



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): \$25/individual; Once two covered individuals in your family have met the <u>deductible</u> , you will have satisfied the maximum <u>deductible</u> for your entire family.	Generally, you must pay all of the costs from <u>providers</u> 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 <u>deductible</u> expenses paid by all family members meets the overall family <u>deductible</u> .
Are there services covered before you meet your <u>deductible</u>?	Yes. Basic Medical benefits, <u>In-Network Preventive care</u> , <u>home health care</u> , <u>hospice services</u> , first inpatient admission for substance abuse rehabilitation, dental/vision and <u>In-Network outpatient prescription drugs</u> are covered before you meet your Major Medical <u>deductible</u> .	This <u>plan</u> covers some items and services even if you haven't yet 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?	No.	You don't have to meet <u>deductibles</u> for specific services.
What is the <u>out-of-pocket limit</u> for this <u>plan</u>?	Network providers and Out-of-Network providers combined (for Major Medical benefits): \$100/individual per calendar year.	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>?	Out-of-Pocket Limit does not include: Basic Medical Benefits, <u>premiums</u> , <u>balance-billing</u> charges, health care this <u>plan</u> doesn't cover, acupuncture, and outpatient <u>prescription drugs</u> charges.	Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u> .
Will you pay less if you use a <u>network provider</u>?	Yes. Medical: See www.anthem.com/ca or call 1-800-688-3828 for a list of <u>network providers</u> . Substance Abuse: call Teamsters Assistance Program of Northern California (TAP) at 1-510-562-3600 for a list of <u>network providers</u> .	This <u>plan</u> uses a provider network. You will pay less if you use a <u>provider</u> in the <u>plan's 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 <u>provider's charge</u> and what your <u>plan</u> pays (balance billing). 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.

Important Questions	Answers	Why This Matters:
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.

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 <u>deductible</u> . Charges over \$18/visit: 10% <u>coinsurance</u> applied after <u>deductible</u>	Up to \$18/visit no charge and no <u>deductible</u> . Charges over \$18/visit: 10% <u>coinsurance</u> applied after <u>deductible</u>	The Basic <u>Plan</u> pays up to \$18/visit not to exceed \$540 in any 6 consecutive months without <u>cost sharing</u> , then 20% <u>coinsurance after deductible</u> .
	Preventive care/ Screening/ Immunization	No charge; <u>deductible</u> does not apply	10% <u>coinsurance</u>	You may have to pay for services that aren't preventive. Check with the Administrative Office whether the services needed are preventive.
If you have a test	Diagnostic test (x-ray, blood work)	Up to \$500 no charge and no <u>deductible</u> per 6-month period or Accident Charges over \$500: 10% <u>coinsurance</u> after <u>deductible</u>	Up to \$500 no charge and no <u>deductible</u> per 6-month period or Accident Charges over \$500: 10% <u>coinsurance</u> after <u>deductible</u>	No charge for lab tests and x-rays performed in the 7 days before you are admitted to the hospital for surgery.
	Imaging (CT/PET scans, MRIs)			
If you need drugs to treat your illness or condition More information about <u>prescription drug coverage</u> is available at www.welldyneRx.com	Generic drugs	Retail (100-day supply) and mail order (100-day supply): no charge	Not covered	<ul style="list-style-type: none"> <u>Deductible</u> does not apply. You pay 100%, even <u>In-Network</u>, for maintenance medications purchased at a retail pharmacy after the first fill.
	Preferred brand drugs	Retail (30-day supply) and mail order (100-day supply): no charge	Not covered	<ul style="list-style-type: none"> You pay 100% when purchasing covered prescription drugs at a Non-<u>Network</u> pharmacy. The <u>Plan</u> will reimburse you up to 175% of the wholesale cost for the smallest therapeutic package plus a \$1.65 professional fee.
	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 <u>deductible</u> . Charges over \$50: 10% <u>coinsurance</u> applied after <u>deductible</u>	Up to \$50 no charge and no <u>deductible</u> . Charges over \$50: 10% <u>coinsurance</u> applied after <u>deductible</u>	None
	Physician/ Surgeon fees	No charge up to \$55 per relative value unit (not to exceed a max of \$4,400/disability), then 10% <u>coinsurance</u> applied after <u>deductible</u>	No charge up to \$55 per relative value unit (not to exceed a max of \$4,400/disability), then 10% <u>coinsurance</u> applied after <u>deductible</u>	<ul style="list-style-type: none"> A “relative value unit” is a measure of value used by Medicare to reimburse doctors. Anesthesia: No charge, <u>deductible</u> does not apply up to \$18 per relative value unit, then 10% <u>coinsurance</u> after <u>deductible</u>. Assistant surgeon: 10% <u>coinsurance</u>.
If you need immediate medical attention	<u>Emergency room care</u>	<p>Emergency: No charge; <u>deductible</u> does not apply.</p> <p>Additional Accident Coverage: Up to \$1,000 no charge and no <u>deductible</u>. Charges over \$1,000: 10% <u>coinsurance</u> applied after <u>deductible</u>.</p> <p>Non-accident: 10% <u>coinsurance</u> applied after <u>deductible</u>.</p>	<p>Emergency: No charge; <u>deductible</u> does not apply.</p> <p>Additional Accident Coverage: Up to \$1,000 no charge and no <u>deductible</u>. Charges over \$1,000: 10% <u>coinsurance</u> applied after <u>deductible</u>.</p> <p>Non-accident: 10% <u>coinsurance</u> applied after <u>deductible</u>.</p>	<ul style="list-style-type: none"> 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 <u>balance-billing</u> that any <u>Out-of-Network</u> provider may charge you unless covered by the No Surprises Act.
	<u>Emergency medical transportation</u>	Up to \$150/trip no charge and no <u>deductible</u> . Charges over \$150/trip: 10% <u>coinsurance</u> applied after <u>deductible</u> .	Up to \$150/trip no charge and no <u>deductible</u> . Charges over \$150/trip: 10% <u>coinsurance</u> applied after <u>deductible</u> .	<ul style="list-style-type: none"> <u>Medically necessary</u> transportation to or from a hospital is covered. You are also responsible for <u>balance-billing</u> that any <u>Out-of-Network</u> provider may charge you unless covered by the No Surprises Act.
	<u>Urgent care</u>	Emergency: No charge <u>deductible</u> does not apply.	Emergency: No charge, <u>deductible</u> does not apply.	<ul style="list-style-type: none"> Additional Accident Coverage: Services must be incurred within 3 months of initial accident.

