IBEW Local 234 Health and Welfare Plan: Joint Board of Trustees

Coverage for: FAMILY | Plan Type: PPO

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, contact the Trust Fund Office at 1-408-588-3753 or Toll Free 877-885-3753 or e-mail websupport@ibew234benefits.org. 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 https://www.healthcare.gov/sbc-glossary or call 1-408-588-3753 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	**$100** per person	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay.
Are there services covered before you meet your deductible?	No.	You will have to meet the deductible before the plan pays for any services.
Are there other deductibles for specific services?	**$100** for Emergency in-network provider services and **$25** per person for Dental Benefits.	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.
What is the out-of-pocket limit for this plan?	**$8,550** Single **$17,100** 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?	Prescription drugs, premiums, balance-billing, copayments 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 1-800-688-3828 for a list of in-network providers. For coverage while traveling abroad, see https://www.bcbsglobalcore.com/	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.

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
		In-Network Provider (You will pay the least)	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	20% coinsurance of network allowance after $25 copay	20% coinsurance of network allowance after $25 copay	For out-of-network provider you pay excess of allowable amount.
	Specialist visit	20% coinsurance of network allowance; first $25 copay waived	20% coinsurance of network allowance	For out-of-network provider you pay excess of allowable amount. Telehealth or virtual visits are also a covered benefit. Non-emergency services provided by a non-PPO provider at a PPO facility is limited to 20% coinsurance after deductible is met unless you consent to the non-PPO billing rates.
	Preventive care/screening/ immunization	No charge	20% coinsurance of network allowance	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. See Article VI, Section 6.35 of Plan Document for more information on limitations.
If you have a test	Diagnostic test (x-ray, blood work)	20% coinsurance of network allowance	20% coinsurance of network allowance	For out-of-network provider you pay excess of allowable amount.
	COVID-19 test	No charge	No charge	No Preauthorization required.
	Imaging (CT/PET scans, MRIs)	20% coinsurance of network allowance	20% coinsurance of network allowance	For out-of-network provider you pay excess of allowable amount.
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.savrx.com.	Generic drugs	20% copay (retail); $10 copay (mail)	Not Covered	Covers up to a 30-day supply (retail subscription) additional $10 for each prescription or refill; 90 day supply for maintenance drugs (mail order prescription). Mandatory use of generic drugs. Please see Article VI, Section 6.10 of the Plan Booklet for more information on covered and excluded drugs. Certain injectable & oral medication therapy require preauthorization.
	Preferred brand drugs	30% copay (retail); $20 copay (mail)	Not Covered	
	Non-preferred brand drugs	30% copay (retail); $20 copay (mail)	Not Covered	
	Specialty drugs Generic	20% copay (retail); $10 copay (mail)	Not Covered	Preauthorization required.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
	Brand	30% copay (retail); $20 copay (mail)		
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance of network allowance	20% coinsurance of network allowance	Preauthorization required. For out-of-network provider you pay excess of allowable amount. Non-emergency services provided by a non-PPO provider at a PPO facility is limited to 20% coinsurance after deductible is met unless you consent to the non-PPO billing rates.
	Physician/surgeon fees			
If you need immediate medical attention	Emergency room care	20% coinsurance after $100 deductible	20% coinsurance of network allowance	Deductible waived if admitted. No Preauthorization required. For out-of-network provider you pay excess of allowable amount.
	Emergency medical transportation	20% coinsurance of network allowance	20% coinsurance of network allowance	No Preauthorization required. Air ambulance subject to medical review. You will have to pay 20% coinsurance after deductible is met for Air Ambulance involving emergency services at a non-PPO facility if (1) you did not have an emergency medical condition; or (2) you receive emergency services for treatment of an emergency medical condition from a non-PPO provider or non-PPO emergency facility and consent to the non-PPO billing rate for certain post-stabilization services.
	Urgent care	20% coinsurance of network allowance	20% coinsurance of network allowance	No Preauthorization required. For out-of-network provider you pay excess of allowable amount.
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance at semi-private room rate	20% coinsurance of network allowance	Preauthorization required. For out-of-network provider you pay excess of allowable amount. Non-emergency services provided by a non-PPO provider at a PPO facility is limited to 20% coinsurance after deductible is met unless you consent to the non-PPO billing rates.
	Physician/surgeon fees	20% coinsurance of network allowance	20% coinsurance of network allowance	

