



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

Important Questions	Answers	Why This Matters:
What is the overall <u>deductible</u> ?	\$300/person or \$900/family	Generally, you must pay all the costs from providers 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 deductible expenses paid by all family members meet the overall family <u>deductible</u> .
Are there services covered before you meet your <u>deductible</u> ?	Yes. <u>Preventive care</u> , prescription drugs and routine dental and vision care are covered before you meet your <u>deductible</u> .	This <u>plan</u> covers some items and services even if you have not met the <u>deductible</u> amount. But a <u>copayment</u> or <u>coinsurance</u> may apply.
Are there other <u>deductibles</u> for specific services?	Yes. \$25 person/\$75 family for dental services. 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.
What is the <u>out-of-pocket limit</u> for this <u>plan</u> ?	\$2,500 per person <u>coinsurance</u> .	The <u>out-of-pocket limit</u> is the most you could pay in a year for covered services.
What is not included in the <u>out-of-pocket limit</u> ?	<u>Premiums</u> , <u>deductibles</u> , <u>copays</u> , <u>balance billing</u> charges, and health care this <u>plan</u> doesn't cover and routine dental and vision care.	Even though you pay these expenses, they do not count toward the <u>out-of-pocket limit</u> .
Will you pay less if you use a <u>network provider</u> ?	Yes. For a list of participating providers, see www.Aetna.com or call (800) 872-8979.	This <u>plan</u> uses a provider <u>network</u> . You will pay less if you use a <u>provider</u> in the plan's <u>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 provider's charge 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.
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.

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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 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.
	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; three exams per year age 1-2. 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	Services should be pre-certified .
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 Mail Order: \$10 copay /prescription		Covers up to a 30-day supply at retail and up to a 90-day supply by mail order. Specialty drugs limited to a 30-day supply. Mail order and specialty drugs covered through Sav-Rx mail order and specialty pharmacy only. Walmart and Sam's Club are not covered pharmacies.
	Brand drugs (Generic not available)	Retail: \$25 copay /prescription Mail Order: \$50 copay /prescription		
	Brand drugs (Generic available)	Retail: \$5 copay /prescription plus difference in cost between the brand name and generic drug. Mail Order: \$10 copay /prescription plus difference in cost between the brand name and generic drug.		
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance	20% coinsurance	Services should be pre-certified .
	Physician/surgeon fees	20% coinsurance	20% coinsurance	None.
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.

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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 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	20% coinsurance	20% coinsurance	None.
	Childbirth/delivery professional services	20% coinsurance	20% coinsurance	Coverage for Employee and Spouse only.
	Childbirth/delivery facility services	20% coinsurance	20% coinsurance	Coverage for Employee and Spouse only.
If you need help recovering or have other special health needs	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 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 .

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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 your child needs dental or eye care	Children’s eye exam	No charge	Any amount over \$92	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 for single vision lens and \$89 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 provided through Delta Dental of Alaska. 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.

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](#).)

- | | | |
|---|---|---|
| <ul style="list-style-type: none"> • Bariatric surgery • Cosmetic surgery • Habilitation services except for treatment for Neurodevelopmental Therapy, including ABA therapy, Speech, Physical and Occupational Therapy when medically necessary | <ul style="list-style-type: none"> • Hearing aids • Infertility treatment • Long-term care • Non-emergency care when traveling outside the U.S. | <ul style="list-style-type: none"> • Private-duty nursing • Routine foot care • Weight loss programs |
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Other Covered Services (Limitations may apply to these services. This isn’t a complete list. Please see your [plan](#) document.)

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|--|---|--|
| <ul style="list-style-type: none"> • Chiropractic care • Acupuncture | <ul style="list-style-type: none"> • Dental care (Adult) | <ul style="list-style-type: none"> • 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: Department of Labor’s Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform and Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, 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

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[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: 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

[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 1-800-872-8979

Chinese (中文): 如果需要中文的帮助, 请拨打这个号码 1-800-872-8979.

Vietnamese (Tiếng Việt): Để được hỗ trợ bằng tiếng Việt, hãy gọi 1-800-872-8979.

Russian (Русский): Для получения помощи на русском языке, пожалуйста, позвоните 1-800-872-8979.

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To see examples of how this [plan](#) might cover costs for a sample medical situation, see the next section.

About these Coverage Examples:

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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	\$12,800
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In this example, Peg would pay:

<i>Cost Sharing</i>	
Deductibles	\$300
Copayments	\$0
Coinsurance	\$2,500
<i>What isn't covered</i>	
Limits or exclusions	\$150
The total Peg would pay is	\$2,950

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	\$7,400
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In this example, Joe would pay:

<i>Cost Sharing</i>	
Deductibles	\$300
Copayments	\$120
Coinsurance	\$1,420
<i>What isn't covered</i>	
Limits or exclusions	\$80
The total Joe would pay is	\$1,920

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	\$2,800
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In this example, Mia would pay:

<i>Cost Sharing</i>	
Deductibles	\$300
Copayments	\$0
Coinsurance	\$344
<i>What isn't covered</i>	
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.