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 call 1-800-872-8979. 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.ewwellpower.com.com or call 1-800-872-8979 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	$300/person or $900/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 meet the overall family **deductible.**
Are there services covered before you meet your deductible?	Yes. **Preventive care**, prescription drugs and routine dental and vision care are covered before you meet your **deductible**.	This **plan** covers some items and services even if you haven't 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. $25 person/$75 family for dental services. 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?	$2,500 per person.	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**, **deductibles**, **copays**, **balance billing** charges, and health care this **plan** doesn't cover and routine dental and vision care.	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. For a list of participating providers, see www.Aetna.com or call (800) 872-8979.	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 don't need a referral to see a specialist.

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**	20% **coinsurance**	None.
	Specialist visit	20% **coinsurance**	20% **coinsurance**	None.
	Other practit oner office visit	20% **coinsurance**	20% **coinsurance**	Acupuncture and massage therapy are not covered.
	Preventive care/screening/ immunization	No charge	No charge	Employees and dependents: One routine physical exam per year, including lab, x-ray and recommended cancer screenings. Well baby exams: seven exams up to age 12 months. Immunizations: as recommended by the Center for Disease Control and Prevention.
If you have a test	Diagnostic test (x-ray, blood work)	20% **coinsurance**	20% **coinsurance**	None.
	Imaging (CT/PET scans, MRIs)	20% **coinsurance**	20% **coinsurance**	None.
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.savrx.com	Generic drugs	Retail: $5 **copay**/prescription		Covers up to a 30-day supply. For an **out-of-network** pharmacy you will also be responsible for the difference between what the pharmacy bills and the **network** negotiated rate.
	Brand drugs	Retail: $25 **copay**/prescription		
	Mail order generic drugs	Mail Order: $10 **copay**/prescription	Not covered	Covers up to a 90-day supply
	Mail order brand drugs	Mail Order: $50 copay/prescription	Not covered	

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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 have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance	20% coinsurance	Should be pre-certified.
	Physician/surgeon fees	20% coinsurance	20% coinsurance	
If you need immediate medical attention	Emergency room care	20% coinsurance	20% coinsurance	None.
	Emergency medical transportation	20% coinsurance	20% coinsurance	None.
	Urgent care	20% coinsurance	20% coinsurance	None.
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance	20% coinsurance	Services should be pre-certified. Certain surgeries are required to be performed on an outpatient basis. Unless inpatient care is determined to be medically necessary, surgery related charges for these surgeries will be paid at 50% if performed on an inpatient basis.
	Physician/surgeon fees	20% coinsurance	20% coinsurance	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	20% coinsurance	20% coinsurance	None.
	Inpatient services	20% coinsurance	20% coinsurance	Services should be pre-certified.
If you are pregnant	Office visits, prenatal and postnatal care	20% coinsurance	20% coinsurance	None.
	Childbirth/delivery professional services	20% coinsurance	20% coinsurance	Services are not eligible for Dependent Children
	Childbirth/delivery facility services	20% coinsurance	20% coinsurance	Coverage for Employee and Spouse only.
If you need help recovering or have other special health	Home health care	20% coinsurance	20% coinsurance	Up to 130 visits per person per calendar year. Services should be pre-certified.
	Rehabilitation services	20% coinsurance	20% coinsurance	Services should be pre-certified.
	Habilitation services	20% coinsurance	20% coinsurance	Services should be pre-certified. Limited

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)	
needs				to treatment for neurodevelopmental disorders, including ABA, Speech, Physical and Occupational Therapies when medically necessary.
	Skilled nursing care	20% **coinsurance**	20% **coinsurance**	Services should be **pre-certified**.
	Durable medical equipment	20% **coinsurance**	20% **coinsurance**	Services should be **pre-certified**.
	Hospice services	20% **coinsurance**	20% **coinsurance**	Covered for a maximum of 6 months. Services should be **pre-certified**.
If your child needs dental or eye care	Children's eye exam	No charge	Any amount over $92.00	One exam every 12 months. Vision services are covered through VSP (Vision Service Plan)
	Children's glasses	No charge for lenses, any amount over **Plan** allowances for frames.	Any amount over $38.00 for single vision lens and $89.00 for frames.	One pair of lenses every 12 months. One set of frames every 24 months.
	Children's dental check-up	30% **coinsurance** in first year, 20% **coinsurance** in second year, 10% **coinsurance** in third year, no charge in fourth year or later provided you visit a dentist at least once each calendar year.	30% **coinsurance** in first year, 20% **coinsurance** in second year, 10% **coinsurance** in third year, no charge in fourth year or later provided you visit a dentist at least once each calendar year.	No more than two exams in a calendar year. Dental services are covered through Delta Dental. **Out-of-network** coverage limited to Delta Dental's **out-of-network** fee schedule. You may be subject to **balance billing** if your **out-of-network provider** charges more than the schedule.

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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
- Bariatric surgery
- Cosmetic surgery
- Habilitation services except for treatment for Neurodevelopmental Therapy, including ABA therapy, Speech, Physical and Occupational Therapy when medically necessary
- Hearing aids
- 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.)

- Chiropractic care
- Dental care (Adult)
- Routine eye care (Adult)

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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 www.dol.gov/ebsa/healthreform, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or 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: Inland Empire Electrical Workers Health and Welfare Plan, PO Box 5433, Spokane WA 99205, 1-800-872-8979. You may also contact the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 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 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 1-800-872-8979
Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-872-8979
Chinese (中文): 如果需要中文的帮助，请拨打这个号码 1-800-872-8979.
Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-800-872-8979.

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 *[cost sharing]*	20%
Hospital (facility) *[cost sharing]*	20%
Other *[cost sharing]*	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	**$7,540**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$300
Copayments	$0
Coinsurance	$1,448
What isn't covered	
Limits or exclusions	$150
The total Peg would pay is	**$1,898**

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 *[cost sharing]*	20%
Hospital (facility) *[cost sharing]*	20%
Other *[cost sharing]*	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	**$5,400**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$300
Copayments	$60
Coinsurance	$1,020
What isn't covered	
Limits or exclusions	$80
The total Joe would pay is	**$1,460**

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

The plan's overall deductible	$300
Specialist *[cost sharing]*	20%
Hospital (facility) *[cost sharing]*	20%
Other *[cost sharing]*	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	**$2,020**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$300
Copayments	$0
Coinsurance	$344
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$644**

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