	<a href="#">Premiums</a> , <a href="#">balance-billing</a> charges, <a href="#">coinsurance</a> for Non-Centers of Excellence organ transplant benefits, <a href="#">prescription drugs</a> , and health care this <a href="#">plan</a> doesn't cover.	Even though you pay these expenses, they don't count toward the <a href="#">out-of-pocket limit</a> .
Will you pay less if you use a <a href="#">network provider</a> ?	Yes*. For a list of preferred <a href="#">network</a> pharmacies for <a href="#">prescription drug</a> benefits, go to <a href="http://www.MyVibrantRx.com">http://www.MyVibrantRx.com</a> , or call 844-826-3451. For medical benefits, this <a href="#">plan</a> does not use a <a href="#">provider network</a> . You can receive covered services from any <a href="#">provider</a> . If the <a href="#">provider</a> accepts Medicare and you meet the Medicare Part B deductible, the service will be covered.	For <a href="#">prescription drugs</a> , this <a href="#">plan</a> uses a <a href="#">provider network</a> . You will pay less if you use a <a href="#">provider</a> in the <a href="#">plan's network</a> . You will pay the most if you use an <a href="#">out-of-network provider</a> , and you might receive a bill from a <a href="#">provider</a> for the difference between the <a href="#">provider's</a> charge and what your <a href="#">plan</a> pays ( <a href="#">balance billing</a> ). Be aware your <a href="#">network provider</a> might use an <a href="#">out-of-network provider</a> for some services (such as lab work). Check with your <a href="#">provider</a> before you get services.
Do you need a <a href="#">referral</a> to see a <a href="#">specialist</a> ?	No.	You can see the <a href="#">specialist</a> you choose without a <a href="#">referral</a>

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Medicare Provider (You will pay the least)	Non-Medicare Provider (You will pay the most)	
If you visit a health care <a href="#">provider's</a> office or clinic	Primary care visit to treat an injury or illness	No charge if allowed by Medicare.	N/A	-----none-----
	<a href="#">Specialist</a> visit			
	<a href="#">Preventive care/screening/immunization</a>			
If you have a test	<a href="#">Diagnostic test</a> (x-ray, blood work)			
	Imaging (CT/PET scans, MRIs)			
If you need <a href="#">drugs</a> to treat your illness or condition <a href="#">prescription drug coverage</a> is available at <a href="http://www.MyVibrantRx.com">www.MyVibrantRx.com</a> or call 844-826-3451.	Generic <a href="#">drugs</a>	\$25 <a href="#">copayment</a> /fill (retail); \$50 <a href="#">copayment</a> /fill (preferred <a href="#">network</a> pharmacy or mail order); and \$75 <a href="#">copayment</a> /fill (non-preferred pharmacy).	50% <a href="#">coinsurance</a> .	34-day supply retail; 90-day supply preferred <a href="#">network</a> pharmacy or mail order; 90-day supply non-preferred pharmacy  If a brand name <a href="#">drug</a> is chosen when a generic <a href="#">drug</a> is available, the brand name <a href="#">copayment</a> will apply. 90-day supply for maintenance <a href="#">drugs</a> available through CVS Mandatory Choice90 (retail and mail order).  <a href="#">Drugs</a> considered preventive services under the ACA are covered at 100% and not subject to <a href="#">prescription drug deductible</a> or <a href="#">copayments</a> .
	Preferred brand name <a href="#">drugs</a>	\$40 <a href="#">copayment</a> /fill (retail); \$80 <a href="#">copayment</a> /fill (preferred <a href="#">network</a> pharmacy or mail order); \$120 <a href="#">copayment</a> /fill (non-preferred pharmacy).		
	Non-preferred brand name <a href="#">drugs</a>	\$50 <a href="#">copayment</a> /fill (retail); \$100 <a href="#">copayment</a> /fill (preferred <a href="#">network</a> pharmacy or mail order); \$150 <a href="#">copayment</a> /fill (non-preferred pharmacy).	50% <a href="#">coinsurance</a> .	

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Medicare Provider (You will pay the least)	Non-Medicare Provider (You will pay the most)	
If you need <a href="#">drugs</a> to treat your illness or condition (continued) <a href="#">prescription drug coverage</a> is available at <a href="http://www.MyVibrantRx.com">www.MyVibrantRx.com</a> or call 844-826-3451.	<a href="#">Specialty drugs</a> through the <a href="#">prescription drug</a> program	10% <a href="#">coinsurance</a> (retail and mail order) up to a maximum of \$125/fill.	50% <a href="#">coinsurance</a> (retail).	Limited to a 30-day supply. Covered persons who were receiving <a href="#">specialty drugs</a> before January 1, 2013 pay retail or mail order <a href="#">copayments</a> , not subject to maximum. Humira, Skyrizi, and Rinvoq are not covered by this <a href="#">plan</a> . GLP-1 drugs for obesity are 1) subject to 50% coinsurance, 2) subject to a lifetime limit of 18 months, 3) subject to <a href="#">prior authorization</a> , and 4) not subject to the Plan's annual Rx <a href="#">out-of-pocket limit</a> .
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	No charge if allowed by Medicare.	N/A	-----none-----
	Physician/surgeon fees			
If you need immediate medical attention	<a href="#">Emergency room care</a>	No charge if allowed by Medicare.	N/A	-----none-----
	<a href="#">Emergency medical transportation</a>			
	<a href="#">Urgent care</a>			
If you have a hospital stay	Facility fee (e.g., hospital room)	No charge up to the Medicare Allowed Amount, if allowed by Medicare, 100% of charges once Medicare is exhausted.	N/A	-----none-----
	Physician/surgeon fees	No charge if allowed by Medicare.	N/A	-----none-----

