



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](http://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](http://www.dol.gov/ebsa/healthreform) or call 1-855-617-2478 to request a copy.

Important Questions	Answers	Why This Matters:
<b>What is the overall deductible?</b>	Network Providers per calendar year: \$2,500/person; \$5,000/family. Out-of-Network Providers per calendar year: \$5,000/person; \$10,000/family.	Generally, you must pay all of the costs from <u>providers</u> up to the <u>deductible</u> amount before this <u>plan</u> begins to pay. If you have other family members on the <u>plan</u> , each family member must meet their own individual <u>deductible</u> until the total amount of <u>deductible</u> expenses paid by all family members meets the overall family <u>deductible</u> .
<b>Are there services covered before you meet your deductible?</b>	Yes. <u>Preventive care</u> performed by <u>network providers</u> is covered before you meet your <u>deductible</u> .	This <u>plan</u> covers some items and services even if you haven't yet met the <u>deductible</u> amount. But a <u>copayment</u> or <u>coinsurance</u> may apply. For example, this plan covers certain <u>preventive services</u> without <u>cost sharing</u> and before you meet your <u>deductible</u> . See a list of covered <u>preventive services</u> at <a href="https://www.healthcare.gov/coverage/preventive-care-benefits/">https://www.healthcare.gov/coverage/preventive-care-benefits/</a> .
<b>Are there other deductibles for specific services?</b>	Yes. \$50/person; \$150/family per calendar year for dental <u>plan</u> benefits. There are no other specific <u>deductibles</u> .	You must pay all of the costs for these services up to the specific <u>deductible</u> amount before this <u>plan</u> begins to pay for these services.
<b>What is the out-of-pocket limit for this plan?</b>	Medical Plan Network Providers per calendar year: \$6,450/person; \$12,900/family. Out-of-Network Providers: No limit.	The <u>out-of-pocket limit</u> is the most you could pay in a year for covered services. If you have other family members in this <u>plan</u> , they have to meet their own <u>out-of-pocket limits</u> until the overall family <u>out-of-pocket limit</u> has been met.
<b>What is not included in the out-of-pocket limit?</b>	<u>Premiums</u> , <u>balance billing</u> charges, health care this <u>plan</u> doesn't cover, penalties for failure to obtain <u>preauthorization</u> , dental & vision <u>plan</u> expenses, non-essential health benefits, and out-of-network <u>deductibles</u> , <u>copayments</u> and <u>coinsurance</u> except an ER visit in case of an emergency.	Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u> .
<b>Will you pay less if you use a network provider?</b>	Yes. See <a href="https://www.wellmark.com">https://www.wellmark.com</a> for a list of <u>Network Providers</u> .	This <u>plan</u> uses a <u>provider network</u> . You will pay less if you use a <u>provider</u> in the <u>plan's network</u> . You will pay the most if you use an <u>out-of-network provider</u> , and you might receive a bill from a <u>provider</u> for the difference between the <u>provider's charge</u> and what your <u>plan</u> pays ( <u>balance billing</u> ). Be aware, your <u>network provider</u> might use an <u>out-of-network provider</u> for some services (such as lab work). Check with your <u>provider</u> before you get services.

Important Questions	Answers	Why This Matters:
Do you need a <u>referral</u> to see a <u>specialist</u> ?	No.	You can see the <u>specialist</u> you choose without a <u>referral</u> .



