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, go to www.ibew332benefits.com or call in San Jose (408) 288-4433 or toll-free at 1-877-827-4239. 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.cciio.cms.gov or call 1-800-878-4445 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	$250 person / $750 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. Most network provider preventive 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?	There are no other medical plan deductibles. Dental benefit deductible: $50 person / $150 family	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?	For network providers: $3,000 person / $6,000 family (including deductible and Rx) For out-of-network providers: $6,000 person / $13,000 family (including deductible and Rx)	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?	Deductibles, 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, this plan uses network providers. If you use a non-network provider your cost may be more. For a list of network providers, see www.anthem.com/ca or call the Member Service number listed on the back of your ID card for a list of Anthem BlueCross PPO 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 permission from this plan.

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	20% coinsurance after deductible	40% coinsurance after deductible	Non-emergency services provided by an out-of-network provider at an in-network facility is limited to 20% coinsurance, unless you consent to the out-of-network billing rates.
	Specialist visit	20% coinsurance after deductible	40% coinsurance after deductible	Non-emergency services provided by an out-of-network provider at an in-network facility is limited to 20% coinsurance, unless you consent to the out-of-network billing rates.
	Preventive care/screening/ immunization	No charge	Not covered	Deductible does not apply. 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.
	Telehealth Services	No charge	No charge	None
If you have a test	Diagnostic test (x-ray, blood work)	20% coinsurance after deductible	40% coinsurance after deductible	None
	Imaging (CT/PET scans, MRIs)	20% coinsurance after deductible	40% coinsurance after deductible	
	COVID-19 Test	None	None	None

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.maxorplus.com.	Preferred and non-preferred generic drugs	Retail: $10 copay/prescription; Mail order: $20 copay/prescription	Not covered	Covers up to a 30-day supply (retail prescription); 31-90 day supply (mail order prescription).
	Preferred brand drugs	Retail: 20% coinsurance/prescription; Mail order: 20% coinsurance/prescription	Not covered	Covers up to a 30-day supply (retail prescription); 31-90 day supply (mail order prescription). Responsible for difference in cost between brand drug and generic, if generic equivalent available. Retail: $15 minimum up to $25 maximum coinsurance. Mail Order: $40 minimum up to $75 maximum coinsurance.
	Non-preferred brand drugs/all other drugs	Retail: 30% coinsurance/prescription Mail order: 30% coinsurance/prescription	Not covered	Covers up to a 30-day supply (retail prescription); 31-90 day supply (mail order prescription). Responsible for difference in cost between brand drug and generic, if generic equivalent available. Retail: $30 minimum up to $75 maximum coinsurance. Mail Order: $75 minimum up to $150 maximum coinsurance.
	Specialty drugs	Retail: 30% coinsurance/prescription Mail order: 30% coinsurance/prescription	Not covered	Must use the MXP Pharmacy Specialty Mail-Order Pharmacy. Maximum 30-day supply. Retail: $30 minimum up to $75 maximum coinsurance. Mail Order: $75 minimum up to $150 maximum coinsurance.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance after deductible	40% coinsurance after deductible	None
	Physician/surgeon fees	20% coinsurance after deductible	40% coinsurance after deductible	Non-emergency services provided by an out-of-network provider at an in-network facility is limited to 20% coinsurance, unless you consent to the out-of-network billing rates.
If you need immediate medical attention	Emergency room care	20% coinsurance, $0 deductible	20% coinsurance, $0 deductible	You will pay 40% coinsurance for emergency services at an out-of-network facility if (1) you did not have an emergency medical condition; or (2)