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Medicare Provider (You will pay the least)	Non-Medicare Provider (You will pay the most)	
<b>If you need mental health, behavioral health, or substance abuse services</b>	Outpatient services	No charge if allowed by Medicare.	N/A	-----none-----
	Inpatient services	Facility: No charge up to the Medicare Allowed Amount if allowed by Medicare, 100% of charges once Medicare is exhausted. Professional: No charge if allowed by Medicare.		-----none-----
<b>If you are pregnant</b>	Office visits	No charge if allowed by Medicare.	N/A	-----none-----
	Childbirth/ delivery professional services			
	Childbirth/ delivery facility services	No charge up to the Medicare Allowed Amount, if allowed by Medicare, 100% of charges once Medicare is exhausted.		-----none-----
<b>If you need help recovering or have other special health needs</b>	<a href="#">Home health care</a>	No charge if allowed by Medicare.	N/A	-----none-----
	<a href="#">Rehabilitation services</a>			
	<a href="#">Habilitation services</a>	Not covered	Not covered	You must pay 100% of this service, even from a Medicare provider.
	<a href="#">Skilled nursing care</a>	No charge if allowed by Medicare. If treatment continues for over 365 days, you must pay full costs.	N/A	You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entering a Medicare-approved facility within 30 days after leaving the hospital.
	<a href="#">Durable medical equipment</a>	No charge if allowed by Medicare.	N/A	-----none-----
	<a href="#">Hospice services</a>			

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Medicare Provider (You will pay the least)	Non-Medicare Provider (You will pay the most)	
If your child needs dental or eye care	Children's eye exam	Not covered	Not covered	You must pay 100% of this service, even from a Medicare provider.
	Children's glasses			
	Children's dental check-up			

#### Excluded Services & Other Covered Services:

Services Your <a href="#">Plan</a> Generally Does NOT Cover (Check your policy or <a href="#">plan</a> document for more information and a list of any other <a href="#">excluded services</a> .)			
<ul style="list-style-type: none"> <li>Acupuncture</li> <li>Cosmetic surgery</li> <li>Dental care (Adult and Child)</li> </ul>	<ul style="list-style-type: none"> <li><a href="#">Habilitation services</a></li> <li>Infertility treatment</li> <li>Non-emergency care when traveling outside the U.S.</li> </ul>	<ul style="list-style-type: none"> <li>Private-duty nursing</li> <li>Routine eye care (Adult and Child)</li> <li>Weight loss programs</li> </ul>	
Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your <a href="#">plan</a> document.)			
<ul style="list-style-type: none"> <li>Bariatric surgery (if allowed by Medicare)</li> <li>Chiropractic Care (if allowed by Medicare)</li> </ul>	<ul style="list-style-type: none"> <li>Hearing aids (up to \$1,250 per ear every 5 years; no limit for individuals under age 18)</li> </ul>	<ul style="list-style-type: none"> <li>Long-term care (if allowed by Medicare)</li> <li>Routine foot care (if allowed by Medicare)</li> </ul>	

**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 <https://www.dol.gov/agencies/ebsa>. 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](http://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 Fund Administrator, NECA-IBEW Welfare Trust Fund, 2120 Hubbard Avenue, Decatur, IL 62526-2871, Telephone 1-800-765-4239. You may also contact the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or <https://www.dol.gov/agencies/ebsa>.

**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](#).

**Language Access Services:**

Para obtener asistencia en Español, llame al 1-800-765-4239.

Pennsylvania Dutch (Deutsch): Fer Hilf griege in Deutsch, ruf 1-800-765-4239 uff.

*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 ([deductible](#), [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 Medicare provider pre-natal care and a hospital delivery)

■ The <a href="#">plan's</a> overall <a href="#">deductible</a>	N/A
■ <a href="#">Specialist</a>	N/A
■ Hospital (facility)	N/A
■ Other	N/A

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:

<a href="#">Cost Sharing</a>	
<a href="#">Deductibles</a>	\$0
<a href="#">Copayments</a>	\$10
<a href="#">Coinsurance</a>	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$60
<b>The total Peg would pay is</b>	<b>\$70</b>

### Managing Joe's Type 2 Diabetes

(a year of routine Medicare provider care of a well-controlled condition)

■ The <a href="#">plan's</a> overall <a href="#">deductible</a>	N/A
■ <a href="#">Specialist</a>	N/A
■ Hospital (facility)	N/A
■ Other	N/A

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:

<a href="#">Cost Sharing</a>	
<a href="#">Deductibles</a>	\$0
<a href="#">Copayments</a>	\$700
<a href="#">Coinsurance</a>	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$20
<b>The total Joe would pay is</b>	<b>\$720</b>

### Mia's Simple Fracture

(Medicare provider emergency room visit and follow up care)

■ The <a href="#">plan's</a> overall <a href="#">deductible</a>	N/A
■ <a href="#">Specialist</a>	N/A
■ Hospital (facility)	N/A
■ Other	N/A

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:

<a href="#">Cost Sharing</a>	
<a href="#">Deductibles</a>	\$0
<a href="#">Copayments</a>	\$10
<a href="#">Coinsurance</a>	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$0
<b>The total Mia would pay is</b>	<b>\$10</b>

The [Plan](#) pays secondary to Medicare.