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 including your plan's Summary plan description, visit www.ibew-west.com or call BeneSys at 1-855-617-2478. 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.dol.gov/ebsa/healthreform or call 1-855-617-2478 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	Network Providers per calendar year: $300/individual; $900/family. Out-of-Network Providers per calendar year: $600/individual; $1,800/family.	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 performed by network providers, provider visit paid with a copayment, telemedicine visit, emergency room visit, in-network urgent care visit, vision, dental plan benefits, and outpatient prescription drugs 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?	Yes, $50/individual; $150/family per calendar year for dental plan benefits. $75/individual; $150/family per calendar year for outpatient drug benefits. There are no other specific deductibles.	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?	Medical Plan Network Providers per calendar year: $4,200/individual; $8,400/family. Out-of-Network Providers: No limit.	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?	Premiums, balance billing charges, health care this plan doesn't cover, penalties for failure to obtain preauthorization, dental & vision plan expenses, non-essential health benefits, and out-of-network deductibles, copayments and coinsurance except an ER visit in case of an emergency.	Even though you pay these expenses, they don't count toward the out-of-pocket limit.

Important Questions	Answers	Why This Matters:
Will you pay less if you use a network provider?	Yes. See https://www.wellmark.com 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 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
		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	$25 copayment/visit. Deductible does not apply.	50% coinsurance.	Preauthorization of certain elective medical services is required to avoid a $200 penalty. There is no charge, and the deductible does not apply if you obtain a telemedicine visit through Doctor On Demand.
	Specialist visit	$50 copayment/visit. Deductible does not apply.	50% coinsurance.	
	Preventive care/screening/ immunization	No charge. Deductible does not apply.	50% coinsurance.	Plan covers required preventive services and supplies described at: https://www.healthcare.gov/what-are-my-preventive-care-benefits/. Plan also covers certain services and supplies for individuals with chronic conditions recognized by the IRS as preventive care. Age and frequency guidelines apply to covered preventive care. You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	10% coinsurance.	50% coinsurance.	Preauthorization of certain genetic testing, endoscopy, colonoscopy, and sleep studies is required to avoid a $200 penalty.
	Imaging (CT/PET scans, MRIs)	10% coinsurance.	50% coinsurance.	Preauthorization of advanced radiology like MRI and CT scans is not required.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.savrx.com. or 1-800-233-4239.	Generic drugs	Retail Pharmacy for 34-day supply: 10% coinsurance with a $10 minimum & $25 maximum payment per prescription; Mail Order for 90-day supply: $10 copayment per prescription. No charge for up to a month's supply of FDA-approved generic contraceptives (or 3-month supply of certain 90-day dosed contraceptives).	40% of the discounted drug cost.	• Medical Plan deductible does not apply; however, a separate drug deductible does apply. • If you purchase a brand drug when a generic drug is available, you pay the brand drug cost sharing plus the difference in cost between the brand drug and generic drug. • If the cost of the drug is less than the minimum payment, you pay just the drug cost. • Some prescriptions are subject to preauthorization (to avoid non-payment), quantity limits or step therapy requirements. • No charge for generic medication used for maintenance purposes when obtained at Mail Order. Maintenance drugs include those to treat chronic conditions like high blood pressure, cholesterol, thyroid, etc. • Certain over the counter (OTC) and prescription drugs are payable at no charge with a prescription. • If you fill a prescription at an Out-of-Network pharmacy, you will need to pay 100% for the drug at the time of purchase and file a claim with SavRx for reimbursement. Plan pays 60% of the discounted drug cost. • No coverage for prescriptions filled at Wal-Mart or Sam's Club Retail or Mail Order locations.
	Preferred brand drugs	Retail Pharmacy for 34-day supply: 20% coinsurance with a $20 minimum & $50 maximum payment per prescription; Mail Order for 90-day supply: $50 copayment per prescription. No charge for up to a month's supply of FDA-approved generic contraceptives (or 3-month supply of certain 90-day dosed contraceptives) if a generic is medically inappropriate or unavailable.	40% of the discounted drug cost.	
	Non-preferred brand drugs	Retail Pharmacy for 34-day supply: 50% coinsurance with a $50 minimum (no maximum) payment per prescription. Mail Order for 90-day supply: $100 copayment per prescription.	40% of the discounted drug cost.	
	Specialty drugs	You pay the same cost-sharing as retail or mail order for up to a 30-day supply.	Not covered.	Separate drug deductible does apply. Specialty drugs require preauthorization (to avoid non-payment) by calling Sav-Rx at 1-866-233-4239.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	10% coinsurance.	50% coinsurance.	Preauthorization of outpatient surgery is required to avoid a $200 penalty.
	Physician/ surgeon fees	10% coinsurance.	50% coinsurance.	Preauthorization of outpatient surgery is required to avoid a $200 penalty.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need immediate medical attention	Emergency room care	$250 copayment/visit. Deductible does not apply.	$250 copayment/visit. Deductible does not apply.	Physician/provider's professional fees may be billed separately. Copayment waived if subsequent immediate hospitalization is required.
	Emergency medical transportation	10% coinsurance.	10% coinsurance.	Preauthorization of non-emergency transportation is required to avoid a $200 penalty.
	Urgent care	$50 copayment/visit. Deductible does not apply.	50% coinsurance.	Copayment waived if subsequent immediate hospitalization is required.
If you have a hospital stay	Facility fee (e.g., hospital room)	10% coinsurance.	50% coinsurance.	Preauthorization of elective hospital admission is required to avoid a $200 penalty. Private room payable only if medically necessary or the facility does not provide semi-private rooms.
	Physician/ surgeon fees	10% coinsurance.	50% coinsurance.	Preauthorization of elective hospital admission and certain surgical services is required to avoid a $200 penalty.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Office Visits: $25 copayment / visit. Deductible does not apply. Other outpatient services: 10% coinsurance.	50% coinsurance.	Plan covers 8 free EAP visits through ComPsych (855-206-4843).
	Inpatient services	Hospital: 10% coinsurance. Residential treatment facility: 10% coinsurance.	Hospital: 50% coinsurance. Residential treatment facility: Not covered.	Preauthorization of elective hospital admission and residential treatment program admission is required to avoid a $200 penalty.
If you are pregnant	Office visits	No charge for office visits and other ACA-required preventive services. Deductible does not apply. All other services for employee/spouse/dependent: 10% coinsurance.	Office visits and ACA-required preventive services: Not covered. All other services for employee/spouse/dependent: 50% coinsurance.	• Cost sharing also does not apply for in-network preventive services. • Depending on the type of services, a copayment, coinsurance or deductible may apply. • Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound).

