

**IBEW LOCAL UNION # 22/NECA
HEALTH AND WELFARE FUND**

LISTED BELOW IS A BRIEF OVERVIEW OF YOUR BENEFITS AND IS ONLY A PARTIAL DESCRIPTION OF WHAT YOUR BENEFITS PROVIDE. FOR A FULL DESCRIPTION AND COMPLETE EXPLANATION OF YOUR BENEFITS (INCLUDING LIMITATIONS AND EXCLUSIONS), PLEASE REFER TO YOUR SUMMARY PLAN DESCRIPTION BOOKLET.

Calendar Year Deductibles:

	Preferred In-Network	Non-Preferred Out-of-Network
Individual	\$200	\$200
Family Maximum	\$400	\$400

Maximum Coinsurance:

Individual	\$1,000	\$2,250
Family Maximum	\$2,000	\$4,500

Total Out-of-Pocket:

Individual	\$1,200	\$2,450
Family Maximum	\$2,400	\$4,900

Present You Pay For Covered
Hospital and Medical Services:

20%	30%
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Routine Care:

20%	30%
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Prescription Drug Card:

(see attached)	N/A
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Mail Order:

Name Brand	\$60 for a 90 day supply	N/A
Generic	\$30 for a 90 day supply	N/A

Weekly Disability Benefits:

Member Only	\$140 per week	N/A
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Life Insurance:

Member

Death Benefit	\$2,000	N/A
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Accidental Death And Dismemberment	\$2,000	N/A
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Dependents

Spouse	\$1,000	N/A
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Children (14 day but less Than six (6) months)	\$100	N/A
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Children (Six (6) months But less than nineteen (19) years)	\$1,000	N/A
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