# 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 contribution) 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, visit www.teamsters631benefits.org or call 1-877-304-6702. 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 1-877-304-6702 to request a copy.

| Important Questions | Answers | Why This Matters: |
|---|---|---|
| **What is the overall deductible?** | For network providers: $0/individual. For out-of-network providers: $500/individual or $1,500/family per Calendar Year. Copayments, non-covered expenses, and a penalty for failure to obtain precertification, do not count toward the deductible. | Generally, you must pay all of the costs from providers up to the deductible amount before this plan 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. |
| **Are there services covered before you meet your deductible?** | Yes. In-network services or in-network prescription drugs are covered before you meet your deductible. | This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost-sharing and before you meet your deductible. See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/. |
| **Are there other deductibles for specific services?** | Yes. $100/in-network hospital admission; $600/person/out-of-network hospital admission. | You must pay all of the costs for these services up to the specific deductible amount before this plan begins to pay for these services. |
| **What is the out-of-pocket limit for this plan?** | The out-of-pocket limit on coinsurance is $2,500 individual / $5,000 family. The out-of-pocket limit on cost-sharing for Essential Health Benefits from network providers is $6,600/individual or $13,200/family. This plan has no | 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. |

| | | |
|---|---|---|
| | out-of-pocket limit on out-of-network providers with the exception of emergency services. | |
| **What is not included in the out-of-pocket limit?** | Penalties for not obtaining any required precertification, 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. For a list of network providers, see www.anthem.com. For in-network Health Services Coalition (HSC) Hospitals and Step Down Facilities in Southern Nevada call1-877-304-6702. For the in-network mental health and substance abuse providers and the Member Assistance Program (MAP), contact Anthem Blue Cross at 1-800-865-1044 or see www.anthem.com. For in-network vision benefits contact Davis Vision at 1-800-999-5431 www.davisvision.com. For in-network Dental benefits contact Nevada Dental Benefits at 1-866-998-3944 or www.nevadadentalbenefits.com. | 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. The No Surprises Act may limit the ability of some out-of-network providers to balance bill you. |
| **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 copay/office visit | 50% coinsurance | None |
| | Specialist visit | $25 copay/visit | 50% coinsurance | $15 copay/visit for in-network chiropractor and |

| 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) | |
| | | | | 50% coinsurance for out-of-network chiropractor; maximum benefit is 20 visits per person per Calendar Year. You pay 100% for acupuncture services. |
| | Preventive care/screening/ Immunization | No charge | 50% coinsurance | You may have to pay for services that aren't preventive. Ask your provider if the services you need are preventive. Then check what your plan will pay for. |
| **If you have a test** | Diagnostic test (x-ray, blood work) | No charge for laboratory services; $20 copay/test for routine radiological and non-radiological diagnostic imaging; $25 copay/test for chemotherapy, therapeutic radiology, allergy testing and serum injections | 50% coinsurance | Certain services, such as CT/PET scans, MRI and sleep studies, require preauthorization to avoid a 50% reduction in Plan paid coinsurance. If multiple tests are performed on one visit, only one copayment will apply. |
| | Imaging (CT/PET scans, MRIs) | $50 copay/test at free-standing facility $150 copay/test at hospital-based facility | 50% coinsurance | |
| **If you need drugs to treat your illness or condition** More information about **prescription drug coverage** is available from SavRx at www.SavRx.com | Generic drugs | Retail Pharmacy: $0 copay/prescription. Mail Order: $0 copay/prescription. | 50% coinsurance | Covers up to a 90 days' supply at both retail and mail. Certain drugs, including Class II and Class III narcotics (after one fill over a rolling 365-day period) and Specialty drugs require Preauthorization or step therapy from SavRx at 1-800- 285-8501. No charge for preferred (formulary) diabetic test strips. If you purchase a brand drug when a generic drug is available, you pay the brand drug cost-sharing plus the difference in cost between the brand drug and the generic drug and this cost will not count towards your out-of-pocket limit. Certain Specialty drugs are only covered if they are |
| | Preferred brand drugs | Retail Pharmacy: $40/$80/$120 copay/prescription for 30/60/90 days. Mail Order: $80 copay/prescription. | Not covered. | |
| | Non-preferred brand drugs | Retail Pharmacy: $80/$160/$240 copay/prescription for | Not covered. | |