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)	
		<p>Additional Accident Coverage: Up to \$1,000 no charge and no <u>deductible</u>. Charges over \$1,000: 10% <u>coinsurance</u> applied after <u>deductible</u>.</p> <p>Non-accident: 10% <u>coinsurance</u> applied after <u>deductible</u>.</p>	<p>Additional Accident Coverage: Up to \$1,000 no charge and no <u>deductible</u>. Charges over \$1,000: 10% <u>coinsurance</u> applied after <u>deductible</u>.</p> <p>Non-accident: 10% <u>coinsurance</u> applied after <u>deductible</u>.</p>	<ul style="list-style-type: none"> Emergency treatment for an accident must begin within 48 hours. Professional/physician charges may be billed separately. You are also responsible for <u>balance-billing</u> that any <u>Out-of-Network</u> 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 10% <u>coinsurance</u> applied after <u>deductible</u>	No charge up to 365 days/disability, then 10% <u>coinsurance</u> applied after <u>deductible</u>	Limited to the hospital's most common rate for a semi-private room, ICU, or CCU.
	Physician / Surgeon fees	<p>Physician visit: Up to \$18/visit no charge and no <u>deductible</u>. Charges over \$18/visit: 10% <u>coinsurance</u> applied after <u>deductible</u>.</p> <p>Surgeon: No charge up to \$55 per relative value unit, (not to exceed a max of \$4,400/ disability) then 10% <u>coinsurance</u> applied after <u>deductible</u>.</p>	<p>Physician visit: Up to \$18/visit no charge and no <u>deductible</u>. Charges over \$18/visit: 10% <u>coinsurance</u> applied after <u>deductible</u>.</p> <p>Surgeon: No charge up to \$55 per relative value unit, (not to exceed a max of \$4,400/ disability) then 10% <u>coinsurance</u> applied after <u>deductible</u>.</p>	<ul style="list-style-type: none"> 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 10% <u>coinsurance after deductible</u>. Assistant surgeon: 10% <u>coinsurance after deductible</u>. Physician visits: Basic <u>Plan</u> pays up to \$18/visit not to exceed \$540 in any 6 consecutive months without <u>cost sharing</u>, then 10% <u>coinsurance after deductible</u>.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	<p>Office visits: Up to \$18/visit no charge and no <u>deductible</u>. Charges over \$18/visit: 10% <u>coinsurance</u> applied after <u>deductible</u>.</p> <p>All other: No charge up to \$55 per relative value unit, (not to exceed a max of \$4,400/ disability) then 10% <u>coinsurance</u> applied after <u>deductible</u>.</p>	<p>Office visits: Up to \$18/visit no charge and no <u>deductible</u>. Charges over \$18/visit: 10% <u>coinsurance</u> applied after <u>deductible</u>.</p> <p>All other: No charge up to \$55 per relative value unit, (not to exceed a max of \$4,400/ disability) then 10% <u>coinsurance</u> applied after <u>deductible</u>.</p>	The Basic <u>Plan</u> pays up to \$18/visit not to exceed \$540 in any 6 consecutive months without <u>cost sharing</u> , then 10% <u>coinsurance after deductible</u> .

