IBEW Local 102 Welfare Fund: 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.ibew102.org or by calling 1-888-423-9102.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	**$400** person / **$800** family Doesn't apply to facility claims, anesthesia claims or participating claims.	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** individual / **$4,000** family	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**.

- **Copayments** are fixed dollar amounts (for example, $25) 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	30% coinsurance after deductible	Secondary coverage only up to $1,500 per automobile accident. No coverage for workmen's compensation claims or out-of-network pain management services.
	Specialist visit	$25 co-pay/visit	30% coinsurance after deductible	
	Other practitioner office visit	$25 co-pay/visit	30% coinsurance after deductible 100% cost to member for all out of network pain management services	Coverage is limited to 40 visits/person, 120 visits/family/year for in-network chiropractic/acupuncture claims and 26 visits/person, 80 visits/family/year for out-of-network chiropractic/acupuncture claims. See page 7. Coverage is limited to 36 combined physical therapy/occupational therapy visits, 24 speech therapy visits and 30 cardiac rehab visits/calendar year.
	Preventive care/screening/ immunization	No charge	No coverage for preventative care/screening/immunizations	No coverage if you use an out-of-network provider.
If you have a test	Diagnostic test (x-ray, blood work)	No charge	30% coinsurance after deductible	All testing and outpatient care is subject to a $100 co-pay if services are billed by a facility. No out-of-network benefits for pain management and drug testing.
	Imaging (CT/PET scans, MRIs)	No charge	30% 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 about prescription drug coverage is available by calling Global Pharmaceutical Benefits, LLC at: 1-800-341-2234 ****Medicare primary members, see page 8** If you are interested in obtaining prescriptions with a $0.00 co-pay and/or 90 day supply for maintenance medications call Global Pharmaceutical Benefits, LLC for further information on Horizon Health Center .	Generic drugs	$10 co-pay	$15 co-pay for the Walgreen/ Duane Reade pharmacy network.	30 day supply on all medications available at most retail pharmacies. All proton pump inhibitors, schedule II substances except attention deficit disorder drugs and compounded medications are not covered under the Plan. There is an additional cost to members for using the Walgreen/Duane Reade pharmacy network. The co-pay for generic drugs is $15 and the co-pay for preferred or non-preferred brand and specialty drugs is 55% with maximum co-pay listed under each section. CVS/Caremark pharmacy does not participate with Global Pharmaceutical Benefits, LLC. No payment will be made to the pharmacy. You may view your formulary brand drug list online at: www.globalpharmaceuticalbenefits.com You will be prompted to create a user name and password.
	Preferred brand drugs	50% coverage with a $60 maximum	55% co-pay for the Walgreen/ Duane Reade pharmacy network with a $150 maximum.	
	Non-preferred brand drugs	50% coverage with a $300 maximum	55% co-pay for the Walgreen/ Duane Reade pharmacy network with a $350 maximum.	
For more information regarding specialty drugs, call: Global Pharmaceutical Benefits LLC at: 800 341-2234	Specialty drugs	Processed under applicable preferred/ non-preferred rate	Processed under applicable preferred/non-preferred rate	

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)	$100 co-pay	$100 co-pay plus 20% coinsurance	Out-of-network pain management services are not covered. **Bariatric surgery** has limitations. See page 7. Pre-authorization required.
	Physician/surgeon charges	No charge	30% coinsurance after deductible	
If you need immediate medical attention	Emergency room services	$100 co-pay	$100 co-pay	For non-participating providers, coverage is limited to 100% of fee schedule after $100 co-pay to the hospital. The member is responsible for all charges in excess of the fee schedule if the providers are out-of-network.
	Emergency medical transportation	No charge	Charges in excess of the fee schedule	Coverage for emergency ground or air ambulance service only, to transport an individual from the place where injury or illness occurred to the closest hospital where treatment can be given.
	Urgent care	$25 co-pay	30% coinsurance after deductible	Secondary coverage only up to $1,500 per automobile accident. No coverage for workmen's compensation claims.
If you have a hospital stay Must be pre-authorized through Horizon BCBS at:1- 800-664-2583	Facility fee (e.g., hospital room)	No charge	20% co-insurance 100% cost to member for all out of network pain management services	Coverage is limited to 180 inpatient days/calendar year for all services, combined. 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 non-covered charges.
	Physician/surgeon fee	No charge	30% after deductible	Must be medically necessary.

