


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: |
|---|---|--|
| What is the overall <u>deductible</u>? | \$200/individual or \$600/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. <u>Preventive care</u> , treatment of an accident within 24 hours, <u>preauthorized</u> inpatient hospital and outpatient surgery, chiropractic and inpatient alcohol/chemical dependency treatment are covered before you meet your <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. For example, this <u>plan</u> covers certain <u>preventive services</u> without <u>cost-sharing</u> and before you meet your <u>deductible</u> . See a list of covered <u>preventive services</u> at https://www.healthcare.gov/coverage/preventive-care-benefits/ . |
| 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>? | For <u>network providers</u> , \$2,000/individual per calendar year. For <u>out-of-network providers</u> , \$2,000/individual 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. |
| What is not included in the <u>out-of-pocket limit</u>? | <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> . |

| | | |
|--|--|---|
| Will you pay less if you use a <u>network provider</u>? | Yes. California residents: see www.anthem.com/ca 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 <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 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 & Reasonable (UCR)</u> . 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. |
| 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 <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: <u>plan</u> 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 <u>preventive</u> . Ask your provider if the services needed are <u>preventive</u> . Then check what your <u>plan</u> will pay for. |

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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) | |
| 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 | |
| If you need drugs to treat your illness or condition More information about <u>prescription drug coverage</u> is available at www.tbtfund.org or www.anthem.com/ca or call 1-833-293-0659. | Generic drugs | 10% <u>coinsurance</u> | 10% <u>coinsurance</u> plus 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>coinsurance</u> | | |
| | Non-preferred brand drugs | Not covered | Not covered | Not covered |
| | <u>Specialty drugs</u> only through Accredo Specialty Pharmacy at 1-833-255-0645 | 10% <u>coinsurance</u> | Not covered | Must use Accredo Specialty Pharmacy for <u>Specialty drugs</u> . Brand restriction explained above. |
| If you have outpatient surgery | Facility fee (e.g., ambulatory surgery center) | No charge | 100% of excess <u>UCR</u> charges | None |
| | Physician/surgeon fees | No charge | 20% <u>coinsurance</u> of <u>UCR</u> charges | None |
| If you need immediate medical attention | <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 | |
| If you have a hospital stay | 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 plan's 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) | |
| If you need mental health, behavioral health, or substance abuse services | 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. |
| If you are pregnant | Office visits | No charge | 20% <u>coinsurance</u> of <u>UCR</u> charges | <u>Cost sharing</u> does not apply to certain <u>preventive services</u> . 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 | 50% <u>coinsurance</u> of <u>UCR</u> charges | |
| If you need help recovering or have other special health needs | <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.)

- | | | |
|---|---|--|
| <input type="checkbox"/> Cosmetic surgery | <input type="checkbox"/> Infertility treatment | <input type="checkbox"/> Private duty nursing |
| <input type="checkbox"/> Dental care (covered under a separate dental plan) | <input type="checkbox"/> Long-term care | <input type="checkbox"/> Routine eye care (covered under a separate vision plan) |
| <input type="checkbox"/> Hearing aids | <input type="checkbox"/> Non-emergency care when traveling outside the U.S. | <input type="checkbox"/> Weight loss programs |

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

- | | | |
|--|--|---------------------|
| • <input type="checkbox"/> Acupuncture (<u>preauthorization</u> required) | • <input type="checkbox"/> Chiropractic care (see limitations on page 2) | • Routine foot care |
| • <input type="checkbox"/> Bariatric surgery (<u>preauthorization</u> required) | | |

* For more information, see the summary plan description materials at <http://www.tbtfund.org> or call the TBT Plan Administration Office at 1-800-533-0119.

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. 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: 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.

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.

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 **\$200**
- Specialist copayment **\$0**
- Hospital (facility) coinsurance **0%**
- 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 | \$12,800 |
|---------------------------|-----------------|

In this example, Peg would pay:

| <i>Cost Sharing</i> | |
|-----------------------------------|--------------|
| Deductibles | \$200 |
| Copayments | \$0 |
| Coinsurance | \$0 |
| <i>What isn't covered</i> | |
| Limits or exclusions | \$60 |
| The total Peg would pay is | \$260 |

Managing Joe's type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

- The plan's overall deductible **\$200**
- Specialist copayment **\$0**
- Hospital (facility) coinsurance **0%**
- 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 | \$7,400 |
|---------------------------|----------------|

In this example, Joe would pay:

| <i>Cost Sharing</i> | |
|-----------------------------------|--------------|
| Deductibles | \$200 |
| Copayments | \$0 |
| Coinsurance | \$430 |
| <i>What isn't covered</i> | |
| Limits or exclusions | \$60 |
| The total Joe would pay is | \$690 |

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

- The plan's overall deductible **\$200**
- Specialist copayment **\$0**
- Hospital (facility) coinsurance **0%**
- 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 | \$1,900 |
|---------------------------|----------------|

In this example, Mia would pay:

| <i>Cost Sharing</i> | |
|-----------------------------------|--------------|
| Deductibles | \$200 |
| Copayments | \$0 |
| Coinsurance | \$0 |
| <i>What isn't covered</i> | |
| Limits or exclusions | \$0 |
| The total Mia would pay is | \$200 |

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

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