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, call 1-800-654-1824. 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.dol.gov/ebsa/healthreform or call 1-800-654-1824 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	In-Network providers and Out-of-Network providers combined: $100/individual/calendar year; Once two covered individuals in your family have met the deductible, you will have satisfied the maximum deductible for your entire 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. In-Network Preventive care, home health care, hospice, first inpatient admission for substance abuse rehabilitation, breast pump and necessary supplies, and In-Network outpatient prescription drugs 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?	No.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	Medical: In-Network providers and Out-of-Network providers combined: $3,100/individual, $5,000/family per calendar year. In-Network prescription drugs: $3,250/Individual, $7,500/family per calendar year.	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?	Medical Out-of-Pocket Limit does not include premiums, balance-billing charges, health care this plan doesn't cover, acupuncture & prescription drug charges. Prescription Drug Out-of-Pocket Limit does not include medical charges, premiums, balance-billing charges, health care this plan doesn't cover and Out-of-Network prescription drugs.	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. Medical: See www.anthem.com/ca or call 1-800-688-3828 for a list of network providers. Substance Abuse: call Teamsters Assistance Program of Northern California (TAP) at 1-510-562-3600 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.

Important Questions	Answers	Why This Matters:
Do you need a referral to see a specialist?	No.	You can see the specialist you choose without a referral.

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	30% coinsurance	50% coinsurance	None.
	Specialist visit	30% coinsurance	50% coinsurance	None.
	Preventive care /Screening/ Immunization	No charge, deductible does not apply	50% coinsurance	You may have to pay for services that aren't preventive. Check with the Administrative Office whether the services needed are considered preventive.
If you have a test	Diagnostic test (x-ray, blood work)	30% coinsurance	50% coinsurance	None.
	Imaging (CT/PET scans, MRIs)	30% coinsurance	50% coinsurance	None.
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.welldyneRx.com.	Generic drugs	Retail:$10 copayment per prescription, Mail Order: $20 copayment per prescription	Not covered.	• Deductible does not apply. • Retail prescription drugs limited to a 30-day supply. • Mail-Order prescription drugs limited to a 100-day supply. • No charge for FDA-approved generic contraceptives purchased at an In-Network pharmacy (or brand name if a generic is medically inappropriate). • You pay 100% when purchasing covered prescription drugs at a Non-Network pharmacy. You must submit a claim to the Plan for reimbursement.
	Preferred brand drugs	Retail: $20 copayment per prescription, Mail Order: $40 copayment per prescription	Not covered.	
	Non-preferred brand drugs	Retail: $20 copayment per prescription, Mail Order: $40 copayment per prescription	Not covered.	
	Specialty drugs	Same copays as noted above under generic and brand drugs	Not covered.	Specialty drugs limited to a 30-day supply.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	30% coinsurance	50% coinsurance	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)	
	Physician / Surgeon fees	30% coinsurance	50% coinsurance	None.
If you need immediate medical attention	Emergency room care	30% coinsurance	30% coinsurance	Professional/physician charges may be billed separately.
	Emergency medical transportation	30% coinsurance	30% coinsurance	Medically necessary transportation to or from a hospital is covered.
	Urgent care	30% coinsurance	50% coinsurance	None.
If you have a hospital stay	Facility fee (e.g., hospital room)	30% coinsurance	50% coinsurance	Limited to the hospital's most common rate for a semi-private room, ICU, or CCU.
	Physician / Surgeon fees	30% coinsurance	50% coinsurance	None.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	**Substance Abuse:** 20% coinsurance, deductible does not apply. **Mental Health:** 30% coinsurance	50% coinsurance	None.
	Inpatient services	**Substance Abuse:** No charge for first confinement, deductible does not apply. Subsequent confinements 30% coinsurance. **Inpatient detox:** No charge, deductible does not apply. **Mental Health:** 30% coinsurance	**Inpatient detox:** No charge, deductible does not apply. **All other:** 50% coinsurance	• If a participant utilizes an Anthem Blue Cross In-Network facility that is NOT a TAP facility for substance abuse, the Fund will allow the contracted rate. • Only semi-private room covered unless private room is medically necessary.
If you are pregnant	Office visits	30% coinsurance	50% coinsurance	• Cost sharing does not apply for preventive services. • Prenatal care (other than ACA-required preventive screenings) is not covered for dependent children. • Delivery charges are not covered for dependent children (except for an Emergency Medical Condition).
	Childbirth / Delivery professional services	30% coinsurance	50% coinsurance	
	Childbirth / Delivery facility services	30% coinsurance	50% coinsurance	

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 help recovering or have other special health needs	Home health care	30% coinsurance, deductible does not apply	50% coinsurance	None.
	Rehabilitation services	30% coinsurance	50% coinsurance	Maximum 15 visits per course of treatment; additional treatments must be pre-approved by Anthem Blue Cross or no benefits are available.
	Habilitation services	Not covered	Not covered	You pay 100% of this service, even In-Network.
	Skilled nursing care	30% coinsurance	50% coinsurance	Professional/physician charges may be billed separately. Only semi-private room covered unless private room is medically necessary.
	Durable medical equipment	**Breast Pump and necessary supplies:** No charge, deductible does not apply **All others:** 30% coinsurance	50% coinsurance	Must be prescribed by a Physician. Rental must not exceed purchase price.
	Hospice services	30% coinsurance, deductible does not apply	50% coinsurance	Physician's treatment plan must be pre-approved by contacting the Administrative Office or there are no benefits available.
If your child needs dental or eye care	Children's eye exam	Not covered.	Not covered.	If elected, coverage will be under a separate vision plan.
	Children's glasses	Not covered.	Not covered.	
	Children's dental check-up	Not covered.	Not covered.	If elected, coverage will be under a separate dental plan.

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
- Dental care (Adult & Child)(covered under separate dental plan).
- Habilitation Services
- Hearing aids
- Infertility treatment (except initial office visit, lab tests and screening laparoscopy to diagnose).
- Long-term care
- Routine eye care (Adult & Child)(covered under a separate vision plan).
- Routine foot care
- Weight loss programs (except as otherwise required under the Affordable Care Act)

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

- Acupuncture (maximum benefit $30/session, 50 sessions/person per calendar year).
- Chiropractic care (maximum 15 visits/course of treatment; additional treatments must be pre-approved)
- Non-emergency care when traveling outside the U.S.

- Bariatric surgery
- Private duty nursing

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: the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (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 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 the Administrative Office at 1-800-654-1824. You may also contact the 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.
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 1-800-654-1824.
Chinese (中文): 如果需要中文的帮助，请拨打这个号码 1-800-654-1824.

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	**$100**
Specialist coinsurance	**30%**
Hospital (facility) coinsurance	**30%**
Other coinsurance	**30%**

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	**$12,700**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$100
Copayments	$10
Coinsurance	$3,000
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$3,170**

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

The plan's overall deductible	**$100**
Specialist coinsurance	**30%**
Hospital (facility) coinsurance	**30%**
Other coinsurance	**30%**

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	**$5,600**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$100
Copayments	$590
Coinsurance	$320
What isn't covered	
Limits or exclusions	$0
The total Joe would pay is	**$1,010**

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

The plan's overall deductible	**$100**
Specialist coinsurance	**30%**
Hospital (facility) coinsurance	**30%**
Other coinsurance	**30%**

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**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$100
Copayments	$10
Coinsurance	$810
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$920**

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