



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, please contact the Fund Office. 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 [anthem.com](#) or call 1-833-639-1634 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall <a href="#">deductible</a> ?	<a href="#">Network</a> : \$500 single / \$1,000 family (Wellness Tier); \$750 single / \$1,250 family (Non-Wellness Tier) <a href="#">Non-Network</a> : \$800 single / \$1,600 family (both Tiers).	Generally, you must pay all of the costs from providers up to the <a href="#">deductible</a> amount before this <a href="#">plan</a> begins to pay. If you have other family members on the <a href="#">plan</a> , each family member must meet their own individual <a href="#">deductible</a> until the total amount of <a href="#">deductible</a> expenses paid by all family members meets the overall family <a href="#">deductible</a> .
Are there services covered before you meet your <a href="#">deductible</a> ?	Yes. <a href="#">Preventive care</a> and primary care services are covered before you meet your <a href="#">deductible</a> .	This <a href="#">plan</a> covers some items and services even if you haven't yet met the <a href="#">deductible</a> amount. But a <a href="#">copayment</a> or <a href="#">coinsurance</a> may apply. For example, this <a href="#">plan</a> covers certain <a href="#">preventive services</a> without <a href="#">cost-sharing</a> and before you meet your <a href="#">deductible</a> . See a list of covered <a href="#">preventive services</a> at <a href="https://www.healthcare.gov/coverage/preventive-care-benefits/">https://www.healthcare.gov/coverage/preventive-care-benefits/</a> .
Are there other <a href="#">deductibles</a> for specific services?	No.	You don't have to meet <a href="#">deductibles</a> for specific services.
What is the <a href="#">out-of-pocket limit</a> for this <a href="#">plan</a> ?	<b>Medical:</b> <a href="#">Network</a> : \$3,000 single / \$6,000 family (Wellness Tier); \$4,000 single / \$7,000 family (Non-Wellness Tier). <a href="#">Non-network</a> : None. <b>Prescription:</b> <a href="#">Network</a> : \$6,200 single / \$12,400 family (Wellness Tier); \$5,200 single / \$11,400 family (Non-Wellness); <a href="#">Non-network</a> : None.	The <a href="#">out-of-pocket limit</a> is the most you could pay in a year for covered services. If you have other family members in this <a href="#">plan</a> , they have to meet their own <a href="#">out-of-pocket limits</a> until the overall family <a href="#">out-of-pocket limit</a> has been met.
What is not included in the <a href="#">out-of-pocket limit</a> ?	<a href="#">Cost sharing</a> for <a href="#">prescription drugs</a> , <a href="#">premiums</a> , <a href="#">Copays</a> , <a href="#">balance-billing</a> charges, and health care the <a href="#">plan</a> doesn't cover.	Even though you pay these expenses, they don't count toward the <a href="#">out-of-pocket limit</a> .
Will you pay less if you use a <a href="#">network provider</a> ?	Yes. See <a href="#">www.anthem.com</a> or call 1-833-639-1634 for a list of <a href="#">network providers</a> .	This <a href="#">plan</a> uses a provider <a href="#">network</a> . You will pay less if you use a <a href="#">provider</a> in the plan's <a href="#">network</a> . You will pay the most if you use an <a href="#">Non-network provider</a> , and you might receive a bill from a <a href="#">provider</a> for the difference between the provider's charge and what your <a href="#">plan</a> pays ( <a href="#">balance billing</a> ). Be aware, your <a href="#">network provider</a> might use an <a href="#">out-of-network provider</a> for some services (such as lab work). Check with your <a href="#">provider</a> before you get services.
Do you need a <a href="#">referral</a> to see a <a href="#">specialist</a> ?	No.	You can see the <a href="#">specialist</a> you choose without a <a href="#">referral</a> .