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	20% coinsurance of network allowance	20% coinsurance of network allowance	Preauthorization is required. Applies to covered plan benefits only. For out-of-network provider you pay excess of allowable amount. Non-emergency services provided by a non-PPO provider at a PPO facility is limited to 20% coinsurance after deductible is met unless you consent to the non-PPO billing rates.
	Inpatient services	20% coinsurance of network allowance	20% coinsurance of network allowance	
If you are pregnant	Office visits	No charge	20% coinsurance of network allowance	For out-of-network provider you pay excess of allowable amount. Cost sharing does not apply for 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).
	Childbirth/delivery professional services	20% coinsurance of network allowance	20% coinsurance of network allowance	
	Childbirth/delivery facility services	20% coinsurance of network allowance	20% coinsurance of network allowance	
If you need help recovering or have other special health needs	Home health care	20% coinsurance	20% coinsurance	For in-network provider 100/visits year & limited to $35/visit maximum benefit. Nutritional counseling maximum benefit $50/year. For out-of-network provider 100/visits year & you pay excess of allowable amount.
	Rehabilitation services	20% coinsurance of network allowance	20% coinsurance of network allowance	For in-network provider 20/visits & no preauthorization required for physical therapy visits. For out-of-network provider you pay excess of allowable amount.
	Habilitation services	Not Covered	Not Covered	None
	Skilled nursing care Room & Board Ancillary	$20/day plus 50% coinsurance of semi-private room rate 20% coinsurance	20% coinsurance 20% coinsurance	Pre-certification required and limited to 365/days. Custodial care is not covered. Physiotherapy not to exceed $50.
	Durable medical equipment	20% coinsurance	20% coinsurance	Rental rate is payable up to the purchase price of the equipment.
	Hospice services	20% coinsurance	20% coinsurance	See Article VI, Section 6.26 of Plan Booklet for limitations. Preauthorization is required.
	ABA Therapy	20% coinsurance	20% coinsurance	Pre-certification required. Contact 1-844-269-

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
				0538 for a list of network providers.
If your child needs dental or eye care	Children's eye exam (through VSP)	$15 copay	Up to $45 (Non-VSP Network provider)	Limited to 1 exam/year.
	Children's glasses (through VSP)	$25 copay for prescription glasses	See Article X of Plan Booklet for scheduled allowance.	Lenses limited to 1 pair/year and Frames limited to 1 every other year. Contact 1-408-588-3753 or for VSP booklet.
	Children's dental check-up (through Delta Dental)	10% coinsurance; deductible waived for preventive care.	20% coinsurance; deductible waived for preventive care.	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 (Gastric Bypass) Surgery
- Cosmetic Surgery (except for certain services, see Article VIII, Section 8.11 of Plan Document)
- Hearing Aids
- Infertility Treatment
- Long Term Care
- Non-emergency care when traveling outside the U.S.
- Habilitation Services
- Private Duty Nursing
- Routine Foot Care
- Weight Loss Program (medications or supplies)
- Abortions (medications or supplies)
- Erectile Dysfunction and female sex dysfunctions

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

- Acupuncture (if provided by physician or licensed by state; limited to 10 visits/year)
- Chiropractic Care (limited to 12 visits/year)
- Dental Care (Adult)- Delta Dental PPO
- Intestinal Bypass (if meets requirements under Plan Rules)
- Routine Eye care (Adult) – through Vision Service Plan

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: **BeneSys Administrators** at 1-408-288-9400 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**

* For more information about limitations and exceptions, see the plan or policy document at **www.ibew234benefits.org**.

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.

Nondiscrimination Statement

The Plan complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability or sex.

Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al 1-408-288-9400.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-408-288-9400.

Chinese (中文): 如果需要中文的帮助， 请拨打这个号码 1-408-288-9400.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-408-288-9400.

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 (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	**$100**
Specialist coinsurance	**20%**
Hospital (facility) coinsurance	**20%**
Other coinsurance	**20%**

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	$100
Copayments	$0
Coinsurance	$2,500
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$2,660**

Managing Joe's type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

The plan's overall deductible	**$100**
Specialist coinsurance	**20%**
Hospital (facility) coinsurance	**20%**
Other coinsurance	**20%**

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	$100
Copayments	$0
Coinsurance	$1,400
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$1,520**

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

The plan's overall deductible	**$100**
Specialist coinsurance	**20%**
Hospital (facility) coinsurance	**20%**
Other coinsurance	**20%**

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	$200
Copayments	$0
Coinsurance	$500
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$700**

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