Coverage for: Family | **Plan Type:** PPO

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, [insert contact information]. 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.[insert].com or call 1-800-[insert] to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	$0	See the chart starting on page 3 for a list of the services that can be covered under this plan up to the amount available in your HRA account. The Southern California IBEW-NECA Health Plan reimburses first dollar for any service that is an eligible HRA expense under Section 213 of the Internal Revenue Code.
Are there services covered before you meet your deductible?	There is no deductible under the HRA.	This HRA plan may be used to offset all or a portion of an eligible and enrolled participant's or eligible expenses and enrolled dependent's expenses that are considered reimbursable under Section 213 of the Internal Revenue Code. See the chart starting on page 3 for a list of the services that may be covered under this plan up to the amount available in your HRA account.
Are there other deductibles for specific services?	No.	There is no deductible under the HRA. See the chart starting on page 3 for a list of the services that may be covered under this plan up to the amount available in your HRA account.
What is the out-of-pocket limit for this plan?	Not applicable.	The HRA can only reimburse you up to the amount accrued in your HRA account. .
What is not included in the out-of-pocket limit?	Not applicable.	There is no **out-of-pocket limit**. The HRA can only reimburse you up to the amount accrued in your HRA account. .
Will you pay less if you use a network provider?	Not applicable.	This **plan** does not use a **network provider**. This HRA **plan** may be used to offset all or a portion of an eligible and enrolled participant or eligible and enrolled dependent's expenses that are considered reimbursable under Section 213 of the Internal Revenue Code.
Do you need a referral to see a specialist?	No.	This HRA **plan** may be used to offset all or a portion of an eligible and enrolled participant or eligible and enrolled dependent's expenses that are considered reimbursable under Section 213 of the Internal Revenue Code.

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	100% up to available HRA balance	100% up to available HRA balance	This HRA plan may be used to offset all or a portion of an eligible and enrolled participant's expenses or eligible and enrolled dependent's expenses that are considered reimbursable under Section 213 of the Internal Revenue Code. The HRA cannot reimburse any part of expense that is payable from another source, such as health insurance.
	Specialist visit	Same as above	Same as above	Same as above
	Preventive care/screening/ immunization	Same as above	Same as above	Same as above
If you have a test	Diagnostic test (x-ray, blood work)	Same as above	Same as above	Same as above
	Imaging (CT/PET scans, MRIs)	Same as above	Same as above	
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.scibew-neca.org	Generic drugs (Tier 1)	Same as above	Same as above	Same as above
	Preferred brand drugs (Tier 2)	Same as above	Same as above	
	Non-preferred brand drugs (Tier 3)	Same as above	Same as above	
	Specialty drugs (Tier 4)	Same as above	Same as above	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	Same as above	Same as above	Same as above
	Physician/surgeon fees	Same as above	Same as above	
If you need immediate medical attention	Emergency room care	Same as above	Same as above	Same as above
	Emergency medical transportation	Same as above	Same as above	

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)	
	Urgent care	Same as above	Same as above	
If you have a hospital stay	Facility fee (e.g., hospital room)	Same as above	Same as above	Same as above
	Physician/surgeon fees			
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Same as above	Same as above	Same as above
	Inpatient services	Same as above	Same as above	
If you are pregnant	Office visits	Same as above	Same as above	Same as above
	Childbirth/delivery professional services	Same as above	Same as above	
	Childbirth/delivery facility services	Same as above	Same as above	
If you need help recovering or have other special health needs	Home health care	Same as above	Same as above	Same as above
	Rehabilitation services	Same as above	Same as above	Same as above
	Habilitation services	Same as above	Same as above	
	Skilled nursing care	Same as above	Same as above	Same as above
	Durable medical equipment	Same as above	Same as above	Same as above
	Hospice services	Same as above	Same as above	Same as above
If your child needs dental or eye care	Children's eye exam	Same as above	Same as above	Same as above
	Children's glasses	Same as above	Same as above	Same as above
	Children's dental check-up	Same as above	Same as above	Same as above

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.)

- Any expense payable through another source such as a health insurance plan. Any services or supplies beyond the amount in the HRA account or services or supplies that are not reimbursable, (even if they meet the definition of medical care) under the Internal Revenue Code Section 213.

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

- Charges reimbursable under Internal Revenue Code Section 213 for an eligible and enrolled participant's expenses or eligible and enrolled dependent's expenses up to the amount available in the eligible participant's HRA account, such as:
  - Acupuncture
  - Chiropractic care
  - Dental care

- Routine Eye care
- Routine Foot care

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: 1-844-739-7956. 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-(877-026-2323 x 61565 or www.cclio.dms.gov). 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 Plan Administrative office at (800) 824-6935

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 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 1-844-739-7956

To see examples of how this plan might cover costs for a sample medical situation, see the next section.

About these Coverage Examples:

The example is based on a participant enrolled in Kaiser Permanente simply to demonstrate the use of the HRA.

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	$0
Specialist copayment	$5
Hospital (facility) coinsurance	$0
Other coinsurance	$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	$0
Copayments	$0
Coinsurance	$0
What isn't covered	
Limits or exclusions	$50
The total Peg would pay is	**$50**

Managing Joe's type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

The plan's overall deductible	$0
Specialist copayment	$5
Hospital (facility) coinsurance	$0
Other coinsurance	$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*	$0
Copayments	$200
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Joe would pay is	**$200**

Mia's Simple Fracture
(in-network emergency room visit and follow up care)

The plan's overall deductible	$0
Specialist copayment	$5
Hospital (facility) coinsurance	$0
Other coinsurance	$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*	$0
Copayments	$30
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$30**

**** The HRA plan may be used to offset all or a portion of the eligible and enrolled participant/dependent expenses that are considered reimbursable under Section 213 of the Internal Revenue Code.**

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