| 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) | |
| | | 30/60/90 days. Mail Order: $160 copay/prescription. | | provided through the Plan's specialty mail order program. |
| | Specialty drugs | 20% coinsurance, up to $200 copay | Not covered. | |
| **If you have outpatient surgery** | Facility fee (e.g., ambulatory surgery center) | $150 copay at free-standing facility $250 copay at hospital-based facility | 50% coinsurance after deductible met. | Preauthorization is required. If you don't get preauthorization, benefits could be reduced by 50% of the total cost of the service. |
| | Physician/surgeon fees | $25 copay | 50% coinsurance after deductible met. | Preauthorization is required. If you don't get preauthorization, benefits could be reduced by 50% of the total cost of the service. |
| **If you need immediate medical attention** | Emergency room care | ER facility: $250 copay/visit. ER Physician: $25 copay/visit | ER facility: $250 copay/visit. ER Physician: $25 copay/visit | Copay waived if admitted. For non-emergency services in an ER, you pay expenses over $75/visit. You may be balance billed from Non-network providers unless the service falls under the rules for the No Surprises Act, in which case you cannot be balanced billed. |
| | Emergency medical transportation | Ground and air ambulance: $50 copay/trip | Ground and air ambulance: $50 copay/trip | |
| | Urgent care | $50 copay/visit | 50% coinsurance | |
| **If you have a hospital stay** | Facility fee (e.g., hospital room) | 20% coinsurance after you pay a $100 admission deductible | After deductible met, you pay the $600 admission deductible plus 50% coinsurance | Preauthorization is required. If you don't get preauthorization, benefits could be reduced by 50% of the total cost of the service. |
| | Physician/surgeon fees | Hospitalist Program (mandatory if admitted to Las Vegas area hospital): No charge. Surgeon & other physicians: $25 copay/procedure | 50% coinsurance | If you refuse care from a Hospitalist Program physician, charges from a Non-Hospitalist Program hospitalist and any primary care physicians (except for OB/GYNs and Pediatricians) will be denied. |

| 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 | $15 copay/office visit | MAP counseling sessions not covered. All other outpatient services covered at 50% coinsurance | Inpatient services require preauthorization to avoid a reduction to payment of 50% coinsurance. If you have an emergency admission at an out-of-network provider, then the in-network provider benefit coverage applies (20% coinsurance after you pay a $100 admission deductible). |
| | Inpatient services | 20% coinsurance after you pay a $100 admission deductible. Residential care: 20% coinsurance and no admission deductible. | After deductible met, you pay the $600 admission deductible plus 50% coinsurance for hospital care. There is NO out of network coverage for residential facilities or other inpatient services. You will pay 100% of these services. | |
| **If you are pregnant** | Office visits | No charge. | 50% coinsurance | Cost sharing does not apply to certain preventive services. Depending on the type of services, coinsurance may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound). If your hospital stay exceeds 48 hours for vaginal delivery or 96 hours for C-section, you are to request preauthorization for any additional hospital days to avoid a 50% reduction in Plan paid coinsurance. |
| | Childbirth/delivery professional services | Hospitalist Program (mandatory if admitted to Las Vegas area hospital): No charge. Surgeon & other physicians: $25 copay/procedure | 50% coinsurance | |
| | Childbirth/delivery facility services | 20% coinsurance after $100 admission deductible. | 50% coinsurance | |
| **If you need help recovering or have other special health needs** | Home health care | None. | 50% coinsurance | Home infusion services (excluding oncology patients) and related nursing visits require preauthorization to avoid a 50% reduction in Plan paid coinsurance. |
| | Rehabilitation services | Outpatient: $15 copay/session. Inpatient: 20% coinsurance after $100 admission deductible | Outpatient covered at 50% coinsurance. Inpatient not covered. | Inpatient & outpatient physical, occupational & speech therapy (short-term rehabilitation) max benefit is 90 visits per Calendar Year with preauthorization after 60th visit. Inpatient rehab admission requires preauthorization to avoid a 50% reduction in Plan paid coinsurance. Admission deductible waived if admitted from acute facility. |
| | Habilitation services | $15 copay/session | 50% coinsurance | |

