

Benefit Plan Comparison Effective January 1, 2018

Medical Benefits Provided by:	IEEW H&W Trust Aetna		NECA Family Medical Care Plan Anthem Blue Cross/Blue Shield							
	Standard Plan	Plan 15	Plan 16	Plan 17	Plan 18					
Benefit Period	Calendar Year	Calendar Year	Calendar Year	Calendar Year	Calendar Year					
Deductibles										
PPO										
Per person	\$300	\$350	\$200	\$500	\$1,000					
Per family	\$900	\$1,050	\$400	\$1,000	\$3,000					
Non-PPO										
Per person	Combined w/ PPO	Combined w/ PPO	\$400	\$500	Combined w/ PPO					
Per family			\$800	\$1,000						
Out-of-Pocket Limits										
PPO										
Per person	\$2,500	\$1,900	\$1,400	\$2,100	\$4,000					
Per family	\$2,500 per person	\$3,800	\$2,800	\$4,200	\$8,000					
Non-PPO										
Per person	Combined with PPO	No limit	\$1,400	\$5,100	No limit					
Per family		No limit	\$2,800	\$10,200	No limit					
Plan Payment Percentage / Member Co-Insurance										
	<i>Plan</i>	<i>Member</i>	<i>Plan</i>	<i>Member</i>	<i>Plan</i>	<i>Member</i>	<i>Plan</i>	<i>Member</i>	<i>Plan</i>	<i>Member</i>
PPO	80%	20%	85%	15%	100%	0	90%	10%	70%	30%
Non-PPO	80%	20%	75%	25%	80%	20%	70%	30%	60%	40%

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All co-payment and co-insurance costs shown are after your deductible has been met, if a deductible applies.

Medical Services										
	IEEW H&W Trust		Plan 15		Plan 16		Plan 17		Plan 18	
	Your Cost In-Network	Your Cost Out-of- Network	Your Cost In-Network	Your Cost Out-of- Network	Your Cost In-Network	Your Cost Out-of- Network	Your Cost In-Network	Your Cost Out-of- Network	Your Cost In-Network	Your Cost Out-of- Network
Primary Care or Specialist Visit	20% co-ins	20% co-ins	15% co-ins	25% co-ins	\$20 co-pay	20% co-ins	\$10 co-pay	30% co-ins	30% co-ins	40% co-ins
Preventive Care	No charge	No charge	No charge	Not covered	No charge	Not covered	No charge	Not covered	No charge	Not covered
Emergency Room Services	20% co-ins	20% co-ins	\$100 deductible* 15% co-ins <i>* waived if admitted</i>		\$100 deductible* No charge <i>* waived if admitted</i>		\$100 deductible* 10% co-ins <i>* waived if admitted</i>		30% co-ins	
Urgent Care Facility	20% co-ins	20% co-ins	15% co-ins	25% co-ins	\$20 co-pay	20% co-ins	\$10 co-pay	30% co-ins	30% co-ins	40% co-ins
Inpatient Facility <i>(hospital room)</i>	20% co-ins	20% co-ins	15% co-ins	25% co-ins	No charge	20% co-ins	10% co-ins	30% co-ins	30% co-ins	40% co-ins
Failure to Pre-Certify Benefit Reduction	\$0	\$0	\$250	\$250	\$250	\$250	\$250	\$250	\$250	\$250
Outpatient Facility Fee <i>(ambulatory surgery center)</i>	20% co-ins	20% co-ins	15% co-ins	Not covered	No charge	Not covered	10% co-ins	Not covered	30% co-ins	Not covered
Home Health Care	20% co-ins <i>130 visits/yr</i>	20% co-ins <i>130 visits/yr</i>	15% co-ins <i>120 visits/yr</i>	25% co-ins <i>120 visits/yr</i>	No charge <i>120 visits/yr</i>	20% co-ins <i>120 visits/yr</i>	10% co-ins <i>120 visits/yr</i>	30% co-ins <i>120 visits/yr</i>	30% co-ins <i>120 visits/yr</i>	40% co-ins <i>120 visits/yr</i>
Skilled Nursing Care	20% co-ins	20% co-ins	15% co-ins <i>30 days/yr</i>	25% co-ins <i>30 days/yr</i>	No charge <i>60 days/yr</i>	20% co-ins <i>60 days/yr</i>	10% co-ins <i>30 days/yr</i>	30% co-ins <i>30 days/yr</i>	30% co-ins <i>30 days/yr</i>	40% co-ins <i>30 days/yr</i>
Hospice Services	20% co-ins up to 6 months	20% co-ins up to 6 months	No charge	25% co-ins	No charge	20% co-ins	No charge	30% co-ins	No charge	40% co-ins

