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, visit www.ibew617benefits.com or call the Trust Fund Office at (408) 288-4400 or toll-free (877) 827-4239. 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 www.https://www.healthcare.gov/sbc-glossary or call 1-408-288-4400 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	**$0** for network providers **$250**/Individual or **$500**/family for out-of-network providers	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.
Are there services covered before you meet your deductible?	Yes. Preventive care and primary care services are covered before you meet your deductible.	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost-sharing and before you meet your deductible. See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/.
Are there other deductibles for specific services?	**No.**	You don't have to meet for deductibles specific services.
What is the out-of-pocket limit for this plan?	**Yes**. For network providers., **$1,250** person/**$2,500** family. For out-of-network providers, **$2,000** person/**$4,000** family.	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.
What is not included in the out-of-pocket limit?	Copayments for certain services, premiums, balance-billing charges, 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.** See www.anthem.com/ca/ or call 1-408-288-4400 or Anthem Blue Cross at 1-800-688-3828 for a list of network providers.	This plan uses a provider network. You will pay less if you use a provider in the plan's Level One network. You will pay the most if you use Level Two 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.

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
		Level One Network Provider (You will pay the least)	Level Two Out-of-Network 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	$15 copay/visit; deductible does not apply. No Charge COVID-19 test (if medically necessary)	$15 copay/visit.	COVID-19 visits for testing covered at no cost for in-network only if medically necessary and ordered by a doctor.
	Specialist visit	$15 copay/visit; 10% coinsurance for chiropractor & acupuncture	$15 copay/visit; 40% coinsurance; after deductible for chiropractor & acupuncture	30 visits/year (chiropractor & acupuncture).
	Preventive care/screening/ immunization	No Charge. Deductible does not apply.	40% coinsurance; after deductible.	You may have to pay for services that aren't preventive. Ask your provider if the services you need are preventive. Then check what your plan will pay for. Well baby care & immunizations covered from birth to age 3. COVID-19 vaccinations are covered at no cost for in-network only.
If you have a test	Diagnostic test (x-ray, blood work)	10% coinsurance	40% coinsurance; after deductible	None.
	Imaging (CT/PET scans, MRIs)	10% coinsurance	40% coinsurance; after deductible	None.
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.savRx.com or call toll free 1-866-233-4239.	Generic drugs	$5 copay retail); $10 copay (mail)	100% less reimbursement to network pharmacy	Covers up to 34-day supply (retail subscription); up to 90-day supply (mail order prescription).
	Preferred brand drugs	$15 copay retail); $30 copay (mail)	100% less reimbursement to network pharmacy	
	Non-preferred brand drugs	$25 copay retail); $50 copay (mail)	100% less reimbursement to network pharmacy	
	Specialty drugs	10% coinsurance (if supplied by doctor/hospital); Same as Generic & Non-Preferred Brand copays if supplied by retail/mail order pharmacy	40% coinsurance after deductible (if supplied by doctor/hospital); Same as Generic & Non-Preferred Brand copays if supplied by retail/mail order pharmacy	Covers up to 90-day supply (retail subscription or mail order prescription). Preauthorization required.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	10% coinsurance	40% coinsurance; after deductible except for No Surprise Act covered services same as PPO Network provider.	Certain **non-emergency services** & **ancillary services** (ex. emergency medicine, anesthesia, pathology, radiology, lab, neonatology, assistant surgeon, hospitalist or intensivist

[* For more information about limitations and exceptions, see the plan or policy document at http://ibew617benefits.com/#.]

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Level One Network Provider (You will pay the least)	Level Two Out-of-Network Provider (You will pay the most)	
	Physician/surgeon fees	10% coinsurance	40% coinsurance; after deductible except for No Surprise Act covered services same as PPO Network provider.	services) received by out-of-network provider at ambulatory surgery center you cannot be billed more than the plan's network contract rate. However, there are certain other non-emergency services and post-stabilization services at these network facilities, you can give written consent to be balance billed.
If you need immediate medical attention	Emergency room care	10% coinsurance after $50 copay if not for emergency care, waived if admitted..	Per No Surprise Act same as PPO Network provider 10% coinsurance; after $50 copay if not for emergency care , waived if admitted.	No Pre-authorization required & No balance billing. Any Non-PPO emergency cost-sharing will count towards any Plan applicable deductible or out-of-pocket limit similar to PPO network emergency care. Emergency room treatment not considered an emergency subject to $50 copay but copay waived if admitted. Emergency includes treatment received in Independent Free standing emergency department.
	Emergency medical transportation	10% coinsurance	40% coinsurance; after deductible except 10% coinsurance No Surprise Act covered services.	See of Article VI, Section J.14 of Plan Document for limitations. For Covered Air ambulance, any cost-sharing will count towards any Plan applicable deductible or out-of-pocket limit & No balance billing.
	Urgent care	10% coinsurance	10% coinsurance per No Surprise Act	Any Non-PPO emergency cost-sharing will count towards any Plan applicable deductible or out-of-pocket limit similar to PPO network urgent care. No Pre-authorization required & No balance billing.
If you have a hospital stay	Facility fee (e.g., hospital room)	10% coinsurance	40% coinsurance; after deductible except for No Surprise Act covered services same as PPO Network provider.	Preauthorization required for non-emergency hospital admissions. Certain **non-emergency services** & **ancillary services** (ex. emergency medicine, anesthesia, pathology, radiology, lab, neonatology, assistant surgeon, hospitalist or intensivist services) received by out-of-network provider at network hospital you cannot be billed more than the plan's network contract rate. However, there are certain other non-emergency services and post-stabilization services at these network facilities, you can give written consent to be balance billed.
	Physician/surgeon fees	10% coinsurance	40% coinsurance; after deductible except for No Surprise Act covered services same as PPO network provider.	