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
		<u>Network Provider</u> (You will pay the least)	<u>Out-of-Network Provider</u> (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% <u>coinsurance</u> .	50% <u>coinsurance</u> .	<u>Preauthorization</u> of certain elective medical services is required to avoid a \$200 penalty. Telemedicine visits obtained through Doctor On Demand are covered.
	<u>Specialist</u> visit	20% <u>coinsurance</u> .	50% <u>coinsurance</u> .	
	<u>Preventive care/screening/immunization</u>	No charge. <u>Deductible</u> does not apply.	50% <u>coinsurance</u> .	<u>Plan</u> covers required <u>preventive services</u> and supplies described at: <a href="https://www.healthcare.gov/what-are-my-preventive-care-benefits/">https://www.healthcare.gov/what-are-my-preventive-care-benefits/</a> . <u>Plan</u> also covers certain services and supplies for individuals with chronic conditions recognized by the IRS as <u>preventive care</u> . Age and frequency guidelines apply to covered <u>preventive care</u> . Age and frequency guidelines apply to covered <u>preventive care</u> . You may have to pay for services that aren't preventive. Ask your <u>provider</u> if the services needed are preventive. Then check what your <u>plan</u> will pay for.
If you have a test	<u>Diagnostic test</u> (x-ray, blood work)	20% <u>coinsurance</u> .	50% <u>coinsurance</u> .	<u>Preauthorization</u> of certain genetic testing, endoscopy, colonoscopy, and sleep studies is required to avoid a \$200 penalty.
	<u>Imaging</u> (CT/PET scans, MRIs)	20% <u>coinsurance</u> .	50% <u>coinsurance</u> .	<u>Preauthorization</u> 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)	
<b>If you need drugs to treat your illness or condition</b> More information about <b>prescription drug coverage</b> is available at <a href="http://www.savrx.com">www.savrx.com</a> . or 1-800-233-4239.	Generic drugs	Retail Pharmacy for 34-day supply: 10% <u>coinsurance</u> with a \$5 minimum (no maximum) payment per prescription; Mail Order for 90-day supply: \$10 <u>copayment</u> 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).	Not covered.	<ul style="list-style-type: none"> <li>Medical <u>Plan deductible</u> does apply and must be met before <u>outpatient drugs</u> are payable by the <u>Plan</u>.</li> <li>If you purchase a brand drug when a generic drug is available, you pay the brand drug <u>cost sharing</u> plus the difference in cost between the brand drug and generic drug.</li> <li>If the cost of the drug is less than the minimum payment, you pay just the drug cost.</li> <li>Some prescriptions are subject to <u>preauthorization</u> (to avoid non-payment), quantity limits or step therapy requirements.</li> <li>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.</li> <li>Certain over the counter (OTC) and <u>prescription drugs</u> are payable at no charge with a prescription.</li> <li>If you fill a prescription at an <u>Out-of-Network</u> pharmacy, you will need to pay 100% for the drug.</li> <li>No coverage for prescriptions filled at Wal-Mart or Sam's Club Retail or Mail Order locations.</li> </ul>
	Preferred brand drugs	Retail Pharmacy for 34-day supply: 20% <u>coinsurance</u> with a \$10 minimum (no maximum) payment per prescription; Mail Order for 90-day supply: \$20 <u>copayment</u> per prescription. No charge for up to a month's supply of FDA-approved brand name contraceptives (or 3-month supply of certain 90-day dosed contraceptives) if a generic is medically inappropriate or unavailable.	Not covered.	
	Non-preferred brand drugs	Retail Pharmacy for 34-day supply: 20% <u>coinsurance</u> with a \$10 minimum (no maximum) payment per prescription. Mail Order for 90-day supply: \$40 <u>copayment</u> per prescription.	Not covered.	
	<u>Specialty drugs</u>	You pay the same <u>cost sharing</u> as retail or mail order for up to a 30-day supply.	Not covered.	
<b>If you have outpatient surgery</b>	Facility fee (e.g., ambulatory surgery center)	20% <u>coinsurance</u> .	50% <u>coinsurance</u> .	<u>Preauthorization</u> of outpatient surgery is required to avoid a \$200 penalty.
	Physician/surgeon fees	20% <u>coinsurance</u> .	50% <u>coinsurance</u> .	<u>Preauthorization</u> 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	<u>Emergency room care</u>	20% <u>coinsurance</u> .	20% <u>coinsurance</u> .	Physician/ <u>provider's</u> professional fees may be billed separately. <u>Copayment</u> waived if subsequent immediate <u>hospitalization</u> is required.
	<u>Emergency medical transportation</u>	20% <u>coinsurance</u> .	50% <u>coinsurance</u> ; except 20% <u>coinsurance</u> for air ambulance services.	<u>Preauthorization</u> of non-emergency transportation is required to avoid a \$200 penalty.
	<u>Urgent care</u>	20% <u>coinsurance</u> .	50% <u>coinsurance</u> .	<u>Copayment</u> waived if subsequent immediate <u>hospitalization</u> is required.
If you have a hospital stay	Facility fee (e.g., hospital room)	20% <u>coinsurance</u> .	50% <u>coinsurance</u> .	<u>Preauthorization</u> of elective hospital admission is required to avoid a \$200 penalty. Private room payable only if <u>medically necessary</u> or the facility does not provide semi-private rooms.
	Physician/surgeon fees	20% <u>coinsurance</u> .	50% <u>coinsurance</u> .	<u>Preauthorization</u> 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: 20% <u>coinsurance</u> . Other outpatient services: 20% <u>coinsurance</u> .	50% <u>coinsurance</u> .	<u>Plan</u> covers 8 free EAP visits through ComPsych (855-206-4843).
	Inpatient services	Hospital: 20% <u>coinsurance</u> . Residential treatment facility: 20% <u>coinsurance</u> .	Hospital: 50% <u>coinsurance</u> . Residential treatment facility: Not covered.	<u>Preauthorization</u> 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 <u>preventive services</u> . <u>Deductible</u> does not apply. All other services for employee or spouse: 20% <u>coinsurance</u> .	Office visits and ACA-required <u>preventive services</u> : Not covered.  All other services for employee and spouse: 50% <u>coinsurance</u> .	<ul style="list-style-type: none"> <li><u>Cost sharing</u> also does not apply for in-<u>network preventive services</u>.</li> <li>Depending on the type of services, a <u>copayment</u>, <u>coinsurance</u> or <u>deductible</u> may apply.</li> <li>Maternity care may include tests and services described elsewhere in the SBC (i.e., ultrasound).</li> <li>Prenatal care (other than ACA-required <u>preventive screenings</u> and prenatal office visits) is not covered for dependent children.</li> </ul>

