

Benefit highlights

IBEW LOCAL 332 100111

Effective January 1, 2016 to December 31, 2016

This is a short description of plan benefits. For complete information, please refer to your Summary of Benefits or Evidence of Coverage. Limitations, exclusions, and restrictions may apply.

Plan Costs	In-Network
Annual out-of-pocket maximum	\$6,700

Medical Benefits	In-Network
Benefits covered by Original Medicare and your plan	
Doctor's office visit	Primary Care Provider: \$10 copay Specialist: \$20 copay
Preventive services	\$0 copay for Medicare-covered in-network preventive services. Refer to the Summary of Benefits or Evidence of Coverage for additional information.
Inpatient hospital care	\$250 copay per admission
Skilled nursing facility (SNF)	\$0 copay per day: days 1-20 \$50 copay per additional day up to 100 days
Outpatient surgery	\$125 copay
Outpatient rehabilitation (physical, occupational, or speech/language therapy)	\$20 copay
Diagnostic radiology services (such as MRIs, CT scans)	\$0 copay
Lab services	\$0 copay
Outpatient x-rays	\$0 copay
Therapeutic radiology services (such as radiation treatment for cancer)	\$0 copay
Ambulance	\$50 copay
Emergency care	\$50 copay (worldwide)
Urgently needed services	\$10 copay (worldwide)
Additional benefits and programs not covered by Original Medicare	
Routine physical	\$0 copay; 1 per plan year
Hearing - routine exam	\$0 copay (1 exam every 12 months)
Hearing aids	Plan pays up to \$500 (every 3 years)
Vision - routine eye exams	\$20 copay (1 exam every 12 months)
Fitness program through SilverSneakers® Fitness program	Stay active with a basic membership at a participating location at no extra cost to you
NurseLine SM	Speak with a registered nurse (RN) 24 hours a day, 7 days a week

Prescription Drugs	Your Cost	
Initial coverage stage	Network Pharmacy (30-day retail supply)	Mail Service Pharmacy (90-day supply)
Tier 1: Preferred generic	\$10 copay	\$20 copay
Tier 2: Preferred brand (includes some generic)	\$20 copay	\$40 copay
Tier 3: Non-preferred brand (includes some generic)	\$20 copay	\$40 copay
Tier 4: Specialty tier	\$20 copay	\$40 copay
Coverage gap stage	After your total drug costs reach \$3,310, the plan continues to pay its share of the cost of your drugs and you pay your share of the cost	
Catastrophic coverage stage	After your total out-of-pocket costs reach \$4,850, you will pay the greater of \$2.95 copay for generic (including brand drugs treated as generic), \$7.40 copay for all other drugs, or 5% of the cost	

Your plan sponsor has elected to offer additional coverage on some prescription drugs that are normally excluded from coverage on your Formulary. Please see your Additional Drug Coverage list for more information.

Plans are insured through UnitedHealthcare Insurance Company or one of its affiliated companies, a Medicare Advantage organization with a Medicare contract. Enrollment in the plan depends on the plan's contract renewal with Medicare.

Retiree plan prospects must meet the eligibility requirements to enroll for group coverage. This information is not a complete description of benefits. Contact the plan for more information. Limitations, copayments, and restrictions may apply. Benefits, premium and/or co-payments/co-insurance may change each plan year.