



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, contact the Teamsters Local Union No. 856 Health and Welfare Fund Administrative Office at (800) 297-4595. 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 <https://www.healthcare.gov/sbc-glossary> or call (800) 297-4595 to request a copy.

Important Questions	Answers	Why This Matters:
<a href="#">What is the overall deductible?</a>	\$250/Individual or \$500/family	Generally, you must pay all of the costs from providers up to the <a href="#">deductible</a> amount before this <a href="#">plan</a> begins to pay. If you have other family members on the <a href="#">plan</a> , each family member must meet their own individual <a href="#">deductible</a> until the total amount of <a href="#">deductible</a> expenses paid by all family members meets the overall family <a href="#">deductible</a> .
<a href="#">Are there services covered before you meet your deductible?</a>	Yes. <a href="#">Preventive care</a> is covered before you meet your <a href="#">deductible</a> .	This <a href="#">plan</a> covers some items and services even if you haven't yet met the <a href="#">deductible</a> amount. But a <a href="#">copayment</a> or <a href="#">coinsurance</a> may apply. For example, this <a href="#">plan</a> covers certain <a href="#">preventive services</a> without <a href="#">cost-sharing</a> and before you meet your <a href="#">deductible</a> . See a list of covered preventive services at <a href="https://www.healthcare.gov/coverage/preventive-care-benefits/">https://www.healthcare.gov/coverage/preventive-care-benefits/</a> .
<a href="#">Are there other deductibles for specific services?</a>	No.	You don't have to meet <a href="#">deductibles</a> for specific services.
<a href="#">What is the out-of-pocket limit for this plan?</a>	There is a <a href="#">co-insurance</a> maximum of \$2,000 per family in a calendar year at <a href="#">network providers</a> .	The <a href="#">out-of-pocket limit</a> is the most you could pay in a year for covered services. If you have other family members in this <a href="#">plan</a> , they have to meet their own <a href="#">out-of-pocket limits</a> until the overall family <a href="#">out-of-pocket limit</a> has been met. Total out-of-pocket expense will never exceed the amount mandated by applicable regulations.
<a href="#">What is not included in the out-of-pocket limit?</a>	<a href="#">Copayments</a> , <a href="#">deductible</a> , <a href="#">premiums</a> , <a href="#">balance-billing</a> charges, and health care this <a href="#">plan</a> doesn't cover.	Even though you pay these expenses, they don't count toward the <a href="#">out-of-pocket limit</a> .
<a href="#">Will you pay less if you use a network provider?</a>	Yes. See <a href="http://www.anthem/ca">www.anthem/ca</a> or call 1-888-887-3725 for a list of <a href="#">network providers</a> .	This <a href="#">plan</a> uses a <a href="#">provider network</a> . You will pay less if you use a <a href="#">provider</a> in the <a href="#">plan's network</a> . You will pay the most if you use an <a href="#">out-of-network provider</a> , and you might receive a bill from a <a href="#">provider</a> for the difference between the <a href="#">provider's</a> charge and what your <a href="#">plan</a> pays ( <a href="#">balance billing</a> ). Be aware, your <a href="#">network provider</a> might use an <a href="#">out-of-network provider</a> for some services (such as lab work). Check with your <a href="#">provider</a> before you get services.
<a href="#">Do you need a referral to see a specialist?</a>	No.	You can see the <a href="#">specialist</a> you choose without a <a href="#">referral</a> .



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 <u>provider's</u> office or clinic	Primary care visit to treat an injury or illness	\$20 <u>copayment</u> (Deductible Waived)	40% <u>coinsurance</u>	None
	<u>Specialist</u> visit	\$20 <u>copayment</u> (Deductible Waived)	40% <u>coinsurance</u>	None
	<u>Preventive care/screening/</u> Immunization	No charge	40% <u>coinsurance</u>	You may have to pay for services that aren't <u>preventive</u> . Ask your <u>provider</u> if the services you need are preventive. Then check what your <u>plan</u> will pay for.
If you have a test	<u>Diagnostic test</u> (x-ray, blood work)	20% <u>coinsurance</u>	40% <u>coinsurance</u>	None
	Imaging (CT/PET scans, MRIs)	20% <u>coinsurance</u>	40% <u>coinsurance</u>	
If you need drugs to treat your illness or condition  More information about <u>prescription drug coverage</u> is available at <a href="http://www.optumrx.com">www.optumrx.com</a>	Generic drugs	\$10 <u>copay</u> /prescription	In-network <u>copay</u> plus non-network cost difference.	Covers up to a 100-day supply (retail and mail order) for <u>Medically Necessary</u> , FDA-approved drugs. If brand is ordered when generic available, you pay cost difference plus <u>copay</u> per prescription. Your Collective Bargaining Agreement may provide for a lower or no <u>copay</u> . You must use the mail order Specialty Pharmacy for <u>Specialty drugs</u> .
	Preferred brand drugs	\$20 <u>copay</u> /prescription	In-network <u>copay</u> plus non-network cost difference.	
	<u>Specialty drugs</u>	30-day supply	Not covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% <u>coinsurance</u>	50% <u>coinsurance</u>	<u>Preauthorization</u> is required.
	Physician/surgeon fees	20% <u>coinsurance</u>	40% <u>coinsurance</u>	None
If you need immediate medical attention	<u>Emergency room care</u>	20% <u>coinsurance</u>	20% <u>coinsurance</u>	None
	<u>Emergency medical transportation</u>	20% <u>coinsurance</u>	20% <u>coinsurance</u>	
	<u>Urgent care</u>	20% <u>coinsurance</u>	20% <u>coinsurance</u>	
If you have a hospital stay	Facility fee (e.g., hospital room)	20% <u>coinsurance</u>	50% <u>coinsurance</u>	<u>Preauthorization</u> is required.
	Physician/surgeon fees	20% <u>coinsurance</u>	50% <u>coinsurance</u>	None

\* For more information about limitations and exceptions, see plan or policy document.