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)	
				you receive emergency services for treatment of an emergency medical condition from an out-of-network provider or out-of-network facility and consent to the out-of-network billing rate for certain post-stabilization services.
	Emergency medical transportation	20% coinsurance, $0 deductible	40% coinsurance after deductible 20% coinsurance, $0 deductible for air ambulance services	Limited to the U.S. and Canada.
	Urgent care	20% coinsurance after deductible	40% coinsurance after deductible	None
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance after deductible	40% coinsurance after deductible	Preauthorization required except in an emergency. See your plan document for details.
	Physician/surgeon fees	20% coinsurance after deductible	40% coinsurance after deductible	Non-emergency services provided by an out-of-network provider at an in-network facility is limited to 20% coinsurance, unless you consent to the out-of-network billing rates.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	20% coinsurance after deductible	40% coinsurance after deductible	Preauthorization required except in an emergency. See your plan document for details. Non-emergency services provided by an out-of-network provider at an in-network facility is limited to 20% coinsurance, unless you consent to the out-of-network billing rates.
	Inpatient services	20% coinsurance after deductible	40% coinsurance after deductible	Preauthorization required except in an emergency. See your plan document for details. Non-emergency services provided by an out-of-network provider at an in-network facility is limited to 20% coinsurance, unless you consent to the out-of-network billing rates.
If you are pregnant	Office visits	20% coinsurance after deductible	40% coinsurance after deductible	Coinsurance applies to provider delivery charges.
	Childbirth/delivery professional services	20% coinsurance after deductible	40% coinsurance after deductible	

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 facility services	20% coinsurance after deductible	40% coinsurance after deductible	
If you need help recovering or have other special health needs	Home health care	20% coinsurance after deductible	40% coinsurance after deductible	Medical treatment only.
	Rehabilitation services	20% coinsurance after deductible	40% coinsurance after deductible	None
	Habilitation services	Not covered	Not covered	No coverage for Habilitation services.
	Skilled nursing care	20% coinsurance after deductible	40% coinsurance after deductible	Routine custodial care excluded. Limitations apply – See your plan document.
	Durable medical equipment	20% coinsurance after deductible	40% coinsurance after deductible	Preauthorization required.
	Hospice services	20% coinsurance after deductible	40% coinsurance after deductible	None
If your child needs dental or eye care	Children's eye exam	$10 copay/visit	Limited to $50	Limited to 1 exam every calendar year.
	Children's glasses	$25 copay	Various reimbursement amounts. Refer to Plan Document.	Lenses limited to once in a calendar year. Frames limited to once every two calendar years.
	Children's dental check-up	No charge	No charge	Limited to 2 exams in any calendar year.

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.)

- Cosmetic Surgery is general excluded except as required by Women's Health and Cancer Rights Act, due to an accidental bodily injury, or due to a birth defect.
- Habilitation Services
- Infertility Treatment
- Long Term Care
- Non-emergency care when traveling outside the U.S.
- Private Duty Nursing
- Routine Foot Care
- Weight Loss Programs

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

- Acupuncture Services
- Bariatric Surgery
- Chiropractic Care
- Dental Care
- Hearing Aids
- Routine Eye Care

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: U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or http://www.dol.gov/ebsa, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or 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 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: For more information about your coverage, contact I.B.E.W. Local 332 Health & Welfare Plan in San Jose at (408) 288-4438 or toll-free at 1-877-827-4239. 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**.
If you don't have Minimum Essential Coverage for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

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 1-800-547-4457.
Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-547-4457.
Chinese (中文): 如果需要中文的帮助，请拨打这个号码1-800-547-4457.
Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-800-547-4457.

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	$250
Specialist copayment	$0
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	**$12,800**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$250
Copayments	$0
Coinsurance	$2,510
What isn't covered	
Limits or exclusions	$0
The total Peg would pay is	**$2,760**

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

The plan's overall deductible	$250
Specialist copayment	$0
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	**$7,400**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$250
Copayments	$0
Coinsurance	$1,430
What isn't covered	
Limits or exclusions	$0
The total Joe would pay is	**$1,680**

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

The plan's overall deductible	$500
Specialist copayment	$0
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	**$1,900**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$250
Copayments	$0
Coinsurance	$330
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$580**