


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, <https://coastbenefits.com/your-plan/southern-california-ibew-neca-health-trust-fund-health-reimbursement-arrangement-hra-3a/>. 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 <https://www.healthcare.gov/sbc-glossary> or call 1-866-444-3272 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall <a href="#">deductible</a> ?	\$0	See the chart starting on page 3 for a list of the services that can be covered under this <a href="#">plan</a> 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 <a href="#">deductible</a> ?	There is no <a href="#">deductible</a> under the HRA.	This HRA <a href="#">plan</a> 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 <a href="#">deductibles</a> 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 <a href="#">out-of-pocket limit</a> for this <a href="#">plan</a> ?	Not applicable.	The HRA can only reimburse you up to the amount accrued in your HRA account.
What is not included in the <a href="#">out-of-pocket limit</a> ?	Not applicable.	There is no <a href="#">out-of-pocket limit</a> . The HRA can only reimburse you up to the amount accrued in your HRA account.
Will you pay less if you use a <a href="#">network provider</a> ?	Not applicable.	This <a href="#">plan</a> does not use a <a href="#">network provider</a> . This HRA <a href="#">plan</a> 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 <a href="#">referral</a> to see a <a href="#">specialist</a> ?	No.	This HRA <a href="#">plan</a> 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)	
<b>If you visit a health care <a href="#">provider's</a> office or clinic</b>	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.
	<a href="#">Specialist</a> visit	Same as above	Same as above	
<b>If you have a test</b>	<a href="#">Preventive care/screening/immunization</a>	Same as above	Same as above	Same as above
	<a href="#">Diagnostic test</a> (x-ray, blood work)	Same as above	Same as above	Same as above
	Imaging (CT/PET scans, MRIs)	Same as above	Same as above	
<b>If you need drugs to treat your illness or condition</b>	Generic drugs (Tier 1)	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	
More information about <a href="#">prescription drug coverage</a> is available at <a href="http://www.scibew-neca.org">www.scibew-neca.org</a>	<a href="#">Specialty drugs</a> (Tier 4)	Same as above	Same as above	Same as above
	Facility fee (e.g., ambulatory surgery center)	Same as above	Same as above	Same as above
<b>If you have outpatient surgery</b>	Physician/surgeon fees	Same as above	Same as above	
	<a href="#">Emergency room care</a>	Same as above	Same as above	Same as above
	<a href="#">Emergency medical transportation</a>	Same as above	Same as above	

\* For more information about limitations and exceptions, see the plan or policy document at.- <https://coastbenefits.com/your-plan/southern-california-ibew-neca-health-trust-fund-health-reimbursement-arrangement-hra-3a/>

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 a hospital stay	<a href="#">Urgent care</a>	Same as above	Same as above	Same as above
	Facility fee (e.g., hospital room)	Same as above	Same as above	
If you need mental health, behavioral health, or substance abuse services	Physician/surgeon fees			Same as above
	Outpatient services	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	<a href="#">Home health care</a>	Same as above	Same as above	Same as above
	<a href="#">Rehabilitation services</a>	Same as above	Same as above	Same as above
	<a href="#">Habilitation services</a>	Same as above	Same as above	Same as above
	<a href="#">Skilled nursing care</a>	Same as above	Same as above	Same as above
	<a href="#">Durable medical equipment</a>	Same as above	Same as above	Same as above
	<a href="#">Hospice services</a>	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:

<p><b>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>.)</b></p> <ul style="list-style-type: none"> <li>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.</li> </ul>
<p><b>Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your <a href="#">plan</a> document.)</b></p> <ul style="list-style-type: none"> <li>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: <ul style="list-style-type: none"> <li>Acupuncture</li> <li>Chiropractic care</li> <li>Dental care</li> </ul> </li> </ul>

\* For more information about limitations and exceptions, see the plan or policy document at.- <https://coastbenefits.com/your-plan/southern-california-ibew-neca-health-trust-fund-health-reimbursement-arrangement-hra-3a/>

- 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: Department of Managed Healthcare, California Help Center, 980 9th St, Suite 500, Sacramento, CA 95814-2725, 888-466-2219. <https://www.dmhc.ca.gov>. 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](http://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](http://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](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 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/No]**

[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 Minimum Value Standards? [Yes/No/Not Applicable]**

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

[Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa ? 1-844-739-7956

[Chinese (中文): 如果需要中文的帮助, 请拨打这个号码 ? 1-844-739-7956

[Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijigo holne' ? 1-844-739-7956

*To see examples of how this [plan](#) might cover costs for a sample medical situation, see the next section*

**PRA Disclosure Statement:** According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is **0938-1146**. The time required to complete this information collection is estimated to average **0.02** hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

\* For more information about limitations and exceptions, see the plan or policy document at - <https://coastbenefits.com/your-plan/southern-california-ibew-neca-health-trust-fund-health-reimbursement-arrangement-hra-3a/>

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:**

<i>Cost Sharing</i>	
Deductibles	\$0
Copayments	\$0
Coinsurance	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$50
<b>The total Peg would pay is</b>	<b>\$50</b>

**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:**

<i>Cost Sharing</i>	
Deductibles*	\$0
Copayments	\$200
Coinsurance	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$0
<b>The total Joe would pay is</b>	<b>\$200</b>

**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:**

<i>Cost Sharing</i>	
Deductibles*	\$0
Copayments	\$30
Coinsurance	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$0
<b>The total Mia would pay is</b>	<b>\$30</b>

\*\* 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 [plan](#) would be responsible for the other costs of these EXAMPLE covered services.