Your summary of benefits

Anthem®

Anthem® Blue Cross

IBEW Local 18 Health & Welfare Trust - PPO

Your Plan: Anthem Custom Incentive PPO 250/35/20 (Rx $5/$10)

Your Network: Prudent Buyer PPO

This summary of benefits is a brief outline of coverage, designed to help you with the selection process. This summary does not reflect each and every benefit, exclusion and limitation which may apply to the coverage. For more details, important limitations and exclusions, please review the formal Evidence of Coverage (EOC). If there is a difference between this summary and the Evidence of Coverage (EOC), the Evidence of Coverage (EOC), will prevail. Non-PPO- For nonemergency care, reimbursement amount is based on: an Anthem Blue Cross rate or fee schedule, a rate negotiated with the provider, information from a third party vendor, or billed charges. Members are responsible for the difference between the provider's usual charges & the maximum allowed

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Overall Deductible *See notes section to understand how your deductible works.*	$250 person / maximum of three separate deductibles / family	$1,000 person / maximum of three separate deductibles / family
Out-of-Pocket Limit *When you meet your out-of-pocket, you will no longer have to pay cost-shares during the remainder of your benefit period. See notes section for additional information regarding your out-of-pocket maximum.*	$2,000 person / $4,000 family	$6,000 person / $12,000 family
The family deductible and out-of-pocket maximum are embedded, meaning the cost shares of one family member will be applied to both per person deductible and per person out-of-pocket maximum; in addition, amounts for all covered family members apply to both the family deductible and family out-of-pocket maximum. No one member will pay more than the per person deductible or per person out-of-pocket maximum. Your copays, coinsurance and deductible count toward your out of pocket amount(s). In-network and out-of-network deductibles and out-of-pocket maximum amounts are separate and do not accumulate toward each other.		
Preventive Care / Screening / Immunization *In-network preventative care is not subject to deductible, if your plan has a deductible.*	No Copay	40% coinsurance after deductible is met
Preventive Care for Chronic Conditions *per IRS guidelines*	No Copay	40% coinsurance after deductible is met

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Virtual Care (Telemedicine / Telehealth Visits) **Virtual Visits - Online visits with Doctors who also provide services in person**		
Primary Care (PCP) *Deductible does not apply to In-Network providers*	No Copay	40% coinsurance after deductible is met
Mental Health and Substance Use Disorder care	Carved out to Optum Behavioral Health	Carved out to Optum Behavioral Health
Specialist *Deductible does not apply to In-Network providers*	$35 copay per visit	40% coinsurance after deductible is met
Virtual Visits from Online Provider LiveHealth Online *via www.livehealthonline.com; our mobile app, website or Anthem-enabled device*		
Primary Care (PCP) - *Deductible does not apply to In-Network providers*	No Copay	Not covered
Mental Health and Substance Use Disorder	Carved out to Optum Behavioral Health	Not covered
Specialist Care - *Deductible does not apply to In-Network providers*	No Copay	Not covered
Visits in an Office		
Primary Care (PCP) *Deductible does not apply to In-Network providers*	No Copay	40% coinsurance after deductible is met
Specialist Care *Deductible does not apply to In-Network providers*	$35 copay per visit	40% coinsurance after deductible is met
Other Practitioner Visits		
Routine Maternity Care (Prenatal and Postnatal) *Deductible does not apply to In-Network providers*	No Copay	40% coinsurance after deductible is met
Retail Health Clinic *Deductible does not apply to In-network providers*	No Copay	40% coinsurance after deductible is met
Chiropractic Services *Coverage for In-Network Provider and Non-Network Provider combined is limited to 30 visits per benefit period. Deductible does not apply to In-Network providers*	No Copay	40% coinsurance after deductible is met
Acupuncture *Coverage for In-Network Provider and Non-Network Provider combined is limited to 20 visit limit per benefit period. Deductible does not apply to In-Network providers.*	No Copay	40% coinsurance after deductible is met

