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?	Network providers and Out-of-Network providers combined (for major medical benefits): $50/individual; 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. Basic Medical Benefits, In-Network Preventive care, home health care, hospice, first inpatient admission for substance abuse rehabilitation 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.
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?	Network providers and Out-of-Network providers combined (for major medical benefits): $300/individual per calendar year.	The out-of-pocket limit is the most you could pay in a year for covered services.
What is not included in the out-of-pocket limit?	Out-of-Pocket Limit does not include: Basic Medical Benefits, premiums, balance-billing charges, health care this plan doesn't cover, acupuncture, and outpatient prescription drugs charges.	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.
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	Up to $18/visit no charge and no deductible. Charges over $18/visit: 20% coinsurance applied after deductible	No charge, deductible does not apply up to $18/per visit, then 20% coinsurance after deductible	The Basic Plan pays up to $18/visit not to exceed $540 in any 6 consecutive months without cost sharing, then 20% coinsurance
	Specialist visit			
	Preventive care / Screening / Immunization	No charge, deductible does not apply	20% 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)	Up to $200 no charge and no deductible. Per 6-month period or accident. Charges over $200: 20% coinsurance after deductible	Up to $200 no charge and no deductible. Per 6-month period or accident. Charges over $200: 20% coinsurance after deductible	No charge for lab tests and x-rays performed in the 7 days before you are admitted to the hospital for surgery (In-Network and Out-of-Network).
	Imaging (CT/PET scans, MRIs)			
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 (100-day supply) and mail order (100-day supply): no charge	Not covered.	• Deductible does not apply. • You pay 100%, even In-Network, for maintenance medications purchased at a retail pharmacy after the first fill. • You pay 100% when purchasing covered prescription drugs at a Non-Network pharmacy. The Plan will reimburse you up to 175% of the wholesale cost for the smallest therapeutic package plus a $1.65 professional fee.
	Preferred brand drugs	Retail (30-day supply) and mail order (100-day supply): no charge	Not covered.	
	Non-preferred brand drugs	Retail (30-day supply) and mail order (100-day supply): no charge	Not covered.	
	Specialty drugs	No charge	Not covered.	Specialty drugs limited to a 30-day supply.

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)	Up to $50 no charge and no deductible. Charges over $50: 20% coinsurance applied after deductible	Up to $50 no charge and no deductible. Charges over $50: 20% coinsurance applied after deductible	None.
	Physician / Surgeon fees	No charge up to $55 per relative value unit (not to exceed a max of $4,400/ disability), then 20% coinsurance applied after deductible	No charge up to $55 per relative value unit ($4,400/disability), then 20% coinsurance applied after deductible	• A "relative value unit" is a measure of value used by Medicare to reimburse doctors. • Anesthesia: No charge, deductible does not apply, up to $18 per relative value unit, then 10% coinsurance • Assistant surgeon: 10% coinsurance.
If you need immediate medical attention	Emergency room care	**Emergency**: No charge, deductible does not apply. **Additional Accident Coverage**: Up to $1,000 no charge and no deductible. Charges over $1,000: 20% coinsurance applied after deductible. **Non-accident:** 20% coinsurance applied after deductible.	**Emergency**: No charge, deductible does not apply. **Additional Accident Coverage**: Up to $1,000 no charge and no deductible. Charges over $1,000: 20% coinsurance applied after deductible. **Non-accident:** 20% coinsurance applied after deductible.	• Additional Accident Coverage: Services must be incurred within 3 months of initial accident. • Emergency treatment for an accident must begin within 48 hours. • Professional/physician charges may be billed separately. • You are also responsible for balance-billing that any Out-of-Network provider may charge you unless covered by the No Surprises Act.
	Emergency medical transportation	Up to $50/trip no charge and no deductible. Charges over $50/trip: 20% coinsurance applied after deductible	Up to $50/trip no charge and no deductible. Charges over $50/trip: 20% coinsurance applied after deductible	Medically necessary transportation to or from a hospital is covered.
	Urgent care	**Emergency**: No charge, deductible does not apply. **Additional Accident Coverage**: Up to $1,000 no charge and no deductible. Charges over $1,000: 20% coinsurance after deductible	**Emergency**: No charge, deductible does not apply. **Additional Accident Coverage**: Up to $1,000 no charge and no deductible. Charges over $1,000: 20% coinsurance after deductible	• Additional Accident Coverage: Services must be incurred within 3 months of initial accident. • Emergency treatment for an accident must begin within 48 hours. • Professional/physician charges may be billed separately.