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)		Non-network Provider (You will pay the most)	
		Wellness Tier	Non-Wellness Tier	Both Tiers	
If you visit a health care <a href="#">provider's office</a> or clinic	Primary care visit to treat an injury or illness	\$20 <a href="#">copay</a> , (Office Visits); <a href="#">Deductible</a> does not apply		50% <a href="#">coinsurance of allowed amount</a>	20% <a href="#">coinsurance</a> applies to all <a href="#">in-network</a> consultations
	<a href="#">Specialist</a> visit	\$20 <a href="#">copay</a> , (Office Visits); <a href="#">Deductible</a> does not apply		50% <a href="#">coinsurance of allowed amount</a>	20% <a href="#">coinsurance</a> applies to all <a href="#">in-network</a> consultations
	<a href="#">Preventive care/screening/immunization</a>	No charge		50% <a href="#">coinsurance of allowed amount</a>	You may have to pay for services that aren't <a href="#">preventive</a> . Ask your <a href="#">provider</a> if the services you need are preventive. Then check what your <a href="#">plan</a> will pay for.
	IBEW 38 and Laborers Fund Health Clinic Services	No charge. Plan pays 100% of services		Not applicable	None.
If you have a test	<a href="#">Diagnostic test</a> (x-ray, blood work)	20% <a href="#">coinsurance of allowed amount</a>	30% <a href="#">coinsurance of allowed amount</a>	50% <a href="#">coinsurance of allowed amount</a>	<a href="#">Preauthorization</a> is required.
	Imaging (CT/PET scans, MRIs)	20% <a href="#">coinsurance of allowed amount</a>	30% <a href="#">coinsurance of allowed amount</a>	50% <a href="#">coinsurance of allowed amount</a>	<a href="#">Preauthorization</a> is required.
If you need drugs to treat your illness or condition More information about <a href="#">prescription drug coverage</a> is available at <a href="http://www.Optumrx.com">www.Optumrx.com</a>	Generic <a href="#">prescription drugs</a> – Tier 1	\$10 <a href="#">copay</a> /prescription (retail); \$20 <a href="#">copay</a> /prescription (mail order); <a href="#">Deductible</a> does not apply		Retail-30-day supply limit; Mail Order-90-day supply limit. If you choose a non-preferred brand drug that is not listed on the <a href="#">Plan's Formulary</a> , your physician must first submit a <a href="#">preauthorization</a> request. Certain medications may also be subject to the Utilization Management Program administered by the Pharmacy Benefit Manager (PBM).  You are responsible for the cost difference between a brand name prescription and a generic prescription if a generic is available. Participation in the Variable Copay Program may apply to some medications, and coinsurance for these drugs may vary, up to 100% of the discounted cost.	
	Preferred brand <a href="#">prescription drugs</a> – Tier 2	\$25 <a href="#">copay</a> /prescription (retail); \$50 <a href="#">copay</a> /prescription (mail order); <a href="#">Deductible</a> does not apply			
	Non-preferred brand <a href="#">prescription drugs</a> -Tier 3	\$40 <a href="#">copay</a> /prescription (retail); \$80 <a href="#">copay</a> /prescription (mail order); <a href="#">Deductible</a> does not apply			
	<a href="#">Specialty drugs</a> – Tier 4	\$50 <a href="#">copay</a> /prescription (retail); \$100 <a href="#">copay</a> /prescription (mail order); <a href="#">generic, if available, must be tried first</a> . <a href="#">Deductible</a> does not apply			

For more information about limitations and exclusions, see Summary Plan Description.

