




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 (315) 474 5729. 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 (315) 474 5729 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall <u>deductible</u> ?	<u>In-Network</u> : \$500/Individual \$1,000/Family <u>Out-of-Network</u> : \$1,000/Individual \$ 2,000/Family	Generally, you must pay all of the costs from <u>providers</u> up to the <u>deductible</u> amount before this <u>plan</u> begins to pay. If you have other family members on the <u>plan</u> , each family member must meet their own individual <u>deductible</u> until the total amount of <u>deductible</u> expenses paid by two or more family members meets the overall family <u>deductible</u> .
Are there services covered before you meet your <u>deductible</u> ?	Yes. Inpatient hospital, skilled nursing facility, home health care, and <u>prescription drugs</u> are covered before you meet your <u>deductible</u> .	This <u>plan</u> covers some items and services even if you haven't yet met the <u>deductible</u> amount. But a <u>copayment</u> or <u>coinsurance</u> may apply.
Are there other <u>deductibles</u> for specific services?	No.	You don't have to meet <u>deductibles</u> for specific services.
What is the <u>out-of-pocket limit</u> for this <u>plan</u> ?	Yes. <u>In-Network</u> : None; <u>Out-of-Network</u> : \$1,500 per Individual	<u>In-Network</u> : This plan does not have an <u>out-of-pocket</u> limit on your <u>in-network</u> benefits. <u>Out-of- Network</u> : The <u>out-of-pocket limit</u> is the most you could pay in a year for covered services.
What is not included in the <u>out-of-pocket limit</u> ?	<u>Premiums</u> , <u>balance-billed</u> charges, health care this <u>plan</u> does not cover, <u>copayments</u> , <u>deductibles</u> , penalties for failure to obtain <u>pre-authorization</u> for services and <u>in-network</u> benefits.	<u>In-Network</u> : This <u>plan</u> does not have an <u>out-of-pocket limit</u> on your <u>in-network</u> expenses. <u>Out-of- Network</u> : Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u> .
Will you pay less if you use a <u>network provider</u> ?	Yes, see www.pomcogroup.com or call 1-800-317-2186 for a list of <u>network providers</u> .	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> .

 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	\$20 <u>copay</u> /visit, after <u>deductible</u>	20% <u>coinsurance</u> + <u>balance-billed</u> charges after <u>deductible</u>	None
	<u>Specialist</u> visit	\$20 <u>copay</u> /visit, after <u>deductible</u>	20% <u>coinsurance</u> + <u>balance-billed</u> after <u>deductible</u>	Acupuncture and chiropractic care not covered.
	<u>Preventive care/screening/immunization</u>	Routine Adult Physical: No charge up to \$250, <u>deductible</u> does not apply; Well Child Visit and other preventive care (e.g., bone density testing, colonoscopy, mammography, cervical cancer screening and prostate cancer screening): \$20 <u>copay</u> /visit	Routine Adult Physical: No charge up to \$250, thereafter 20% <u>coinsurance</u> plus <u>balance-billed</u> charges after <u>deductible</u> ; Well Child Visit: 20% <u>coinsurance</u> plus <u>balance-billed</u> charges after <u>deductible</u> ; Other preventive care (bone density testing, colonoscopy, mammography, cervical cancer screening and prostate cancer screening): No charge except <u>balance billed</u> charges	Subject to age and frequency limitations.
If you have a test	<u>Diagnostic test</u> (x-ray, blood work)	Physician office and freestanding lab: No charge, after <u>deductible</u> ; Outpatient hospital facility: No charge.	Physician office, freestanding lab and outpatient skilled nursing facility: No charge except <u>balance-billed</u> charges; Outpatient hospital facility: 50% <u>coinsurance</u> + <u>balance-billed</u> charges.	Failure to precertify an MRA or MRI will result in a benefit reduction of the lesser of 50% or \$250.
	Imaging (CT/PET scans, MRIs)	Physician office and freestanding lab: \$20 <u>copay</u> /test; Outpatient hospital or <u>skilled nursing</u> facility: No charge	Physician office, freestanding lab: No charge except <u>balance billed</u> charges; Outpatient hospital facility: 50% <u>coinsurance</u> + <u>balance billed</u> charges	