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	$100 co-pay plus 20% coinsurance at a facility. 30% coinsurance after deductible at a doctor's office.	The network is: Intervention Strategies 351 Evelyn Street Paramus, NJ 07652 Contact **Intervention Strategies at: 800 663-0404** for pre-authorization and claim filing information. Co-pays apply to Intensive Outpatient and Partial Hospitalization Program services. **Out-of-network drug testing is not covered. ABA therapy is not covered.**
	Substance use disorder outpatient services	$25 co-pay/visit		
	Mental/behavioral health inpatient services	No charge	20% co-insurance and excess UCR charges	Coverage is limited to 180 inpatient days/calendar year for all services combined. Out-of-network drug testing is not covered. Pre-authorization through Intervention Strategies at 800 663-0404 is required. 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 non-covered charges.
	Substance use disorder inpatient services	No charge	20% co-insurance and excess UCR charges	
If you are pregnant	Prenatal and postnatal care	$25 co-pay	30% coinsurance after deductible	No coverage for pregnancy related charges and complications of pregnancy for dependent children.
	Delivery and all inpatient services	No charge	30% coinsurance after deductible	
If your child needs dental or eye care	Eye exam	No charge	No charge	Coverage is limited to $400/person, $1000/family combined for exam and glasses.
	Glasses	No charge	No charge	
	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	No charge	30% coinsurance after deductible	Coverage is limited to 3 days for full time home care services and 120 annual visits for combined home care services and a $10,000 annual max for home care nursing. Pre-authorization required. Service must begin within 14 days of a hospital discharge.
	Rehabilitation services	No charge for inpatient facility claims	$100 co-pay plus 20% coinsurance for outpatient services at a facility. 30% coinsurance after deductible at a doctor's office. 20% coinsurance for inpatient facility.	Coverage is limited to 180 inpatient days/calendar year for all services combined. 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 non-covered charges. Coverage for outpatient services is limited to 36 combined physical therapy/occupational therapy visits, 24 speech therapy visits and 30 cardiac rehab visits/calendar year.
		$25 co-pay/visit for outpatient claims		
	Habilitation services	Not covered	Not covered	----------none----------
	Skilled nursing care	No charge	20% co-insurance	Coverage is limited to 120 days/calendar year combined with the Home health care benefit. Pre-authorization required.
	Durable medical equipment	20% coinsurance	30% coinsurance after deductible	Pre-authorization is required for all charges exceeding $1,500.
	Hospice Service	No charge	Excess UCR charges	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; Auto accidents (other than $1500 secondary coverage); Infertility; ABA therapy; Massage Therapy; Cosmetic Surgery; Pregnancy related charges and complications of pregnancy for any dependent other than a spouse; Charges for/or related to sex change surgery or any treatment of gender identity disorders; Habilitation services; Long Term Care; Gym Memberships; Weight Loss Programs; Orthotics; All routine preventive and well care visits with an out-of-network provider; 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; All drug testing by an out-of-network provider; All nerve conduction studies and testing, TENS unit and durable medical equipment performed or provided by a chiropractor or acupuncturist; Sea Ambulance Service; Non-Emergency Ambulance Services (for example, from hospital to rehab would not be covered); Services that are deemed to be Investigational; Services that are not Medically Necessary; Medical services rendered outside of the country, except as specified below in section titled Other Covered Services; All Compounded drugs; Proton Pump Inhibitors including, but not limited to Omeprazole, Prilosec, Prevacid, Zegerid, Aciphex, Dexilant, and Nexium, along with any other drugs classified as proton pump inhibitors; Any prescription available over the counter; All Schedule II substances including, but not limited to Codeine, Morphine, Hydrocodone, Oxycodone, and Percocet, with the exception of attention deficit disorder drugs. For Medicare primary members, any services not covered by Medicare will not be covered by the Fund.