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Non-network Provider (You will pay the most)		
		Wellness Tier	Non-Wellness Tier	Both Tiers	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% <a href="#">coinsurance</a> of <a href="#">allowed amount</a>	30% <a href="#">coinsurance</a> of <a href="#">allowed amount</a>	50% <a href="#">coinsurance</a> of <a href="#">allowed amount</a>	None
	Physician/surgeon fees	20% <a href="#">coinsurance</a> of <a href="#">allowed amount</a>	30% <a href="#">coinsurance</a> of <a href="#">allowed amount</a>	50% <a href="#">coinsurance</a> of <a href="#">allowed amount</a>	None
If you need immediate medical attention	<a href="#">Emergency room care</a>	\$100 <a href="#">copay</a> and 20% <a href="#">coinsurance</a>	\$100 <a href="#">copay</a> and 30% <a href="#">coinsurance</a>	\$100 <a href="#">copay</a> and 20% <a href="#">coinsurance</a> of <a href="#">allowed amount</a>	\$100 copay waived if admitted for <a href="#">network providers</a> and <a href="#">Non-network providers</a> .
	<a href="#">Emergency room care</a> (Non-Emergency Services)	\$100 <a href="#">copay</a> and 20% <a href="#">coinsurance</a>	\$100 <a href="#">copay</a> and 30% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a> of <a href="#">allowed amount</a> if non-emergency	\$100 copay waived if admitted for <a href="#">network providers</a> and <a href="#">Non-network providers</a> .
	<a href="#">Emergency medical transportation</a>	20% <a href="#">coinsurance</a> of <a href="#">allowed amount</a>	30% <a href="#">coinsurance</a> of <a href="#">allowed amount</a>	50% <a href="#">coinsurance</a> of <a href="#">allowed amount</a>	None
	<a href="#">Urgent care</a>	\$20 <a href="#">copay</a> for office visit		50% <a href="#">coinsurance</a> of <a href="#">allowed amount</a>	20% <a href="#">coinsurance</a> applies to all <a href="#">in-network</a> consultations.
If you have a hospital stay	Facility fee (e.g., hospital room)	20% <a href="#">coinsurance</a> of <a href="#">allowed amount</a>	30% <a href="#">coinsurance</a> of <a href="#">allowed amount</a>	50% <a href="#">coinsurance</a> of <a href="#">allowed amount</a>	<a href="#">Preauthorization</a> is required before you are admitted as an inpatient in a Hospital.
	Physician/surgeon fees	20% <a href="#">coinsurance</a> of <a href="#">allowed amount</a>	30% <a href="#">coinsurance</a> of <a href="#">allowed amount</a>	50% <a href="#">coinsurance</a> of <a href="#">allowed amount</a>	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	20% <a href="#">coinsurance</a> of <a href="#">allowed amount</a>	30% <a href="#">coinsurance</a> of <a href="#">allowed amount</a>	50% <a href="#">coinsurance</a> of <a href="#">allowed amount</a>	<a href="#">Preauthorization</a> is required before you are admitted as an inpatient in a Hospital.
	Inpatient services	20% <a href="#">coinsurance</a> of <a href="#">allowed amount</a>	30% <a href="#">coinsurance</a> of <a href="#">allowed amount</a>	50% <a href="#">coinsurance</a> of <a href="#">allowed amount</a>	
	Inpatient/Outpatient Alcohol and Substance Abuse Services	20% <a href="#">coinsurance</a> of <a href="#">allowed amount</a>	30% <a href="#">coinsurance</a> of <a href="#">allowed amount</a>	50% <a href="#">coinsurance</a> of <a href="#">allowed amount</a>	
If you are pregnant *Covered for subscriber and spouse only.	Office visits	\$20 <a href="#">copay</a>		50% <a href="#">coinsurance</a>	<b>Coverage for you or your spouse only.</b> <a href="#">Cost sharing</a> does not apply to certain <a href="#">preventive services</a> . Depending on the type of services, <a href="#">copay</a> or <a href="#">coinsurance</a> may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound).
	Childbirth/delivery professional services	20% <a href="#">coinsurance</a> of <a href="#">allowed amount</a>	30% <a href="#">coinsurance</a> of <a href="#">allowed amount</a>	50% <a href="#">coinsurance</a> of <a href="#">allowed amount</a>	
	Childbirth/delivery facility services	20% <a href="#">coinsurance</a> of <a href="#">allowed amount</a>	30% <a href="#">coinsurance</a> of <a href="#">allowed amount</a>	50% <a href="#">coinsurance</a> of <a href="#">allowed amount</a>	

For more information about limitations and exclusions, see Summary Plan Description.

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)		Non-network Provider (You will pay the most)	
		Wellness Tier	Non-Wellness Tier	Both Tiers	
<b>If you need help recovering or have other special health needs</b>	<a href="#">Home health care</a>	20% <a href="#">coinsurance</a> of <a href="#">allowed amount</a>	30% <a href="#">coinsurance</a> of <a href="#">allowed amount</a>	50% <a href="#">coinsurance</a> of <a href="#">allowed amount</a>	None
	<a href="#">Rehabilitation services</a> (physical therapy)	\$20 copay, 20% <a href="#">coinsurance</a> of <a href="#">allowed amount</a>	\$20 copay, 30% <a href="#">coinsurance</a> of <a href="#">allowed amount</a>	50% <a href="#">coinsurance</a> of <a href="#">allowed amount</a>	Limited to 25 visits per benefit period.
	<a href="#">Habilitation services</a> (occupational therapy)	\$20 copay, 20% <a href="#">coinsurance</a> of <a href="#">allowed amount</a>	\$20 copay, 30% <a href="#">coinsurance</a> of <a href="#">allowed amount</a>	50% <a href="#">coinsurance</a> of <a href="#">allowed amount</a>	Limited to 25 visits per benefit period.
	<a href="#">Habilitation services</a> (speech therapy)	\$20 copay, 20% <a href="#">coinsurance</a> of <a href="#">allowed amount</a>	\$20 copay, 30% <a href="#">coinsurance</a> of <a href="#">allowed amount</a>	50% <a href="#">coinsurance</a> of <a href="#">allowed amount</a>	Limited to 25 visits per benefit period.
	<a href="#">Skilled nursing care</a>	20% <a href="#">coinsurance</a> of <a href="#">allowed amount</a>	30% <a href="#">coinsurance</a> of <a href="#">allowed amount</a>	50% <a href="#">coinsurance</a> of <a href="#">allowed amount</a>	Limited to 60 Days
	<a href="#">Durable medical equipment</a>	20% <a href="#">coinsurance</a> of <a href="#">allowed amount</a>	30% <a href="#">coinsurance</a> of <a href="#">allowed amount</a>	50% <a href="#">coinsurance</a> of <a href="#">allowed amount</a>	Rental cost covered up to purchase price. Coverage may be available to purchase pending Prior Approval.
	<a href="#">Hospice services</a>	20% <a href="#">coinsurance</a> of <a href="#">allowed amount</a>	30% <a href="#">coinsurance</a> of <a href="#">allowed amount</a>	50% <a href="#">coinsurance</a> of <a href="#">allowed amount</a>	None
<b>If your child needs dental or eye care</b>	Children's eye exam	Based on VSP Schedule of Benefits.		Based on VSP Schedule of Benefits.	Once every 12 months if age 18 and younger. Once every 24 months if over the age of 18.
	Children's glasses	Based on VSP Schedule of Benefits.		Based on VSP Schedule of Benefits.	None.
	Children's dental check-up	Based on Delta Dental PPO Summary of Dental Benefits.		Based on Delta Dental PPO Summary of Dental Benefits.	Four exams per 12-month period included. Annual maximums: \$1,500 Delta Dental PPO; \$1,250 Delta Dental Premier; \$1,000 non-participating providers.