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)	
		Non-accident: 20% coinsurance applied after deductible	**Non-accident:** 20% coinsurance applied after deductible	• You are also responsible for balance-billing that any Out-of-Network provider may charge you unless covered by the No Surprises Act.
If you have a hospital stay	Facility fee (e.g., hospital room)	No charge up to 365 days/disability, then 20% coinsurance applied after deductible	No charge up to 365 days/disability, then 20% coinsurance applied after deductible	Limited to the hospital's most common rate for a semi-private room, ICU, or CCU.
	Physician / Surgeon fees	**Physician visit:** Up to $18/visit no charge and no deductible. Charges over $18/visit: 20% coinsurance applied after deductible. **Surgeon:** No charge up to $55 per relative value unit, (not to exceed a max of $4,400/ disability) then 20% coinsurance applied after deductible	**Physician visit:** Up to $18/visit no charge and no deductible. Charges over $18/visit: 20% coinsurance applied after deductible. **Surgeon:** No charge up to $55 per relative value unit, (not to exceed a max of $4,400/ disability) then 20% coinsurance applied after deductible	• A "relative value unit" is a measure of value used by Medicare to reimburse doctors. • Anesthesia: No charge up to $18 per relative value unit, then 20% coinsurance after deductible. Assistant surgeon: 20% coinsurance after deductible. • Physician visits: Basic Plan pays up to $18/visit not to exceed $540 in any 6 consecutive months without cost sharing, then 20% coinsurance after deductible.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	**Office visits:** Up to $18/visit no charge and no deductible. Charges over $18/visit: 20% coinsurance applied after deductible. **All other:** No charge up to $55 per relative value unit, (not to exceed a max of $4,400/ disability) then 20% coinsurance applied after deductible.	**Office visits:** Up to $18/visit no charge and no deductible. Charges over $18/visit: 20% coinsurance applied after deductible. **All other:** No charge up to $55 per relative value unit, (not to exceed a max of $4,400/ disability) then 20% coinsurance applied after deductible	The Basic Plan pays up to $18/visit not to exceed $540 in any 6 consecutive months without cost sharing, then 20% coinsurance after deductible.
	Inpatient services	No charge, deductible does not apply, up to 365 days/disability, then 20% coinsurance applied after deductible.	No charge, deductible does not apply up to 365 days/disability, then you pay 20% coinsurance applied after deductible.	• If a participant utilizes an Anthem Blue Cross Network facility that is NOT a TAP facility for substance abuse, the Fund will allow the contracted rate.

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)	
		Deductible does not apply for the first inpatient substance abuse rehabilitation admission.	Deductible does not apply for the first inpatient substance abuse rehabilitation admission.	• Limited to the hospital's most common rate for a semi-private room or ICU.
If you are pregnant	Office visits	Up to $18/visit no charge and no deductible. Charges over $18/visit: 20% coinsurance applied after deductible.	Up to $18/visit no charge and no deductible. Charges over $18/visit: 20% coinsurance applied after deductible.	• A "relative value unit" is a measure of value used by Medicare to reimburse doctors. • Depending on the type of services, a coinsurance, or deductible may apply. • Maternity care may include tests and services described elsewhere in the SBC (i.e., ultrasound). • Physician visits: Basic Plan pays up to $18/visit not to exceed $540 in any 6 consecutive months without cost sharing, then 20% coinsurance after deductible. • Pregnancy and delivery charges for dependent children are not covered (even In-Network) and you pay 100% (except for complications).
	Childbirth / Delivery professional services	No charge up to $55 per relative value unit, (not to exceed a max of $4,400/ disability) then 20% coinsurance applied after deductible	No charge up to $55 per relative value unit, (not to exceed a max of $4,400/ disability) then 20% coinsurance applied after deductible	
	Childbirth / Delivery facility services	No charge, deductible does not apply up to 365 days/disability, then 20% coinsurance applied after deductible.	No charge, deductible does not apply up to 365 days/disability, then 20% coinsurance applied after deductible.	
If you need help recovering or have other special health needs	Home health care	No charge. Deductible does not apply.	No charge. Deductible does not apply.	Must immediately follow a confinement in the hospital.
	Rehabilitation services	20% coinsurance applied after deductible.	20% coinsurance applied after deductible.	Maximum 15 visits per course of treatment; additional treatments must be pre-approved or no benefits are available.
	Habilitation services	Not covered		You pay 100% of this service, even In-Network.
	Skilled nursing care	20% coinsurance applied after deductible.	20% coinsurance applied after deductible.	Professional/physician charges may be billed separately. Only semi-private room covered unless private room is medically necessary.
	Durable medical equipment	20% coinsurance applied after deductible.	20% coinsurance applied after deductible.	Must be prescribed by a Physician. Rental must not exceed purchase price.

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)	
	Hospice services	No charge. Deductible does not apply	No charge. Deductible does not apply.	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, additional 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 (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 (covered under a separate vision plan).
- 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.)

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

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 1-800-654-1824.

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.

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	**20%**
Hospital (facility) coinsurance	**20%**
Other coinsurance	**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	**$12,700**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$50
Copayments	$0
Coinsurance	$300
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$410**

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	**20%**
Hospital (facility) coinsurance	**20%**
Other coinsurance	**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	**$5,600**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$50
Copayments	$0
Coinsurance	$200
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$270**

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

The plan's overall deductible	**$100**
Specialist coinsurance	**20%**
Hospital (facility) coinsurance	**20%**
Other coinsurance	**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**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$50
Copayments	$0
Coinsurance	$300
What isn't covered0	
Limits or exclusions	$0
The total Mia would pay is	**$350**

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