



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:
What is the overall deductible ?	\$0.	See the Common Medical Events chart below for your costs for services this plan covers.
Are there services covered before you meet your deductible ?	No.	You will have to meet the deductible before the plan pays for any services.
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 ?	\$2,000/single or \$3,000/family for In- Network Providers .	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 ?	Prescription Drugs , Infertility services, Premiums , balance-billing charges, and health care this plan doesn't cover.	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, EPO. See www.anthem.com/ca 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	\$15/visit	Not covered	None
	Specialist visit	\$15/visit	Not covered	None
	Preventive care/screening/immunization	No charge	Not covered	You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	No charge	Not covered	None
	Imaging (CT/PET scans, MRIs)	No charge	Not covered	None
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at http://www.anthem.com/ca/pharmacyinformation/ National	Generic Drugs	\$10/prescription (retail) and \$10/prescription (home delivery)	In-network Co-Pay plus non-network cost difference	Covers up to a 100-day supply (retail and mail order) for Medically Necessary , FDA-approved drugs. If brand is ordered when generic available, you pay cost difference plus copay per prescription. Your Collective Bargaining Agreement may provide for a lower or no copay . You must use the mail order Specialty Pharmacy for Specialty drugs .
	Preferred / Brand Name Drugs	\$20/prescription (retail) and \$20/prescription (home delivery)	In-network Co-Pay plus non-network cost difference	
	Specialty Drugs	30 Day supply	Not Covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	No charge	Not covered	Preauthorization is required.
	Physician/surgeon fees	No charge	Not covered	None
If you need immediate medical attention	Emergency room care	\$50/visit	Covered as In-Network	If directly admitted to a hospital, ER copay is waived. No charge for Emergency Room Physician Fee.
	Emergency medical transportation	No charge	Covered as In-Network	None
	Urgent care	\$15/visit	\$50/visit	Copay waived if admitted.
If you have a hospital stay	Facility fee (e.g., hospital room)	No charge	Not covered	Preauthorization is required
	Physician/surgeon fees	No charge	Not covered	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	Office Visit No charge Other Outpatient No charge	Office Visit Not covered Other Outpatient Not covered	None
	Inpatient services	No charge	Not covered	No charge for Inpatient Physician Fee In-Network Providers . No coverage for Inpatient Physician Fee Non-Network Providers . Preauthorization is required
If you are pregnant	Office visits	No charge	Not covered	Cost sharing does not apply for preventive services . Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound).
	Childbirth/delivery professional services	No charge	Not covered	
	Childbirth/delivery facility services	No charge	Not covered	
If you need help recovering or have other special health needs	Home health care	No charge	Not covered	None
	Rehabilitation services	\$15/visit	Not covered	*See Therapy Services section
	Habilitation services	\$10/visit	Not covered	None
	Skilled nursing care	No charge	Not covered	100 days limit/benefit period for In-Network Providers .
	Durable medical equipment	No charge	Not covered	Hearing Aids are covered with a 20% coinsurance , up to \$2,000 per ear in a 3 year period.
	Hospice services	No charge	Not covered	None
If your child needs dental or eye care	Children's eye exam	Not covered	Not covered	Your Collective Bargaining Agreement may provide for no copayment . Contact VSP at 800-877-7195 or VSP.com. Dental Plans I and C have a benefit maximum allowance of \$30.40 for a periodic oral evaluation.
	Children's glasses	Not covered	Not covered	
	Children's dental check-up	Not covered	Not covered	

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) • Dental check-up • Eye exams for a child • Glasses for a child	• Long-term care • Non-emergency care when traveling outside the U.S. • Private-duty nursing	• Routine eye care (Adult) • Routine foot care unless you have been diagnosed with diabetes • Weight loss programs
Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)		
• Abortion • Acupuncture	• Bariatric surgery • Chiropractic care	• Hearing aids • Infertility treatment

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: Department of Managed Health Care, California Help Center, 980 9th Street, Suite 500, Sacramento, CA 95814-2725, (888) HMO-2219.

Department of Labor, Employee Benefits Security Administration, (866) 444-EBSA (3272), 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 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 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 (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, kwijigo holne' (800) 227-3670

—————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 deductible	\$0
■ Specialist copayment	\$15
■ Hospital (facility) coinsurance	0%
■ Other coinsurance	0%

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
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In this example, Peg would pay:

Cost Sharing	
Deductibles	\$0
Copayments	\$10
Coinsurance	\$0
What isn't covered	
Limits or exclusions	\$60
The total Peg would pay is	\$70

Managing Joe's type 2 Diabetes

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

■ The plan's overall deductible	\$0
■ Specialist copayment	\$15
■ Hospital (facility) coinsurance	0%
■ Other coinsurance	0%

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
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In this example, Joe would pay:

Cost Sharing	
Deductibles	\$0
Copayments	\$500
Coinsurance	\$0
What isn't covered	
Limits or exclusions	\$20
The total Joe would pay is	\$520

Mia's Simple Fracture

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

■ The plan's overall deductible	\$0
■ Specialist copayment	\$15
■ Hospital (facility) coinsurance	0%
■ Other coinsurance	0%

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
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In this example, Mia would pay:

Cost Sharing	
Deductibles	\$0
Copayments	\$200
Coinsurance	\$0
What isn't covered	
Limits or exclusions	\$0
The total Mia would pay is	\$200