## 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](#).)

- Acupuncture
- Cosmetic Surgery
- Infertility Treatment
- Long Term Care
- Routine Foot Care
- Weight Loss Programs
- Non-emergency care when traveling outside U.S

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

- Bariatric Surgery
- Chiropractic Care (10 visits)
- Limited emergency care when traveling outside
- Dental Care (Adult)
- Hearing Aids (\$500 maximum every 5 years)
- Private Duty Nursing
- Routine eye care (Adult)

**Your Rights to Continue Coverage:** If you lose coverage under the [plan](#), then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a [premium](#), which may be significantly higher than the premium you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply.

There are agencies that can help if you want to continue your coverage after it ends. For more information on your rights to continue coverage, contact the [plan](#) at 216.431.7738. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 866.444.3272 or [www.dol.gov/ebsa](http://www.dol.gov/ebsa), or the U.S. Department of Health and Human Services at 877.267.2323 X61565 or [www.cciio.cms.gov](http://www.cciio.cms.gov). 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 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: 216.431.7738. You may also contact 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). If coverage is insured, also insert applicable State Department of Insurance contact information.

**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 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 216.431.7738.]

[Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 216.431.7738.]

[Chinese (中文): 如果需要中文的帮助, 请拨打这个号码 216.431.7738.]

[Navajo (Dine): Dine'ehgo shika at'ohwol ninisingo, kwijigo holne' 216.431.7738.]

[Pennsylvania Dutch (Deitsch): Fer Hilf griege in Deitsch, ruf 419-248-2401 uff.]

—————*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 exclusions, see **Summary Plan Description**.

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](#) \$750
- [Specialist copayment](#) \$20
- Hospital (facility) [coinsurance](#) 30%
- Other [coinsurance](#) 30%

**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>\$12,800</b>
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**In this example, Peg would pay:**

<i>Cost Sharing</i>	
Deductibles	\$750
Copayments	\$0
Coinsurance	\$3,250
<i>What isn't covered</i>	
Limits or exclusions	\$0
<b>The total Peg would pay is</b>	<b>\$4,000</b>

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

- The [plan's](#) overall [deductible](#) \$750
- [Specialist copayment](#) \$20
- Hospital (facility) [coinsurance](#) 30%
- Other [coinsurance](#) 30%

**This EXAMPLE event includes services like:**

Primary care physician office visits (*including disease education*)  
 Diagnostic tests (*blood work*)  
 Prescription drugs  
 Durable medical equipment (*Insulin pump*)

<b>Total Example Cost</b>	<b>\$7,400</b>
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**In this example, Joe would pay:**

<i>Cost Sharing</i>	
Deductibles	\$750
Copayments	\$80
Coinsurance	\$1,915
<i>What isn't covered</i>	
Limits or exclusions	\$0
<b>The total Joe would pay is</b>	<b>\$2,745</b>

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

- The [plan's](#) overall [deductible](#) \$750
- [Specialist copayment](#) \$20
- Hospital (facility) [coinsurance](#) 30%
- Other [coinsurance](#) 30%

**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>\$1,900</b>
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**In this example, Mia would pay:**

<i>Cost Sharing</i>	
Deductibles	\$750
Copayments	\$20
Coinsurance	\$325
<i>What isn't covered</i>	
Limits or exclusions	\$0
<b>The total Mia would pay is</b>	<b>\$1,095</b>

Note: These numbers assume the patient does not participate in the plan's wellness program. If you participate in the plan's wellness program, you may be able to reduce your costs. For more information about the wellness program, please contact the Fund Office: 216-431-7738.