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Medical Services (Continued)										
	IEEW H&W Trust		Plan 15		Plan 16		Plan 17		Plan 18	
	Your Cost In-Network	Your Cost Out-of- Network	Your Cost In-Network	Your Cost Out-of- Network	Your Cost In-Network	Your Cost Out-of- Network	Your Cost In-Network	Your Cost Out-of- Network	Your Cost In-Network	Your Cost Out-of- Network
Chiropractic Services	20% co-ins 12 visits/yr	20% co-ins 12 visits/yr	15% co-ins 15 visits/yr	25% co-ins 15 visits/yr	No charge 30 visits/yr	20% co-ins 30 visits/yr	10% co-ins 15 visits/yr	30% co-ins 15 visits/yr	30% co-ins 15 visits/yr	40% co-ins 15 visits/yr
Mental Behavioral Health & Substance Abuse Inpatient and Outpatient	20% co-ins	20% co-ins	15% co-ins	25% co-ins	No charge	20% co-ins	10% co-ins	30% co-ins	30% co-ins	40% co-ins
Rehabilitation Services (PT, OT and Cardio)	20% co-ins	20% co-ins	15% co-ins	25% co-ins	No charge	20% co-ins	10% co-ins	30% co-ins	30% co-ins	40% co-ins
Durable Medical Equipment	20% co-ins	20% co-ins	15% co-ins	25% co-ins	No charge	20% co-ins	10% co-ins	30% co-ins	30% co-ins	40% co-ins
Restorative Speech Therapy due to Stroke	20% co-ins	20% co-ins	15% co-ins 35 visits/yr	25% co-ins 35 visits/yr	No charge 50 visits/yr	20% co-ins 50 visits/yr	10% co-ins 35 visits/yr	30% co-ins 35 visits/yr	30% co-ins 35 visits/yr	40% co-ins 35 visits/yr
Developmental Speech Therapy	20% co-ins, if medically necessary		Not covered							
Bariatric Surgery	Not covered		Not covered							
Standard Hearing Aids	Not covered		One per year per lifetime							
Orthotics	Not covered		One pair custom molded foot orthotics every two years when prescribed and performed in network							

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Prescription Benefits Provided by:	IEEW H&W Trust Sav-Rx		NECA Family Medical Care Plan Sav-Rx	
Out-of-Pocket Limits				
Per person	None	None	\$1,000 per calendar year	
Per family			\$2,000 per calendar year	
Member Co-Pays / Co-Insurance				
	Your Cost In-Network*		Your Cost In-Network*	
	Retail	Mail	Retail	Mail
Generic drugs (mandatory) (Tier 1)	\$5	\$10	No charge	No charge
Preferred brand drugs (Tier 2)	\$25	\$50	20% co-ins	20% co-ins
Non-preferred brand drugs (Tier 3)	\$25	\$50	30% co-ins <i>(minimum \$40)</i>	30% co-ins <i>(minimum \$80)</i>
Out-of-network	Copay plus amount above in-network rate	Copay plus amount above in-network rate	Not Covered	Not Covered

**Wal-Mart and Sam's Club are NOT part of the Sav-Rx network, and the Plan will not cover drugs purchased from their pharmacies*

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Dental Benefits Provided by:	IEEW H&W Trust Delta Dental		NECA Family Medical Care Plan MetLife							
			Plan 15		Plan 16		Plan 17		Plan 18	
Benefit Period	Calendar Year		Calendar Year		Calendar Year		Calendar Year		Not applicable	
Deductibles										
Per person	\$25		None		\$25		None			
Per family	\$75		None		\$75		None			
Maximum Payable Benefits										
Per person	\$2,500		\$1,000		\$1,500		\$1,000			
Plan Payment Percentage										
	<i>Plan</i>	<i>Member</i>	<i>Plan</i>	<i>Member</i>	<i>Plan</i>	<i>Member</i>	<i>Plan</i>	<i>Member</i>		
Preventative	Plan pays 70% in first calendar year, with benefit payments increasing 10% each year, up to 100% provided the dentist is visited once per year	Member pays 30% in first calendar year, with benefit payments decreasing 10% each year, down to 0% provided the dentist is visited once per year	80%	20%	100%	0	80%	20%		
Minor Restorative			80%	20%	80%	20%	80%	20%		
Major Restorative	50%	50%	50%	50%	60%	40%	50%	50%		
Other Benefits										
Orthodontia	50% up to \$1,500 (children up to age 26)		50% up to \$1,000		50% up to \$2,000 (children up to age 26)		\$50% up to \$1,000			

Benefit Plan Comparison Effective January 1, 2018

Weekly Disability Benefits Provided by: <i>(Employees Only)</i>	IEEW H&W Plan	NECA Family Medical Care Plan Plans 15, 16 & 17 Only
Benefit Period	1 to 4 weeks 5 to 26 weeks	26 weeks
Amount Per Week		
Occupational	Not Covered	\$125 per week
Non-Occupational	\$400 per week – weeks 1 -4 \$500 per week – weeks 5 - 26	\$250 per week

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Vision Benefits Provided by:	IEEW H&W Plan VSP		NECA Family Medical Care Plan Plans 15, 16 and 17 Only VSP	
	Your Cost In-Network	Your Cost Out-of-Network	Your Cost In-Network	Your Cost Out-of-Network
Benefits				
Vision Exam	No charge	All above \$92	No charge	\$35
Frames	All above \$150	All above \$89	\$180	\$35
Lenses (per pair):		All above:		
Single vision	No charge	\$38	No charge	\$30
Lined bifocal	No charge	\$60	No charge	\$40
Lined trifocal	No charge	\$78	No charge	\$55
Lined lenticular	No charge	\$109	No charge	\$55
Contacts (elective)	All above \$130	All above \$115	\$150	\$120
Safety Glasses *		All above:		
Frames	No charge	\$25	\$65	\$25
Lenses (per pair):				
Single vision	No charge	\$35	No charge	\$30
Bifocal	No charge	\$45	No charge	\$35
Trifocal	No charge	\$60	No charge	\$45
Lenticular	No charge	\$109	No charge	\$60

Life and AD&D Benefits Provided by:	IEEW H&W Plan	NECA Family Medical Care Plan			
		Plan 15	Plan 16	Plan 17	Plan 18
Benefits					
Employee Death	\$5,000	\$10,000	\$20,000	\$10,000	\$5,000
Employee AD &D	\$5,000	\$10,000	\$20,000	\$10,000	\$5,000
Retiree Death	N/A	\$7,500	\$7,500	\$7,500	None