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Other Services in an Office		
Allergy Testing	20% coinsurance after deductible is met	40% coinsurance after deductible is met
Chemo/Radiation Therapy	20% coinsurance after deductible is met	40% coinsurance after deductible is met
Dialysis/Hemodialysis	20% coinsurance after deductible is met	40% coinsurance after deductible is met
Prescription Drugs *Dispensed in the office through infusion/injection*	20% coinsurance after deductible is met	40% coinsurance after deductible is met
Surgery	20% coinsurance after deductible is met	40% coinsurance after deductible is met
Diagnostic Services		
Lab		
Office	20% coinsurance after deductible is met	40% coinsurance after deductible is met
Freestanding Lab	20% coinsurance after deductible is met	40% coinsurance after deductible is met
Outpatient Hospital	20% coinsurance after deductible is met	40% coinsurance after deductible is met
X-Ray		
Office	20% coinsurance after deductible is met	40% coinsurance after deductible is met
Freestanding Radiology Center	20% coinsurance after deductible is met	40% coinsurance after deductible is met
Outpatient Hospital	20% coinsurance after deductible is met	40% coinsurance after deductible is met
Advanced Diagnostic Imaging *for example: MRI, PET and CAT scans*		
Office	20% coinsurance after deductible is met	40% coinsurance after deductible is met
Freestanding Radiology Center	20% coinsurance after deductible is met	40% coinsurance after deductible is met
Outpatient Hospital	20% coinsurance after deductible is met	40% coinsurance after deductible is met

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Emergency and Urgent Care		
Urgent Care (Office Setting)	$25 copay per visit deductible does not apply	40% coinsurance after deductible is met
Emergency Room Facility Services *Copay waived if admitted. This is for the hospital/facility charge only. The ER physician charge may be separate*	$100 copay per visit and then 20% coinsurance after deductible is met	Covered as In-Network
Emergency Room Doctor and Other Services	20% coinsurance after deductible is met	Covered as In-Network
Ambulance (Air & Ground)	30% coinsurance after medical deductible is met	Covered as In-Network
Outpatient Mental Health and Substance Use Disorder		
Doctor Office Visit	Carved out to Optum Behavioral Health	Carved out to Optum Behavioral Health
Facility Visit		
Facility Fees	Carved out to Optum Behavioral Health	Carved out to Optum Behavioral Health
Doctor Services	Carved out to Optum Behavioral Health	Carved out to Optum Behavioral Health
Outpatient Surgery		
Facility Fees		
Hospital	20% coinsurance after deductible is met	40% coinsurance after deductible is met
Freestanding Surgical Center *Coverage for out of network provider is limited to $350 maximum per visit*	20% coinsurance after deductible is met	40% coinsurance after deductible is met
Doctor and Other Services	20% coinsurance after deductible	40% coinsurance after deductible is met
Hospital (Including Maternity) *Mental/behavioral health and substance abuse is carved out to Optum Behavioral Health*		

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Facility Fees *(for example, room & board)* *Member is responsible for an additional $500 copay if prior authorization is not obtained from Anthem for non-emergency Inpatient admissions to non-network providers.*	20% coinsurance after deductible is met	40% coinsurance after deductible is met
Doctor and other services	20% coinsurance after deductible is met	40% coinsurance after deductible is met
Recovery & Rehabilitation		
Home Health Care *Coverage is limited to 100 visits per benefit period. Limit is combined In-Network and Non-Network*	20% coinsurance after deductible is met	40% coinsurance after deductible is met
Rehabilitation services *(for example, physical/speech/occupational therapy)*		
Office	20% coinsurance after deductible is met	40% coinsurance after deductible is met
Outpatient Hospital	20% coinsurance after deductible is met	40% coinsurance after deductible is met
Habilitation services *(for example, physical/speech/occupational therapy)*		
Office *Costs may vary by site of service*	20% coinsurance after deductible is met	40% coinsurance after deductible is met
Outpatient Hospital	20% coinsurance after deductible is met	40 % coinsurance after deductible is met
Cardiac rehabilitation		
Office	20% coinsurance after deductible is met	40% coinsurance after deductible is met
Outpatient Hospital	20% coinsurance after deductible is met	40% coinsurance after deductible is met
Skilled Nursing Care (facility) *Coverage is limited to 100 days per benefit period.*	20% coinsurance after deductible is met	40% coinsurance after deductible is met
Hospice	20% coinsurance deductible does not apply	30% coinsurance after deductible is met
Durable Medical Equipment	20% coinsurance after deductible is met	40% coinsurance after deductible is met