| 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) | |
| | Skilled nursing care | 20% coinsurance after a $100 admission deductible | Not covered. | Preauthorization is required. 60 visits/calendar year maximum. |
| | Durable medical equipment | $50 copay | 50% coinsurance | Preauthorization is required for charges of $500 or more. Excludes vehicle modifications, home modifications and exercise equipment. |
| | Hospice services | 20% coinsurance | Outpatient: 50% coinsurance. After deductible met, you pay the $600 admission deductible, plus 50% coinsurance | Covered if terminally ill. Preauthorization is required to avoid a 50% reduction in Plan paid coinsurance. |
| **If your child needs dental or eye care** | Children's eye exam | No charge. | Varies according to Davis Vision network schedule. | Coverage limited to one exam/year. Use the Davis Vision network. |
| | Children's glasses | No charge for frames and single vision lenses | Varies according to Davis Vision network schedule. | Coverage limited to one pair of glasses/year. Use the Davis Vision network. |
| | Children's dental check-up | No charge | Not covered | Nevada Dental Benefits is the dental network. |

## 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.)**

- Acupuncture
- Cosmetic Surgery
- Infertility Treatment
- Long Term Care
- Non-emergency care when traveling outside the U.S.
- Private Duty Nursing
- Weight Loss Programs

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

- Bariatric Surgery (for network providers only: no charge after $1,000 copay/outpatient bariatric surgery, $2,500 copay/inpatient bariatric surgery; no coverage for non-spousal dependents)
- Chiropractic Care (maximum benefit is 20 visits per person per Calendar Year)
- Dental Care (Adult)
- Hearing Aids (up to $500/ear/3 years)
- Routine Eye Care (Adult)
- Routine Foot Care (payable when treating metabolic or peripheral vascular disease)

**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: 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 Administrative Office at 1-877-304-6702 or www.teamsters631benefits.org, or the Department of Labor's 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 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 1-877-304-6702.

*To see examples of how this plan might cover costs for a sample medical situation, see the next section.*

## 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 | $20 |
| Hospital (facility) coinsurance | 20% |
| 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** | **$12,700** |
|---|---|

**In this example, Peg would pay:**

| *Cost Sharing* | |
|---|---|
| Deductibles* | $0 |
| Copayments | $160 |
| Coinsurance | $1,400 |
| *What isn't covered* | |
| Limits or exclusions | $60 |
| **The total Peg would pay is** | **$1,620** |

### 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 | $20 |
| Hospital (facility) coinsurance | 20% |
| 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** | **$5,600** |
|---|---|

**In this example, Joe would pay:**

| *Cost Sharing* | |
|---|---|
| Deductibles | $0 |
| Copayments | $100 |
| Coinsurance | $700 |
| *What isn't covered* | |
| Limits or exclusions | $20 |
| **The total Joe would pay is** | **$820** |

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

| | |
|---|---|
| The plan's overall deductible | $0 |
| Specialist copayment | $20 |
| Hospital (facility) coinsurance | 20% |
| 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** | **$2,800** |
|---|---|

**In this example, Mia would pay:**

| *Cost Sharing* | |
|---|---|
| Deductibles* | $0 |
| Copayments | $510 |
| Coinsurance | $0 |
| *What isn't covered* | |
| Limits or exclusions | $0 |
| **The total Mia would pay is** | **$510** |

*Note: This plan has other deductibles for specific services included in this coverage example. See "Are there other deductibles for specific services?" row above.

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