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)	
	Inpatient services	No charge, <u>deductible</u> does not apply up to 365 days/disability, then 10% <u>coinsurance</u> . <u>Deductible</u> does not apply for the first inpatient substance abuse rehabilitation admission.	No charge, <u>deductible</u> does not apply up to 365 days/disability, then you pay 10% <u>coinsurance</u> . <u>Deductible</u> does not apply for the first inpatient substance abuse rehabilitation admission.	<ul style="list-style-type: none"> If a participant utilizes an Anthem Blue Cross In-Network facility that is NOT a TAP facility for substance abuse, the <u>Plan</u> will allow the contracted rate. 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 <u>deductible</u> . Charges over \$18/visit: 10% <u>coinsurance</u> applied after <u>deductible</u> .	Up to \$18/visit no charge and no <u>deductible</u> . Charges over \$18/visit: 10% <u>coinsurance</u> applied after <u>deductible</u> .	<ul style="list-style-type: none"> A "relative value unit" is a measure of value used by Medicare to reimburse doctors. Depending on the type of services, a <u>coinsurance</u>, or <u>deductible</u> 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 <u>cost sharing</u>, then 10% <u>coinsurance</u> after <u>deductible</u>. Pregnancy and delivery charges for dependent children is 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 10% <u>coinsurance</u> applied after <u>deductible</u> .	No charge up to \$55 per relative value unit, (not to exceed a max of \$4,400/disability) then 10% <u>coinsurance</u> applied after <u>deductible</u> .	
	Childbirth/ delivery facility services	No charge, <u>deductible</u> does not apply up to 365 days/disability, then 10% <u>coinsurance</u> applied after <u>deductible</u> .	No charge, <u>deductible</u> does not apply up to 365 days/disability, then 10% <u>coinsurance</u> applied after <u>deductible</u> .	
If you need help recovering or have other special health needs	<u>Home health care</u>	No charge. <u>Deductible</u> does not apply.	No charge. <u>Deductible</u> does not apply.	Must immediately follow a confinement in the hospital.
	<u>Rehabilitation services</u>	10% <u>coinsurance</u> applied after <u>deductible</u> .	10% <u>coinsurance</u> applied after <u>deductible</u> .	Maximum 15 visits per course of treatment; additional treatments must be pre-approved or no benefits are available.
	<u>Habilitation services</u>	Not covered		You pay 100% of this service, even In-Network.
	<u>Skilled nursing care</u>	10% <u>coinsurance</u> applied after <u>deductible</u> .	10% <u>coinsurance</u> applied after <u>deductible</u> .	Professional/physician charges may be billed separately.
	<u>Durable medical equipment</u>	10% <u>coinsurance</u> applied after <u>deductible</u> .	10% <u>coinsurance</u> applied after <u>deductible</u> .	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)	
	<u>Hospice services</u>	No charge. <u>Deductible</u> does not apply.	No charge. <u>Deductible</u> does not apply.	Physician's treatment plan must be pre-approved by contacting the <u>Plan</u> 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 <u>plan</u> .
	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 <u>plan</u> .

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 <http://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.

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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 <u>deductible</u>	\$25
■ <u>Specialist coinsurance</u>	10%
■ <u>Hospital (facility) coinsurance</u>	10%
■ <u>Other coinsurance</u>	10%

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	
<u>Deductibles</u>	\$25
<u>Copayments</u>	\$0
<u>Coinsurance</u>	\$100
What isn't covered	
Limits or exclusions	\$60
The total Peg would pay is	\$185

Managing Joe's type 2 Diabetes

(a year of routine in-network care of a well-controlled condition)

■ The plan's overall <u>deductible</u>	\$25
■ <u>Specialist coinsurance</u>	10%
■ <u>Hospital (facility) coinsurance</u>	10%
■ <u>Other coinsurance</u>	10%

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	
<u>Deductibles</u>	\$25
<u>Copayments</u>	\$0
<u>Coinsurance</u>	\$100
What isn't covered	
Limits or exclusions	\$20
The total Joe would pay is	\$145

Mia's Simple Fracture

(in-network emergency room visit and follow up care)

■ The plan's overall <u>deductible</u>	\$25
■ <u>Specialist coinsurance</u>	10%
■ <u>Hospital (facility) coinsurance</u>	10%
■ <u>Other coinsurance</u>	10%

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	
<u>Deductibles</u>	\$25
<u>Copayments</u>	\$0
<u>Coinsurance</u>	\$100
What isn't covered	
Limits or exclusions	\$0
The total Mia would pay is	\$125

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