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Prosthetic Devices	20% coinsurance after deductible is met	40% coinsurance after deductible is met
Refractive Eye Surgeries (LASIK benefit) *Including astigmatic keratotomy, lamellar keratoplasty and laser procedure for the purpose of correcting refractive defects of the eye such as nearsightedness (myopia), hyperopia (farsightedness) or astigmatism. Limited to a lifetime benefit of $1,500/eye. Cost may vary by site of service. Limited is combined In-Network and Non-Network.*	Plan pays $1,500 per eye, lifetime	Plan pays $1,500 per eye, lifetime

Covered Prescription Drug Benefits	Cost if you use an In-Network Pharmacy	Cost if you use a Non-Network Pharmacy
Pharmacy Deductible	$0	$0
Home Delivery Pharmacy *Maintenance medication are available through CarelonRx Home Delivery Pharmacy. You will need to call us on the number on your ID card to sign up when you first use the service.*		
Preventive Pharmacy **Preventive Immunization**	No Copay	50% coinsurance (retail only)
Female oral contraceptive **Generic and Single Source brand**	No Copay	50% coinsurance (retail only)
Tier 1 - Typically Generic *Member pays the retail copay plus 50% for out of network. Covers up to a 30 day supply (retail pharmacy). Covers up to a 90 day supply (home delivery).*	$5 copay per prescription (retail) and $10 copay per prescription (home delivery)	Member pays the retail participating pharmacies copay plus 50% coinsurance (retail only)
Tier 2 – Typically Preferred Brand *Member pays the retail copay plus 50% for out of network. Covers up to a 30 day supply (retail pharmacy). Covers up to a 90 day supply (home delivery).*	$10 copay per prescription (retail) and $20 copay per prescription (home delivery)	Member pays the retail participating pharmacies copay plus 50% coinsurance (retail only)

Notes:

- The family deductible and out-of-pocket maximum are embedded meaning the cost shares of one family member will be applied to both the individual deductible and individual out-of-pocket maximum; in addition,

amounts for all covered family members apply to both the family deductible and family out-of-pocket maximum. No one member will pay more than the individual deductible and individual out-of-pocket maximum.