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)	
	Childbirth delivery professional services	For employee and spouse: 20% <u>coinsurance</u> .	For employee and spouse: 50% <u>coinsurance</u> .	You must pay 100%, even in- <u>network</u> , for delivery expenses for a dependent child except for <u>emergency services</u> . <u>Preauthorization</u> 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 and spouse: 20% <u>coinsurance</u> .	For employee and spouse: 50% <u>coinsurance</u> .	
If you need help recovering or have other special health needs	<u>Home health care</u>	20% <u>coinsurance</u> .	50% <u>coinsurance</u> .	<u>Plan</u> covers part-time or intermittent <u>skilled nursing care</u> . <u>Preauthorization</u> of <u>home health care</u> is required to avoid a \$200 penalty. Maximum benefit is 100 visits/calendar year.
	<u>Rehabilitation services</u>	Outpatient visits: 20% <u>coinsurance</u> . Inpatient Rehab. Admission: 20% <u>coinsurance</u> .	Outpatient visits: 50% <u>coinsurance</u> . Inpatient Rehab. Admission: Not covered.	<u>Preauthorization</u> 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. <u>Preauthorization</u> of inpatient rehabilitation admission is required to avoid a \$200 penalty.
	<u>Habilitation services</u>	Not covered.	Not covered.	You must pay 100% of these expenses, even in- <u>network</u> .
	<u>Skilled nursing care</u>	20% <u>coinsurance</u> .	Not covered.	<u>Preauthorization</u> of skilled nursing facility admission is required to avoid a \$200 penalty. Maximum 120 days/calendar year.
	<u>Durable medical equipment</u>	20% <u>coinsurance</u> .	50% <u>coinsurance</u> .	<u>Preauthorization</u> of CPAP equipment is required to avoid a \$200 penalty. No charge from <u>network providers</u> for breastfeeding pump & supplies needed to operate pump.
	<u>Hospice services</u>	20% <u>coinsurance</u> .	Home hospice: 50% <u>coinsurance</u> . Inpatient hospice: Not covered.	<u>Plan</u> covers up to 8 days of respite care during a hospice benefit.
If your child needs dental or eye care	Children's eye exam	No charge	You pay 100%. <u>Plan</u> reimburses up to \$75 per exam. You pay any amount over \$75 for exam. Medical <u>plan deductible</u> does not apply.	If you elect vision coverage, it will be available under a separate vision <u>plan</u> . One vision exam is payable each calendar year. Your <u>cost sharing</u> is not included in the medical <u>plan's in-network out-of-pocket limit</u> .