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Level One Network Provider (You will pay the least)	Level Two Out-of-Network Provider (You will pay the most)	
				Contact the Trust Fund Office for more information.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	10% coinsurance	40% coinsurance; after deductible except for No Surprise Act covered services same as PPO Network provider.	For Substance abuse services, preauthorization required through Beat It! Optum is the primary provider for Behavioral Health/Mental Health Services. The Plan also has an Employee Assistance Program through Optum. Non-PPO Network emergency services covered same as PPO network provider.
	Inpatient services	10% coinsurance	40% coinsurance; after deductible except for No Surprise Act covered services same as PPO Network provider.	
If you are pregnant	Office visits	10% coinsurance	40% coinsurance; after deductible	Cost sharing does not apply to certain preventive services. Depending on the type of services, coinsurance may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound). Non-PPO Network emergency services covered same as PPO network provider.
	Childbirth/delivery professional services	10% coinsurance	40% coinsurance; after deductible except for No Surprise Act covered services same as PPO Network provider.	
	Childbirth/delivery facility services	10% coinsurance	40% coinsurance; after deductible except for No Surprise Act covered services same as PPO Network provider.	
If you need help recovering or have other special health needs	Home health care	10% coinsurance	40% coinsurance; after deductible	30 visits/year (Out-of-network care).
	Rehabilitation services	10% coinsurance	40% coinsurance; after deductible	30 visits/year. See Section J.6 of Plan Document for more information on limitations.
	Habilitation services	10% coinsurance	40% coinsurance; after deductible	30 visits/year.
	Skilled nursing care	10% coinsurance	40% coinsurance; after deductible	Plan will only cover costs following discharge from acute care facility.
	Durable medical equipment	10% coinsurance	40% coinsurance; after deductible	See Article VI, Section J. 23 of Plan Document for more information on limitations.
	Hospice services	10% coinsurance	40% coinsurance; after deductible	See of Article VI, Section J.14 of Plan Document for limitations.
If your child needs	Children's eye exam (VSP)	$25 copay	Up to $50	Coverage limited to one exam/year.

[* For more information about limitations and exceptions, see the plan or policy document at http://ibew617benefits.com/#.]

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Level One Network Provider (You will pay the least)	Level Two Out-of-Network Provider (You will pay the most)	
dental or eye care	Children's glasses (VSP)	$25 copay and covered up to $120 plus 20% discount on out-of-pocket expenses (Frames)	See Article X of Plan Booklet for scheduled allowance.	Coverage limited to one pair of glasses/year and one set of lenses/year. Contact 1-408-288-4400 or 1-800-877-7195 or for VSP booklet.
	Children's dental check-up (Delta Dental)	No Charge	No Charge	Deductibles waived for diagnostic & preventive services. See Article IX of Plan Booklet.

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.)

- Bariatric Surgery (unless medically necessary)
- Dental Care (Adult) except as permitted under Plan Document & Covered under Delta Dental
- Non-emergency care when traveling outside U.S.
- Routine eye care (Adult) except as covered under VSP
- Routine foot care
- Weight Loss Program ()
- Holistic medicine

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

- Acupuncture (limited to 30 visits/year).
- AD&D Benefit (subject to Plan limitations)
- Cancer Clinical Trials (Subject to Plan limitations)
- Chiropractic Care (limited to 30 visits/year)
- Infertility Treatment (See Plan rules for limitations)
- Cosmetic Surgery (subject to Plan limitations)
- Disability Benefit (subject to Plan limitations)
- Hearing Aids (limited to Participants, no Dependents)
- Life Insurance (subject to Plan limitations)
- Long-term care
- Nutritional Counseling
- Private-Duty Nursing
- Sleep Apnea Screening/Assessment (limited to Participants, no Dependents)(Aloha Dental ONLY)

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 www.dol.gov/ebsa/healthreform . 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 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: **United Administrative Service** at 1-408-288-4400 or 1-877-827-4239 or Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform.

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

[* For more information about limitations and exceptions, see the plan or policy document at http://ibew617benefits.com/#.]

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 1-408-288-4400 or 1-877-827-4239.
Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-408-288-4400 or 1-877-827-4239.

*To see examples of how this **plan** might cover costs for a sample medical situation, see the next section.*

[* For more information about limitations and exceptions, see the plan or policy document at http://ibew617benefits.com/#.]

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 (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	$0
Hospital (facility) coinsurance	10%
Other coinsurance	10%

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	**$12,800**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$0
Copayments	$0
Coinsurance	10%
What isn't covered	
Limits or exclusions	N/A
The total Peg would pay is	**$1280.0**

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	$15
Hospital (facility) coinsurance	10%
Other coinsurance	10%

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	**$7,400**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$0
Copayments	$15
Coinsurance	10%
What isn't covered	
Limits or exclusions	N/A
The total Joe would pay is	**$738.50**

Mia's Simple Fracture
(in-network emergency room visit and follow up care)

The plan's overall deductible	$0
Specialist copayment	$50
Hospital (facility) coinsurance	10%
Other coinsurance	10%

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	**$1,900**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$0
Copayments	$50
Coinsurance	10%
What isn't covered	
Limits or exclusions	N/A
The total Mia would pay is	**$185.00**

The **plan** would be responsible for the other costs of these EXAMPLE covered services.