- If your plan includes an emergency room facility copay and you are directly admitted to a hospital, your emergency room facility copay is waived.
- For additional information on this plan, please visit www.sbc.anthem.com to obtain a "Summary of Benefits and Coverage".
- Certain types of physicians may not be represented in the PPO network in the state where the member receives services. If such physician is not available in the service area, the member's copay is the same as for PPO (with and without pre-notification, if applicable). Member is responsible for applicable copays, deductibles and charges which exceed covered expense.
- Behavioral Health and Substance Abuse is covered by Optum Behavioral Health.
- If your plan includes out of network benefit and you use a non-network provider, you are responsible for any difference between the covered expense and the actual non-participating providers charge.
- Non-emergency, out-of-network air ambulance services are limited to Anthem maximum payment of $50,000 per trip.
- Bariatric Surgery covered only when performed at Blue Distinction Center for Specialty Care for Bariatric Surgery.
- For plans with an office visit copay, the copay applies to the actual office visit and additional cost shares may apply for any other service performed in the office (i.e., X-ray, lab, surgery), after any applicable deductible.
- Transplants covered only when performed at Centers of Medical Excellence or Blue Distinction Centers.
- All medical services subject to a coinsurance are also subject to the annual medical deductible.
- Annual Out-of-Pocket Maximums includes deductible, copays, coinsurance and prescription drug.
- Certain drugs require pre-authorization approval to obtain coverage.
- Certain services are subject to the utilization review program. Before scheduling services, the member must make sure utilization review is obtained. If utilization review is not obtained, benefits may be reduced or not paid, according to the plan.
- Coordination of Benefits: The benefits of this plan may be reduced if the member has any other group health or dental coverage so that the services received from all group coverage do not exceed 100% of the covered expense.
- When using non-network pharmacy; members are responsible for in-network pharmacy copay plus 50% of the remaining prescription drug maximum allowed amount & costs in excess of the prescription drug maximum allowed amount. Members will pay upfront and submit a claim form.
- Freestanding Lab and Radiology Center is defined as services received in a non-hospital based facility.
- In addition to the benefits described in this summary, coverage may include additional benefits, depending upon the member's home state. The benefits provided in this summary are subject to federal and California laws. There are some states that require more generous benefits be provided to their residents, even if the Anthem Blue Cross is the trade name of Blue Cross of California. Anthem Blue Cross and Anthem Blue Cross Life and Health Insurance Company are independent licensees of the Blue Cross Association. ® ANTHEM is a registered trademark of Anthem Insurance Companies, Inc. The Blue Cross name and symbol are registered marks of the Blue Cross Association. Questions: (855) 333-5730 or visit us at www.anthem.com/ca master policy was not issued in their state. If the member's state has such requirements, we will adjust the benefits to meet the requirements.
- Preventive Care Services includes physical exam, preventive screenings (including screenings for cancer, HPV, diabetes, cholesterol, blood pressure, hearing and vision, immunization, health education, intervention services, HIV testing) and additional preventive care for women provided for in the guidance supported by Health Resources and Service Administration.
- Respite Care limited to 5 consecutive days per admission.
- Skilled Nursing Facility day limit does not apply to mental health and substance abuse.
- Supply limits for certain drugs may be different, go to Anthem website or call customer service.

- This Summary of Benefits has been updated to comply with federal and state requirements, including applicable provisions of the recently enacted federal health care reform laws. As we receive additional guidance and clarification on the new health care reform laws from the U.S. Department of Health and Human Services, Department of Labor and Internal Revenue Service, we may be required to make additional changes to this Summary of Benefits. This Summary of Benefits, as updated, is subject to the approval of the California Department of Insurance and the California Department of Managed Health Care (as applicable).
- For additional information on limitations and exclusions and other disclosure items that apply to this plan, go to https://le.anthem.com/pdf?x=CA_LG_PPO.
- Additional visits maybe authorized if medically necessary. Pre-service review must be obtained prior to receiving the additional services.
- If your plan includes out of network benefits, all services with calendar/plan year limits are combined both in and out of network

Your summary of benefits

Anthem®

Anthem® Blue Cross

Your Plan: Infertility Rider

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Infertility *In-Network and non-network infertility is not subject to deductible, if your plan has a deductible.*	50% coinsurance	50% coinsurance
Out-of-Pocket Limit	Infertility services do **not** apply toward Out-of-Pocket Limit.	
Infertility Benefit Maximum	Anthem payment of $5,000 per lifetime per Member.	
Additional Covered Services includes artificial insemination, in-vitro fertilization, GIFT (gamete intrafallopian transfer), ZIFT (Zygote intra-fallopian transfer), supplies, appliances, and Drugs administered in a Physician's office. These services are subject to Coinsurance stated above and the $5,000 lifetime per Member maximum. Covered services also exist for diagnostic tests to find the cause of infertility, such as diagnostic laparoscopy, endometrial biopsy, and semen analysis, and services to treat the underlying medical conditions that cause Infertility (e.g., endometriosis, obstructed fallopian tubes, and hormone deficiency). These services are provided on the same basis, at the same cost shares, as any other medical condition and **not** subject to the above lifetime maximum. **Not Covered:** Reversals of elective sterilizations.		

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Anthem

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Get help in your language

Language Assistance Services

Curious to know what all this says? We would be too. Here's the English version:
IMPORTANT: Can you read this letter? If not, we can have somebody help you read it. You may also be able to get this letter written in your language. For free help, please call right away at 1-888-254-2721. (TTY/TDD: 711)

Separate from our language assistance program, we make documents available in alternate formats for members with visual impairments. If you need a copy of this document in an alternate format, please call the customer service telephone number on the back of your ID card.

