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, [insert contact information]. 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.569trusts.com or call 1-800-632-2569 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	**$**250/Individual or 2 $250 deductibles or $750/family Doesn't apply to office visits, Rx or preventive care.	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. Some Preventive care and some primary 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?	Yes. $250 for out-of-network hospitals and $50 out-patient hospital services.	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 $1500 individual after the $250 deductible has been met.	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 per IRS is $16,300 for 2020.
What is not included in the out-of-pocket limit?	Any 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. Costs for services rendered by out-of-network providers are not subject to the out–of–pocket limit
Will you pay less if you use a network provider?	Yes. See www.anthem.com or call **800-685-7774** for a list of 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 don't need a referral	This plan will pay some or all of the costs to see a specialist for covered services.

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	$10, $15 or $30 co-pay/visit	Not covered	In San Diego County: Sharp-$10, $30 all other PPO. $15 outside of San Diego County
	Specialist visit	$10, $15 or $30 co-pay/visit	Not covered	In San Diego County: Sharp-$10, $30 all other PPO. $15 outside of San Diego County
	Preventive care/screening/ immunization	A co-pay may or may not be payable	Not covered	In San Diego County: Sharp-$10, $30 all other PPO. $15 outside of San Diego County
If you have a test	Diagnostic test (x-ray, blood)	20% co-insurance	Not covered	None
	Imaging (CT/PET scans, MRIs)	20% co-insurance	Not covered	None
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.navitus.com	Tier 1 drugs	20% co-insurance	Not covered	30 day supply retail;31-90 days mail order
	Tier 2 drugs	40% co-insurance	Not covered	30 day supply retail;31-90 days mail order
	Tier 3 drugs	60% co-insurance	Not covered	30 day supply retail;31-90 days mail order
	Specialty drugs	Same as above Tiers	Not covered	Step therapy/prior authorizations may apply
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% co-insurance	Not covered	None
	Physician/surgeon fees	20% co-insurance	Not covered	None
If you need immediate medical attention	Emergency room care	20% co-insurance	20% co-insurance	None
	Emergency medical transportation	20% co-insurance	20% co-insurance	None
	Urgent care	20% co-insurance	20% co-insurance	None
If you have a hospital stay	Facility fee (e.g., hospital room)	20% co-insurance	Not covered	None
	Physician/surgeon fees	20% co-insurance	Not covered	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$15 co-pay/visit	Not covered	Must use Optum Behavioral Providers
	Inpatient services	20% co-insurance	Not covered	Must use Optum Behavioral Providers

If you are pregnant	Office visits	$10, $15 or $30 co-pay/visit	Not covered	None
	Childbirth/delivery professional services	20% co-insurance	Not covered	None
	Childbirth/delivery facility services	20% co-insurance	Not covered	None
If you need help recovering or have other special health needs	Home health care	20% co-insurance	Not covered	None
	Rehabilitation services	20% co-insurance	Not covered	None
	Habilitation services	20% co-insurance	Not covered	None
	Skilled nursing care	20% co-insurance	Not covered	Prior Authorization required above 6 visits
	Durable medical equipment	20% co-insurance	Not covered	Must be medically necessary
	Hospice services	20% co-insurance	Not covered	None
If your child needs dental or eye care	Children's eye exam	$20 co-pay	Not covered	None
	Children's glasses	Per VSP Schedule	Not covered	None
	Children's dental check-up	Per Delta Dental Schedule	Not covered	Per the Plan Document

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.)

- Certain cosmetic surgeries
- Long-term care
- Experimental or investigative surgery or therapy
- Infertility treatment
- Never Events or Hospital Acquired Conditions
- Medically unnecessary services

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

- Chiropractic/Acupuncture up to 12 visits per year
- Medical and Dental services in Mexico (via Pinnacle PPO Networks)
- Bariatric Surgery (must be pre-authorized)
- Hearing aids up to $2500/3 years
- Non-emergency care outside of the U.S.

[* For more information about limitations and exceptions, see the plan or policy document at www.569trusts.org.

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 1-866-444-3272 or 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 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: the Trust Office by mail at San Diego Electrical Health & Welfare Trust, PO Box 231219, San Diego, CA 92193-1219. You may also contact the Department of Labor's 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 858-569-6322 or 800-632-2569, x312

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 *[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	**$15440**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$250
Copayments	$100
Coinsurance	$1400
What isn't covered	
Limits or exclusions	$0
The total Peg would pay is	**$1750**

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 *[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	**$4100**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$250
Copayments	$30
Coinsurance	$624
What isn't covered	
Limits or exclusions	$0
The total Joe would pay is	**$904**

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

- **The plan's overall deductible** **$250**
- **The plan's accident benefit ($300)** **100%**
- **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	**$1450**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$250
Copayments	$0
Coinsurance	$180
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$430**

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