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.)
Breast pump: covered up to $50; Wigs: covered up to $500; Hearing benefit: $3,000/person/every 3 years; TMJ benefit: $1,000/person/calendar year; Full Bony Impacted Wisdom Teeth – Limited benefit; Nutritional counseling: up to 3 visits per year, participating providers only; Vision therapy: up to 12 visits per year; Growth hormones: up to $15,000/year for a maximum of 3 years, Member must utilize Horizon Health Center and growth hormone must be approved for medical necessity by Horizon Health Center; Bariatric surgery and complications of bariatric surgery: limited to $15,000 lifetime. Pre-authorization is required; Chiro benefit: under no circumstances will the Fund ever pay more than 40 visits/person, 120 visits/family for the calendar year, regardless of whether the provider is participating or non-participating.; All expenses arising out of injuries on school property or during after school related activities, along with sponsored athletic activities such as Little League, Pop Warner Football or any organized sports activities will be covered up to $2500 per accident. The Fund will pay as primary if there is another insurance involved. Expenses for emergency medical care only, out of the country will be reimbursed to member under the out of network benefit upon receipt of a medical claim (translated), proof of payment (converted into dollars) and medical records proving emergency (translated). Travel insurance is highly recommended.

FOR MEDICARE PRIMARY MEMBERS ONLY

If your Medicare Plan is your primary coverage and the IBEW Local Union102 is your supplement 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 IBEW Local 102 Plan annual $400 deductible is satisfied, your IBEW Local 102 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 IBEW Local 102 Plan annual $400 deductible is satisfied, your IBEW Local 102 Plan will pay you the balance after Medicare, up to the Medicare approved amount. Co-pays and coinsurances do not apply.

Note: If you do not accept Medicare Part B the Plan will process all claims as if Medicare Part B were chosen and your benefits will be reduced by the amount that Medicare would have paid.

Your IBEW Local 102 Medicare Supplement Plan follows the Medicare Plan of Benefits to determine coverage, therefore if Medicare approves a procedure or service your Local 102 Plan will consider that procedure or service to be covered under the Local 102 Plan. If Medicare does not allow a procedure or service or considers any benefit to be exhausted then your Local 102 Plan will deny the procedure or service as not covered. If any Medicare Benefit is exhausted then that benefit will be considered to be exhausted under your Local 102 Plan as well.

PRESCRIPTION PLAN FOR MEDICARE PRIMARY MEMBERS ONLY

Prescription drug benefits are provided by Express Scripts Medicare®PDP

Prescription Coverage	30 Day Retail You Pay (up to)	90 Day Retail/Mail Order You Pay (up to)
Deductible	$0	$0
Generics (Tier 1)	$10	$30
Preferred Brands (Tier 2)	50% to max of $47	50% to max of $141
Non-Preferred Brands (Tier 3)	50% to max of $300	50% to max of $900
Specialty (Tier 4)	$100	$300

Important things to know

- The Express Scripts Pharmacy Network contains over 65,000 in-network pharmacies nationwide.
- Express Script also offers the Express Scripts Mail Order program for your convenience.
- For most non –specialty drugs, you can get a 90-day supply at retail for the mail order pricing.
- Testing strips, lancets, and meters are processed under Medicare Part B. You will need to show your red, white, and blue Medicare card along with your Horizon card at your pharmacy for these claims.
- All insulin will be covered under Express Scripts Medicare ® PDP. You will be subject to copays.

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 1-800-792-3666. 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 1-888-423-9102.

For group health coverage subject to ERISA, contact the plan at 1-888-423-9102 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 888 423-9102

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 $7,465**
- **Patient pays $75**

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:	
Deductibles	$0
Co-pays	$75
Coinsurance	$0
Limits or exclusions	$0
Total	**$75**

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

- **Amount owed to providers: $5,400**
- **Plan pays $5,325**
- **Patient pays $75**

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:	
Deductibles	$0
Co-pays	$75
Coinsurance	$0
Limits or exclusions	$0
Total	**$75**

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.