Spanish
IMPORTANTE: ¿Puede leer esta carta? De lo contrario, podemos hacer que alguien lo ayude a leerla. También puede recibir esta carta escrita en su idioma. Para obtener ayuda gratuita, llame de inmediato al 1-888-254-2721. (TTY/TDD: 711)

Arabic
مهم: هل يمكنك قراءة هذه الرسالة؟ إذا لم تستطع، فيمكننا الاستعانة بشخص ما ليساعدك على قراءتها. كما يمكنك أيضًا الحصول على هذا الخطاب مكتوبًا بلغتك. للحصول على المساعدة المجانية، يُرجى الاتصال فورًا بالرقم1-888-254-2721 (TTY/TDD:711).

Armenian
ՈՒՇԱԴՐՈՒԹՅՈՒՆ. Կարողանո՞ւմ եք ընթերցել այս նամակը: Եթե ոչ, մենք կարող ենք տրամադրել ինչ-որ մեկին, ով կօգնի Ձեզ՝ կարդալ այն: Կարող ենք նաև այս նամակը Ձեզ գրավոր տարբերակով տրամադրել: Անվճար օգնություն ստանալու համար կարող եք անհապաղ զանգահարել 1-888-254-2721 հեռախոսահամարով: (TTY/TDD: 711)

Chinese
重要事項：您能看懂這封信函嗎？如果您看不懂，我們能夠找人協助您。您有可能可以獲得以您的語言而寫的本信函。如需免費協助，請立即撥打1-888-254-2721。(TTY/TDD: 711)

Farsi
مهم: آیا می‌توانید این نامه را بخوانید؟ اگر نمی‌توانید، می‌توانیم شخصی را به شما معرفی کنیم تا در خواندن این نامه شما را کمک کند. همچنین می‌توانید این نامه را به صورت مکتوب به زبان خودتان دریافت کنید. برای دریافت کمک رایگان، همین حالا با شماره 1-888-254-2721 تماس بگیرید.(TTY/TDD:711)

Hindi
महत्वपूर्ण: क्या आप यह पत्र पढ़ सकते हैं? अगर नहीं, तो हम आपको इसे पढ़ने में मदद करने के लिए किसी को उपलब्ध करा सकते हैं। आप यह पत्र अपनी भाषा में लिखवाने में भी सक्षम हो सकते हैं। निःशुल्क मदद के लिए, कृपया 1-888-254-2721 पर तुरंत कॉल करें। (TTY/TDD: 711)

Hmong
TSEEM CEEB: Koj puas muaj peev xwm nyeem tau daim ntawv no? Yog hais tias koj nyeem tsis tau, peb muaj peev xwm cia lwm tus pab nyeem rau koj mloog. Tsis tas li ntawd tej zaum koj kuj tseem yuav tau txais daim ntawv no sau ua koj hom lus thiab. Txog rau kev pab dawb, thov hu tam sim no rau tus xov tooj 1-888-254-2721. (TTY/TDD: 711)

Japanese

重要：この書簡を読めますか？もし読めない場合には、内容を理解するための支援を受けることができます。また、この書簡を希望する言語で書いたものを入手することもできます。次の番号にいますぐ電話して、無料支援を受けてください。
1-888-254-2721 (TTY/TDD: 711)

Khmer
សំខាន់៖ តើអ្នកអាចអានលិខិតនេះទេ? បើមិនអាចទេ យើងអាចឲ្យនរណាម្នាក់អានវាជូនអ្នក។ អ្នកក៏អាចទទួលលិខិតនេះជាភាសារបស់អ្នកផងដែរ។ ដើម្បីទទួលជំនួយឥតគិតថ្លៃ សូមហៅទូរស័ព្ទតាមម៉ោងធ្វើការ 1-888-254-2721។ (TTY/TDD: 711)

Korean
중요: 이 서신을 읽으실 수 있으십니까? 읽으실 수 없을 경우 도움을 드릴 사람이 있습니다. 귀하가 사용하는 언어로 쓰여진 서신을 받으실 수도 있습니다. 무료 도움을 받으시려면 즉시 1-888-254-2721로 전화하십시오. (TTY/TDD: 711)

