


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, see <http://www.tbtfund.org> or call the TBT Plan Administration Office at 1-800-533-0119. 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 <http://www.tbtfund.org> or call the TBT Plan Administration Office at 1-800-533-0119 to request a copy.

Important Questions	Answers	Why This Matters:
<b>What is the overall <u>deductible</u>?</b>	<b>\$100/individual or \$300/family</b>	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 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.
<b>Are there services covered before you meet your <u>deductible</u>?</b>	Yes. Treatment of an accident within 24 hours, <u>preauthorized</u> inpatient hospital, chiropractic and inpatient alcohol/chemical dependency treatment.	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.
<b>Are there other <u>deductibles</u> for specific services?</b>	No.	You don't have to meet <u>deductibles</u> for specific services.
<b>What is the <u>out-of-pocket limit</u> for this <u>plan</u>?</b>	For <u>network providers</u> , <b>\$2,000/individual</b> per calendar year. For <u>out-of-network providers</u> , <b>\$4,000/individual</b> per calendar year for most services.	The <u>out-of-pocket limit</u> is the most you could pay in a calendar year for covered services.
<b>What is not included in the <u>out-of-pocket limit</u>?</b>	<u>Premiums</u> , <u>balance billing</u> charges, health care this <u>plan</u> doesn't cover, and penalties for failure to obtain <u>preauthorization</u> for certain services.	Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u> .

<b>Will you pay less if you use a <u>network provider</u>?</b>	Yes. California residents: see <a href="http://www.anthem.com/ca">www.anthem.com/ca</a> or call 1-888-887-3725 for <u>network providers</u> . If substance abuse, call Teamsters Alcohol/Drug Program (TAP) at 1-800-253-8326 for <u>network providers</u> . Non-California, residents: call Anthem Blue Cross Blue Shield Nationwide network at 1-800-810-2583 for <u>network providers</u> .	This <u>plan</u> uses a <u>provider network</u> . You will pay less if you use a <u>provider</u> in the plan's <u>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 provider's charge and what your <u>plan</u> pays ( <u>balance billing</u> ). Plan does not pay for out-of-network charges that are higher than <u>Usual, Customary &amp; Reasonable</u> (UCR). 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.
<b>Do you need a <u>referral</u> to see a <u>specialist</u>?</b>	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 <u>provider's office</u> or clinic	Primary care visit to treat an injury or illness	No charge	20% <u>coinsurance</u> of <u>UCR</u> charges	None
	<u>Specialist</u> visit	No charge	20% <u>coinsurance</u> of <u>UCR</u> charges.	Chiropractic: plan will not pay more than \$25 per visit/\$1,250 per calendar year. Additional \$300 maximum/person per calendar year for muscle spasms, soft tissue, back strain.
	<u>Preventive care/screening/Immunization</u>	No charge	10% <u>coinsurance</u> of <u>UCR</u> charges	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	<u>Diagnostic test</u> (x-ray, blood work)	No charge	20% <u>coinsurance</u> of <u>UCR</u> charges	None
	Imaging (CT/PET scans, MRIs)	No charge	20% <u>coinsurance</u> of <u>UCR</u> charges	

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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)	
<b>If you need drugs to treat your illness or condition</b>  <b>More information about <u>prescription drug coverage</u> is available at <a href="http://www.tbtfund.org">www.tbtfund.org</a> or <a href="http://www.OptumRx.com">www.OptumRx.com</a> or call 1-800-797-9791.</b>	Generic drugs	\$5 <u>copayment</u> per prescription	\$5 in-network <u>copayment</u> per prescription and you pay the difference between <u>network provider</u> and <u>out-of-network</u> cost.	Covers up to 100-day supply (retail or mail order). If brand drug ordered when generic drug is available, you pay cost difference per prescription.
	Preferred brand drugs	\$10 <u>copayment</u> per prescription	\$10 in-network <u>copayment</u> per prescription and you pay the difference between <u>network provider</u> and <u>out-of-network</u> cost.	
	Non-preferred brand drugs	Not covered	Not covered	Not covered
	<u>Specialty drugs</u> (only through Specialty Pharmacy Program)	\$5 <u>copayment</u> per generic drug or \$10 <u>copayment</u> per brand drug	Not covered	Must use Specialty Pharmacy Program for <u>Specialty drugs</u> . Brand restriction explained above.
<b>If you have outpatient surgery</b>	Facility fee (e.g., ambulatory surgery center)	20% <u>coinsurance</u>	20% <u>coinsurance</u> of <u>UCR</u> charges	None
	Physician/surgeon fees	No charge		None
<b>If you need immediate medical attention</b>	<u>Emergency room care</u>	20% <u>coinsurance</u>	20% <u>coinsurance</u> of <u>UCR</u> charges	None
	<u>Emergency medical transportation</u>	No charge		Ambulance or air ambulance for convenience not covered.
	<u>Urgent care</u>	20% <u>coinsurance</u>	None	
<b>If you have a hospital stay</b>	Facility fee (e.g., hospital room)	No charge	50% <u>coinsurance</u> of <u>UCR</u> charges	<u>Preauthorization</u> is required. If you don't get <u>preauthorization</u> by the <u>plan's</u> medical review organization, benefits could be reduced by 50% of the total cost of services.
	Physician/surgeon fees	No charge	20% <u>coinsurance</u> of <u>UCR</u> charges	None

