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

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 provider's office or clinic	Primary care visit to treat an injury or illness	No charge if allowed by Medicare.	N/A	----------none----------
	Specialist visit			
	Preventive care/screening/ immunization			
If you have a test	Diagnostic test (x-ray, blood work)			
	Imaging (CT/PET scans, MRIs)			
If you need drugs to treat your illness or condition prescription drug coverage is available at www.MyVibrantRx.com or call 844-826-3451.	Generic drugs	$25 copayment/fill (retail); $50 copayment/fill (preferred network pharmacy or mail order); and $75 copayment/fill (non-preferred pharmacy).	50% coinsurance.	34-day supply retail; 90-day supply preferred network pharmacy or mail order; 90-day supply non-preferred pharmacy If a brand name drug is chosen when a generic drug is available, the brand name copayment will apply. 90-day supply for maintenance drugs available through CVS Mandatory Choice90 (retail and mail order). Drugs considered preventive services under the ACA are covered at 100% and not subject to prescription drug deductible or copayments.
	Preferred brand name drugs	$40 copayment/fill (retail); $80 copayment/fill (preferred network pharmacy or mail order); $120 copayment/fill (non-preferred pharmacy).		
	Non-preferred brand name drugs	$50 copayment/fill (retail); $100 copayment/fill (preferred network pharmacy or mail order); $150 copayment/fill (non-preferred pharmacy).	50% coinsurance.	
	Specialty drugs through the prescription drug program	10% coinsurance (retail and mail order) up to a maximum of $125/fill.	50% coinsurance (retail).	Limited to a 30-day supply. Covered persons who were receiving specialty drugs before January 1, 2013 pay retail or mail order copayments, not subject to maximum. Humira, Skyrizi, and Rinvoq are not covered by this plan

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 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	Emergency room care	No charge if allowed by Medicare.	N/A	----------none----------
	Emergency medical transportation			
	Urgent care			
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----------
If you need mental health, behavioral health, or substance abuse services	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----------
If you are pregnant	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----------

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 help recovering or have other special health needs	Home health care	No charge if allowed by Medicare.	N/A	----------none----------
	Rehabilitation services			
	Habilitation services	Not covered	Not covered	You must pay 100% of this service, even from a Medicare provider.
	Skilled nursing care	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.
	Durable medical equipment	No charge if allowed by Medicare.	N/A	----------none----------
	Hospice services			
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 Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)

- Acupuncture
- Cosmetic surgery
- Dental care (Adult and Child)
- Habilitation services
- Infertility treatment
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing
- Routine eye care (Adult and Child)
- Weight loss programs

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

- Bariatric surgery (if allowed by Medicare)
- Chiropractic Care (if allowed by Medicare)
- Hearing aids (up to $1,250 per ear every 5 years; no limit for individuals under age 18)
- Long-term care (if allowed by Medicare)
- Routine foot care (if allowed by Medicare)

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 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 (Deitsch): Fer Hilf griege in Deitsch, 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 plan's overall deductible	**N/A**
Specialist	**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**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$0
Copayments	$10
Coinsurance	$0
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$70**

Managing Joe's Type 2 Diabetes
(a year of routine Medicare provider care of a well-controlled condition)

The plan's overall deductible	**N/A**
Specialist	**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**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$0
Copayments	$700
Coinsurance	$0
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$720**

Mia's Simple Fracture
(Medicare provider emergency room visit and follow up care)

The plan's overall deductible	**N/A**
Specialist	**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**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$0
Copayments	$10
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$10**

The Plan pays secondary to Medicare.