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 mental health, behavioral health, or substance abuse services	Outpatient services	20% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	<a href="#">Preauthorization</a> is required.
	Inpatient services	20% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	
If you are pregnant	Office visits	\$20 <a href="#">copayment</a> ( <a href="#">Deductible Waived</a> )	40% <a href="#">coinsurance</a>	<a href="#">Cost sharing</a> does not apply to certain <a href="#">preventive services</a> . Depending on the type of services, <a href="#">coinsurance</a> may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound).
	Childbirth/delivery professional services	20% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	
	Childbirth/delivery facility services	20% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	
If you need help recovering or have other special health needs	<a href="#">Home health care</a>	20% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	Maximum of 100 visits/year
	<a href="#">Rehabilitation services</a>	20% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	Must be pre-certified by Plan's Medical Review Organization.
	<a href="#">Habilitation services</a>	20% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	<a href="#">Preauthorization</a> is required.
	<a href="#">Skilled nursing care</a>	20% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	
	<a href="#">Durable medical equipment</a>	20% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	For rental or pre-approved purchase. Hearing Aids are covered with a 20% <a href="#">coinsurance</a> , up to \$2,000 per ear in a 3 year period.
	<a href="#">Hospice services</a>	20% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	<a href="#">Preauthorization</a> is required.
If your child needs dental or eye care	Children's eye exam	\$15 <a href="#">copay</a> /visit	\$15 <a href="#">copay</a> /visit	Your Collective Bargaining Agreement may provide for no <a href="#">copayment</a> . Contact VSP at 800-877-7195 or VSP.com.
	Children's glasses	\$15 <a href="#">copay</a> /visit	\$15 <a href="#">copay</a> /visit	
	Children's dental check-up	No <a href="#">coinsurance</a>	No <a href="#">coinsurance</a>	Dental Plans I and C have a benefit maximum allowance of \$30.40 for a periodic oral evaluation.

### 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](#).)

<ul style="list-style-type: none"> <li>Cosmetic surgery</li> <li>Dental care (covered under a separate dental plan)</li> </ul>	<ul style="list-style-type: none"> <li>Long-term care</li> <li>Non-emergency care when traveling outside the U.S.</li> <li>Private-duty nursing</li> </ul>	<ul style="list-style-type: none"> <li>Routine eye care (covered under separate vision plan)</li> <li>Routine foot care</li> <li>Weight loss programs</li> </ul>
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\* For more information about limitations and exceptions, see [plan](#) or policy document.

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

• Acupuncture	• Chiropractic care	• Infertility treatment
• Bariatric surgery ( <a href="#">preauthorization</a> required)	• Hearing aids	

**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 U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-EBSA (3272) or [www.dol.gov/ebsa/healthreform](http://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](http://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: Teamsters Local #856 Plan Administrative Office at (800) 297-4595.

**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 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 (800) 227-3670]

[Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa (800) 227-3670]

[Chinese (中文): 如果需要中文的帮助, 请拨打这个号码 (800) 227-3670]

[Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijjigo holne' (800) 227-3670]

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*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 <a href="#">plan's</a> overall <a href="#">deductible</a>	\$250
■ <a href="#">Specialist copayment</a>	\$20
■ <a href="#">Hospital (facility) coinsurance</a>	20%
■ <a href="#">Other coinsurance</a>	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*)

<b>Total Example Cost</b>	<b>\$12,700</b>
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In this example, Peg would pay:

Cost Sharing	
<a href="#">Deductibles</a>	\$250
<a href="#">Copayments</a>	\$0
<a href="#">Coinsurance</a>	\$1,800

*What isn't covered*

Limits or exclusions	\$60
<b>The total Peg would pay is</b>	<b>\$2,110</b>

### Managing Joe's type 2 Diabetes

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

■ The <a href="#">plan's</a> overall <a href="#">deductible</a>	\$250
■ <a href="#">Specialist copayment</a>	\$20
■ <a href="#">Hospital (facility) coinsurance</a>	20%
■ <a href="#">Other coinsurance</a>	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*)

<b>Total Example Cost</b>	<b>\$5,600</b>
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In this example, Joe would pay:

Cost Sharing	
<a href="#">Deductibles</a>	\$250
<a href="#">Copayments</a>	\$600
<a href="#">Coinsurance</a>	\$100

*What isn't covered*

Limits or exclusions	\$20
<b>The total Joe would pay is</b>	<b>\$970</b>

### Mia's Simple Fracture

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

■ The <a href="#">plan's</a> overall <a href="#">deductible</a>	\$250
■ <a href="#">Specialist copayment</a>	\$20
■ <a href="#">Hospital (facility) coinsurance</a>	20%
■ <a href="#">Other coinsurance</a>	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*)

<b>Total Example Cost</b>	<b>\$2,800</b>
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In this example, Mia would pay:

Cost Sharing	
<a href="#">Deductibles</a>	\$250
<a href="#">Copayments</a>	\$70
<a href="#">Coinsurance</a>	\$400

*What isn't covered*

Limits or exclusions	\$0
<b>The total Mia would pay is</b>	<b>\$720</b>

The [plan](#) would be responsible for the other costs of these EXAMPLE covered services.