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)	
	Children's glasses	No charge up to the retail allowance of \$250 per frame. No charge for lenses.	You pay 100%. <u>Plan</u> reimburses up to \$125/frame and up to \$45/single lens. You pay expenses over \$125/frame and over \$45/single lens. <u>Medical plan deductible</u> does not apply.	If you elect vision coverage, it will be available under a separate vision <u>plan</u> . One frame and lenses are payable each calendar year. Your <u>cost sharing</u> is not included in the medical <u>plan's in-network out-of-pocket limit</u> .
	Children's dental check-up	No charge. Dental <u>deductible</u> does not apply.	30% <u>coinsurance</u> .	If you elect dental coverage, it will be available under a separate dental <u>plan</u> .

## 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 for adult payable up to \$500/person every three years. For child with an audiology exam revealing bilateral hearing loss of 30 decibels or greater, additional payment up to \$1,500/person permitted every 3 years.
- 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](http://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](http://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](http://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, kwijigo 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 <u>plan's</u> overall <u>deductible</u>	\$2,500
■ <u>Specialist</u> <u>coinsurance</u>	20%
■ Hospital (facility) <u>coinsurance</u>	20%
■ Other <u>coinsurance</u>	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*)

<b>Total Example Cost</b>	<b>\$12,700</b>
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#### In this example, Peg would pay:

<u>Cost sharing</u>	
<u>Deductibles</u>	\$2,500
<u>Copayments</u>	\$0
<u>Coinsurance</u>	\$1,740
<u>What isn't covered</u>	
Limits or exclusions	\$20
<b>The total Peg would pay is</b>	<b>\$4,260</b>

### Managing Joe's Type 2 Diabetes

(a year of routine in-network care of a well-controlled condition)

■ The <u>plan's</u> overall <u>deductible</u>	\$2,500
■ <u>Specialist</u> <u>coinsurance</u>	20%
■ Hospital (facility) <u>coinsurance</u>	20%
■ Other <u>coinsurance</u>	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*)

<b>Total Example Cost</b>	<b>\$5,600</b>
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#### In this example, Joe would pay:

<u>Cost sharing</u>	
<u>Deductibles</u>	\$2,500
<u>Copayments</u>	\$0
<u>Coinsurance</u>	\$600
<u>What isn't covered</u>	
Limits or exclusions	\$0
<b>The total Joe would pay is</b>	<b>\$3,100</b>

### Mia's Simple Fracture

(in-network emergency room visit and follow up care)

■ The <u>plan's</u> overall <u>deductible</u>	\$2,500
■ <u>Specialist</u> <u>coinsurance</u>	20%
■ Hospital (facility) ER <u>coinsurance</u>	20%
■ Other <u>coinsurance</u>	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*)

<b>Total Example Cost</b>	<b>\$2,800</b>
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#### In this example, Mia would pay:

<u>Cost sharing</u>	
<u>Deductibles</u>	\$2,500
<u>Copayments</u>	\$0
<u>Coinsurance</u>	\$60
<u>What isn't covered</u>	
Limits or exclusions	\$0
<b>The total Mia would pay is</b>	<b>\$2,560</b>

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