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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)	
<b>If you need mental health, behavioral health, or substance abuse services</b>	Outpatient services	No charge	20% <u>coinsurance</u> of <u>UCR</u> charges	For substance abuse treatment, review by Teamsters Alcohol/Drug Program (TAP) is recommended.
	Inpatient services	No charge	50% <u>coinsurance</u> of <u>UCR</u> charges	<u>Preauthorization</u> required for all non-emergency stays and within 72 hours if emergency. If you don't get <u>preauthorization</u> by the <u>plan's</u> medical review organization (or by TAP for substance abuse), benefits could be reduced by 50% of the total cost of services.
<b>If you are pregnant</b>	Office visits	No charge	20% <u>coinsurance</u> of <u>UCR</u> charges	Maternity care may include tests and services described elsewhere in the SBC (such as ultrasound).
	Childbirth/delivery professional services	No charge		
	Childbirth/delivery facility services	No charge		
<b>If you need help recovering or have other special health needs</b>	<u>Home health care</u>	No charge	20% <u>coinsurance</u> of <u>UCR</u> charges	<u>Preauthorization</u> is required. If you don't get <u>preauthorization</u> by the <u>plan's</u> medical review organization, benefits could be reduced by 20% of the total cost of services.
	<u>Rehabilitation services</u>	No charge		
	<u>Habilitation services</u>	Not covered	Not covered	Not covered
	<u>Skilled nursing care</u>	No charge	20% <u>coinsurance</u> of <u>UCR</u> charges	60-day maximum per disability. Services must be <u>preauthorized</u> within 7 days of inpatient stay of 5 or more days. If you don't get <u>preauthorization</u> by the <u>plan's</u> medical review organization, benefits could be reduced by 20% of the total cost of services.

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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>Durable medical equipment</u>	No charge	20% <u>coinsurance</u> of <u>UCR</u> charges	Covered for rental or <u>preauthorized</u> purchase.
	<u>Hospice services</u>	No charge	20% <u>coinsurance</u> of <u>UCR</u> charges	<u>Preauthorization</u> is required. If you don't get <u>preauthorization</u> by the <u>plan's</u> medical review organization, benefits could be reduced by 20% of the total cost of services.
If your child needs dental or eye care	Children's eye exam	Not covered	Not covered	Coverage provided under a separate vision plan.
	Children's glasses	Not covered	Not covered	Coverage provided under a separate vision plan.
	Children's dental check-up	Not covered	Not covered	Coverage provided 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 a separate dental plan)
- Hearing aids
- Infertility treatment
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Private duty nursing
- Routine eye care (covered under a separate vision plan)
- Weight loss programs

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

- Acupuncture (preauthorization required)
- Bariatric surgery (preauthorization required)
- Chiropractic care (see limitations on page 2)
- Routine foot care

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**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: the TBT Plan Administration Office at 1-800-533-0119 or 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).

**Does this plan provide Minimum Essential Coverage? Yes.**

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 1-800-533-0119.

Chinese (中文): 如果需要中文的帮助, 请拨打这个号码1-800-533-0119.

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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 plan's overall deductible **\$100**
- Specialist **\$0**
- Hospital (facility) **20%**
- Other **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>\$12,800</b>
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**In this example, Peg would pay:**

<i>Cost Sharing</i>	
Deductibles	\$100
Copayments	\$0
Coinsurance	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$60
<b>The total Peg would pay is</b>	<b>\$160</b>

**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 **\$0**
- Hospital (facility) **20%**
- Other **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>\$7,400</b>
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**In this example, Joe would pay:**

<i>Cost Sharing</i>	
Deductibles	\$100
Copayments	\$285
Coinsurance	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$55
<b>The total Joe would pay is</b>	<b>\$440</b>

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

- The plan's overall deductible **\$100**
- Specialist **\$0**
- Hospital (facility) **20%**
- Other **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>\$1,900</b>
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**In this example, Mia would pay:**

<i>Cost Sharing</i>	
Deductibles	\$100
Copayments	\$0
Coinsurance	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$0
<b>The total Mia would pay is</b>	<b>\$100</b>

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

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