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you are pregnant	Childbirth delivery professional services	For employee/spouse/dependent: 10% coinsurance.	For employee/spouse/dependent: 50% coinsurance.	Preauthorization is required to avoid a financial penalty only if hospital stay is longer than 48 hours for vaginal delivery or 96 hours for C-section.
	Childbirth delivery facility services	For employee/spouse/dependent: 10% coinsurance.	For employee/spouse/dependent: 50% coinsurance.	
If you need help recovering or have other special health needs	Home health care	10% coinsurance.	50% coinsurance.	Plan covers part-time or intermittent skilled nursing care. Preauthorization of home health care is required to avoid a $200 penalty. Maximum benefit is 100 visits/calendar year.
	Rehabilitation services	Outpatient visits: 10% coinsurance. Inpatient Rehab. Admission: 10% coinsurance.	Outpatient visits: 50% coinsurance. Inpatient Rehab. Admission: Not covered.	Preauthorization of outpatient physical and occupational therapy after the first 3 visits, speech therapy beyond 2 months, and cardiac rehab. is required to avoid a $200 penalty. Preauthorization of inpatient rehabilitation admission is required to avoid a $200 penalty.
	Habilitation services	Not covered.	Not covered.	You must pay 100% of these expenses, even in-network.
	Skilled nursing care	10% coinsurance.	Not covered.	Preauthorization of skilled nursing facility admission is required to avoid a $200 penalty. Maximum 120 days/calendar year.
	Durable medical equipment	10% coinsurance.	50% coinsurance.	Preauthorization of CPAP equipment is required to avoid a $200 penalty. No charge from network providers for breastfeeding pump & supplies needed to operate pump.
	Hospice services	10% coinsurance.	Home hospice: 50% coinsurance. Inpatient hospice: Not covered.	Plan covers up to 8 days of respite care during a hospice benefit.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If your child needs dental or eye care	Children's eye exam	No charge	You pay 100%. Plan reimburses up to $75 per exam. You pay any amount over $75 for exam. Medical plan deductible does not apply.	If you elect vision coverage, it will be available under a separate vision plan. One vision exam is payable each calendar year. Your cost sharing is not included in the medical plan's in-network out-of-pocket limit.
	Children's glasses	No charge up to the retail allowance of $250 per frame. No charge for lenses.	You pay 100%. Plan reimburses up to $125/frame and up to $45/single lens. You pay expenses over $125/frame and over $45/single lens. Medical plan deductible does not apply.	If you elect vision coverage, it will be available under a separate vision plan. Two frames and lenses are payable each calendar year. Your cost sharing is not included in the medical plan's in-network out-of-pocket limit.
	Children's dental check-up	No charge. Dental plan deductible does not apply.	30% coinsurance.	Medical plan deductible does not apply. If you elect dental coverage, it will be available under a separate dental plan.

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
- Cosmetic surgery
- Habilitation services
- Infertility treatment
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing.
- Weight loss programs (except as required by health reform law).

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

- Acupuncture payable to a maximum of $500/calendar year.
- Chiropractic care payable to a maximum of $500/calendar year.
- Dental care (Adult), if you elect dental coverage, it is payable up to $2,000/calendar year.
- Hearing aids payable up to $500 every 3 years for adults; $2,000 every 3 years for dependent children up to age 26.
- Routine eye care (Adult), if you elect the separate vision plan.
- Routine foot care payable when treating diabetic (metabolic) or peripheral vascular insufficiency affecting the feet.

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 on how 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 the Administrative Office (BeneSys) at 1-855-617-2478 or the 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.** 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 1-855-617-2478.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-855-617-2478.

Chinese (中文): 如果需要中文的帮助，请拨打这个号码 1-855-617-2478.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-855-617-2478.

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** **$300**
- **Specialist copayment** **$50**
- **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	**$12,700**

In this example, Peg would pay:

Cost sharing	
*Deductibles	$310
Copayments	$0
Coinsurance	$1,080
What isn't covered	
Limits or exclusions	$20
The total Peg would pay is	**$1,410**

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

- **The plan's overall deductible** **$300**
- **Specialist copayment** **$50**
- **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	**$5,600**

In this example, Joe would pay:

Cost sharing	
Deductibles	$200
Copayments	$270
Coinsurance	$940
What isn't covered	
Limits or exclusions	$0
The total Joe would pay is	**$1,410**

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

- **The plan's overall deductible** **$300**
- **Specialist copayment** **$50**
- **Hospital (facility) ER copayment** **$250**
- **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	**$2,800**

In this example, Mia would pay:

Cost sharing	
*Deductibles	$310
Copayments	$440
Coinsurance	$180
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$930**

*Note: This plan has other deductibles for specific services included in this coverage example. See "Are there other deductibles for specific services?" row above.

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