Punjabi
ਮਹੱਤਵਪੂਰਨ: ਕੀ ਤੁਸ ਇਹ ਪੱਤਰ ਪੜਹ ਸਕਦੇ ਹੋ? ਜੇ ਨਹ, ਤਾਂ ਅਸ ਇਸਨੂੰ ਪੜਹ ਿ ਵੱਚ ਤੁਹਾਡੀ ਮਦਦ ਲਈ ਿ ਕਸੇਨੂੰ ਬੁਲਾ ਸਕਦਾ ਹਾਂ ਤੁਸ ਸ਼ਾਇਦ ਪੱਤਰਨੂੰ ਆਪਣੀ ਭਾਸ਼ਾ ਿ ਵੱਚ ਿ ਲਖਆ ਹੋਇਆ ਵਬੀ ਪਰ ਾਪ ਾਪ ਕਰ ਸਕਦੇ ਹੋ। ਮੁਫ਼ਤ ਮਦਦ ਲਈ, ਿ ਕਰਪਾ ਕਰਕੇ ਫੋਰਨ 1-888-254-2721 ਤੇ ਕਾਲ ਕਰੋ। (TTY/TDD: 711)

Russian
ВАЖНО. Можете ли вы прочитать данное письмо? Если нет, наш специалист поможет вам в этом. Вы также можете получить данное письмо на вашем языке. Для получения бесплатной помощи звоните по номеру 1-888-254-2721. (TTY/TDD: 711)

Tagalog
MAHALAGA: Nababasa ba ninyo ang liham na ito? Kung hindi, may taong maaaring tumulong sa inyo sa pagbasa nito. Maaari ninyo ring makuha ang liham na ito nang nakasulat sa ginagamit ninyong wika. Para sa libreng tulong, mangyaring tumawag kaagad sa 1-888-254-2721. (TTY/TDD: 711)

Thai
หมายเหตส าคัญ: ทา่ นสามารถอา่ ไม่ หากท่านไม่สามารถอา่ นจดหมายฉบับนี้ นจดหมายฉบับนี้หรอ
เราสามารถจัดหาเจา้ หนา้ าอา่ ่านฟังได ทา่ นยังอาจใหเ้ จา้ ่วยแปล นจดหมายในภาษาของทา่ ตัว ย
หม นใหท หนา้ ท่ นอก
หากตอ้ งการความชว่ ยเหลอ โดยไม่ม คา่ ใชจ้ ่าย ต่อท่ หมายเลข 1-888-254-2721 (TTY/TDD: 711)
โปรดโทรตด

Vietnamese
QUAN TRỌNG: Quý vị có thể đọc thư này hay không? Nếu không, chúng tôi có thể bố trí người giúp quý vị đọc thư này. Quý vị cũng có thể nhận thư này bằng ngôn ngữ của quý vị. Để được giúp đỡ miễn phí, vui lòng gọi ngay số 1-888-254-2721. (TTY/TDD: 711)

It's important we treat you fairly

That's why we follow federal civil rights laws in our health programs and activities. We don't discriminate, exclude people, or treat them differently on the basis of race, color, national origin, sex, age or disability. For people with disabilities, we offer free aids and services. For people whose primary language isn't English, we offer free language assistance services through interpreters and other written languages. Interested in these services? Call the Member Services number on your ID card for help (TTY/TDD: 711). If you think we failed to offer these services or discriminated based on race, color, national origin, age, disability, or sex, you can file a complaint, also known as a grievance. You can file a complaint with our Compliance Coordinator in writing to Compliance Coordinator, P.O. Box 27401, Mail Drop VA2002-N160, Richmond, VA 23279. Or you can file a complaint with the U.S. Department of Health and Human Services, Office for Civil Rights at 200 Independence Avenue, SW; Room 509F, HHH Building; Washington, D.C. 20201 or by calling 1-800-368-1019 (TDD: 1- 800-537-7697) or online at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf. Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.