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.savrx.com or 1-866-233-4239.	Generic drugs (Tier 1)	Retail: \$5 <u>copay</u> /script; Mail Order: \$10 <u>copay</u> /script <u>Deductible</u> does not apply	Not covered	Retail pharmacy will provide up to a 30-day supply per prescription. Mail Order pharmacy will provide up to a 90-day supply per prescription. Mandatory Generic Substitution Program: If you purchase a brand name drug and a generic substitution is available, you will pay the difference in price between the brand name drug and the generic substitute. Step Therapy Program applies to proton pump inhibitors. Prior authorization required for certain drugs. <u>Specialty drugs</u> that cost more than \$5,000 are subject to clinical review.
	Preferred brand drugs (Tier2)	Retail: \$20 <u>copay</u> /script Mail Order: \$40 <u>copay</u> /script <u>Deductible</u> does not apply	Not covered	
	Non-preferred brand drugs (Tier 3)	Retail: \$35 <u>copay</u> /script Mail Order: \$70 <u>copay</u> /script <u>Deductible</u> does not apply	Not covered	
	<u>Specialty drugs</u>	Retail: \$35 <u>copay</u> /script Mail Order: \$70 <u>copay</u> /script <u>Deductible</u> does not apply	Not covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	Freestanding facility: \$20 <u>copay</u> /procedure; Outpatient hospital surgical center: No charge. <u>Deductible</u> does not apply	Freestanding facility: No charge except <u>balance billed</u> charges; Outpatient hospital surgical center: 50% <u>coinsurance</u> + <u>balance billed</u> charges; <u>deductible</u> does not apply.	None.
	Physician/surgeon fees	\$20 <u>copay</u> /procedure	No charge except <u>balance billed</u> charges	Failure to precertify certain procedures will result in a benefit reduction of the lesser of 50% or \$250.

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 immediate medical attention	<u>Emergency room care</u>	Facility fee: No charge; Physician fee: \$20 <u>copay</u> /visit; <u>deductible</u> does not apply	Facility fee: 50% <u>coinsurance</u> + <u>balance billed</u> charges; Physician fee: No charge except <u>balance billed</u> charges	Must be within 72 hours of accident or 12 hours of onset of sudden and serious symptoms. Treatment of non-emergency conditions not covered.
	<u>Emergency medical transportation</u>	Land and Air: No charge after <u>deductible</u>	Land: 20% <u>coinsurance</u> + <u>balance billed</u> charges after <u>deductible</u> ; Air: No charge after <u>deductible</u> except <u>balance billed</u> charges	Land ambulance: transfer from an inpatient facility (or other facility) to another facility (or other location) must be ordered by a physician and not be merely for the convenience of the patient.
	<u>Urgent care</u>	No charge; <u>deductible</u> does not apply	No charge except <u>balance billed</u> charges; <u>deductible</u> does not apply	For urgent care visits not within 72 hours of accident or 12 hours of onset of sudden and serious symptoms: In-Network: No charge after <u>deductible</u> ; Out-of-Network: 20% <u>coinsurance</u> + <u>balance-billed</u> charges.
If you have a hospital stay	Facility fee (e.g., hospital room)	No charge; <u>deductible</u> does not apply	No charge except <u>balance billed</u> charges; <u>deductible</u> does not apply	Precertification required. Failure to precertify services will result in a benefit reduction of \$250. Limited to 120 days per approved inpatient stay. Semi-private room only unless a private room is medically necessary.
	Physician/surgeon fees	\$20 <u>copay</u> /visit; <u>deductible</u> does not apply	No charge except <u>balance billed</u> charges; <u>deductible</u> does not apply	Precertification required. Failure to precertify certain procedures will result in a benefit reduction of the lesser of 50% or \$250. Limited to one visit per day per approved inpatient hospital stay.

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 mental health, behavioral health, or substance abuse services	Outpatient services	Office visit: No charge after <u>deductible</u> ; Other outpatient services: No charge; <u>deductible</u> does not apply	Office visit: 20% <u>co-insurance</u> + <u>balance billed</u> charges after <u>deductible</u> ; Other outpatient services: No charge except <u>balance billed</u> charges; <u>deductible</u> does not apply	None.
	Inpatient services	Facility and professional fees: No charge; <u>deductible</u> does not apply	Facility and professional fees: No charge except <u>balance billed</u> charges; <u>deductible</u> does not apply	Same as hospital stay facility fee limitations.
If you are pregnant	Office visits	\$20 <u>copay</u> /visit	No charge except <u>balance-billed</u> charges	Elective abortions and services and supplies related to surrogate maternity care are not covered.
	Childbirth/delivery professional services	\$20 <u>copay</u> /visit	No charge except <u>balance-billed</u> charges	
	Childbirth/delivery facility services	No charge; <u>deductible</u> does not apply	No charge except <u>balance-billed</u> charges; <u>deductible</u> does not apply	

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 help recovering or have other special health needs	<u>Home health care</u>	First 40 visits: No charge; <u>deductible</u> does not apply All visits thereafter: No charge after <u>deductible</u>	First 40 visits: No charge; All visits thereafter: 20% <u>coinsurance</u> + <u>balance billed</u> charges after <u>deductible</u>	Failure to precertify services will result in a benefit reduction of \$250. After the first 40 covered visits, there is a limit of an additional 325 visits per calendar year. Services must be in lieu of inpatient bed stay and provided by an agency licensed by New York State. Up to four hours of care is equal to one visit.
	<u>Rehabilitation services</u>	Physician office and freestanding facility: \$20 <u>copay</u> /visit after <u>deductible</u> ; Outpatient hospital or <u>skilled nursing</u> facility and inpatient facilities: No charge; <u>deductible</u> does not apply	Physician office and freestanding facility: 20% <u>coinsurance</u> + <u>balance billed</u> charges after <u>deductible</u> ; Outpatient hospital: 50% <u>coinsurance</u> + <u>balance billed</u> charges; Outpatient <u>skilled nursing</u> facility and inpatient facilities: No charge except <u>balance billed</u> charges; <u>deductible</u> does not apply	Services must be ordered by a physician. Includes physical therapy, speech therapy and vision therapy. <u>Deductible</u> applies to outpatient hospital and <u>skilled nursing</u> facility based physical or occupational therapies not furnished within six months of a related surgery or hospital discharge.
	<u>Habilitation services</u>	Not covered	Not covered	You must pay 100% of these services, even in-network.
	<u>Skilled nursing care</u>	No charge; <u>deductible</u> does not apply	No charge except <u>balance billed</u> charges; <u>deductible</u> does not apply	Failure to precertify services will result in a benefit reduction of \$250. Services must be in lieu of <u>hospitalization</u> and provided by a licensed facility. Limited to one visit per day for up to 120 days per approved inpatient Hospital or <u>Skilled Nursing Facility</u> stay.
	<u>Durable medical equipment</u>	\$20 <u>copay</u> /DME after <u>deductible</u>	20% <u>coinsurance</u> + <u>balance billed</u> charges after <u>deductible</u>	Failure to precertify DME will result in a benefit reduction of the lesser of 50% or \$250. Must be ordered by a physician.
	<u>Hospice services</u>	No charge	No charge except <u>balance billed</u> charges	Limited to 210 days per lifetime and up to 5 bereavement counseling visits for family members. Facility must be certified by NYSDOH or, if outside NY, certified under similar standards.

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	Not covered	Not covered	You must pay 100% of these expenses, even in-network.
	Children's glasses	Not covered	Not covered	
	Children's dental check-up	50% <u>coinsurance</u>	50% <u>coinsurance</u> + <u>balance-billed</u> charges	Limited to two dental check-ups per individual per calendar year.

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.)

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|---|--|--|
| <ul style="list-style-type: none"> • Acupuncture • Chiropractic care • Cosmetic surgery (Except to restore tissue damaged by an illness or injury or for reconstructive surgery) | <ul style="list-style-type: none"> • Elective abortions • <u>Habilitation services</u> • Hearing aids • Infertility treatment (Limited to diagnosis and treatment of underlying medical condition) | <ul style="list-style-type: none"> • Long-term care • Routine eye care (Adult) (Child) • Routine foot care (Except for patients with severe systemic disorders, such as diabetes) • Weight loss programs |
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Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

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| <ul style="list-style-type: none"> • Bariatric surgery (For treatment of Morbid Obesity) | <ul style="list-style-type: none"> • Dental care (Adult) (Limited to dental check-ups, bitewing x-rays and prophylaxis two times per calendar year) | <ul style="list-style-type: none"> • Non-emergency care when traveling outside the U.S. • Private-duty nursing (Only when Medically Necessary) |
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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 U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 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 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 Office at IBEW Local No. 43 and Electrical Contractors Welfare Fund, 4568 Waterhouse Road, Clay, New York 13041 or via phone at (315) 474 5729. You may also contact the Department of Labor's Employee Benefits Security administration at 1-866-444-EBSA (3272) or dol.gov/ebsa/healthreform.

Does this plan provide Minimum Essential Coverage? Yes

If you don't have Minimum Essential Coverage for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

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:

Spanish (Español): Para obtener asistencia en Español, llame al (315) 474 5729.

—————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>	\$500
■ <u>Specialist copayment</u>	\$20
■ Hospital (facility) <u>coinsurance</u>	None
■ Other <u>copayments</u>	\$20

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	\$12,800
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In this example, Peg would pay:

<i>Cost Sharing</i>	
Deductibles	\$500
Copayments	\$110
Coinsurance	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$60
The total Peg would pay is	\$670

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>	\$500
■ <u>Specialist copayment</u>	\$20
■ Hospital (facility) <u>coinsurance</u>	None
■ Other <u>copayment</u>	\$20

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	\$7,400
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In this example, Joe would pay:

<i>Cost Sharing</i>	
Deductibles	\$500
Copayments	\$1,140
Coinsurance	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$70
The total Joe would pay is	\$1710

Mia's Simple Fracture

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

■ The plan's overall <u>deductible</u>	\$500
■ <u>Specialist copayment</u>	\$20
■ Hospital (facility) <u>coinsurance</u>	None
■ Other <u>copayment</u>	\$20

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	\$1,900
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In this example, Mia would pay:

<i>Cost Sharing</i>	
Deductibles	\$500
Copayments	\$40
Coinsurance	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$0
The total Mia would pay is	\$540

Your Health Reimbursement Account (HRA) may be available for reimbursement for out-of-pocket expenses.

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