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?	$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?	Not Applicable.	Not Applicable.
Are there other deductibles for specific services?	No	You do not have to meet a deductible for specific services.
What is the out-of-pocket limit for this plan?	$6,250 individual / $12,500 family.	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?	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 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.	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	$25 copay/visit	Not Covered	None
	Specialist visit	$50 copay/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 you need are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	$15 copay/visit for laboratory services; $25 copay/test for routine radiological and non-radiological diagnostic imaging	Not Covered	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)	$100 copay/test at free-standing facility $150 copay/test at hospital-based facility	Not Covered	
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.	Not covered.	Covers up to a 90-day supply (retail and mail order prescription). 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 provided through the Plan's specialty mail
	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 30/60/90 days.	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)	
		Mail Order: $160 copay/prescription.		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	Not Covered	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	$150 copay if in an outpatient facility $75 copay if in a physician office	Not Covered	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: No charge	ER facility: $250 copay/visit. ER Physician: No charge	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: $250 copay/trip	Ground and air ambulance: $250 copay/trip	
	Urgent care	$50 copay/visit	Not Covered	
If you have a hospital stay	Facility fee (e.g., hospital room)	$300 copay/day up to $900 per admission	Not Covered	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: $150 copay/procedure	Not Covered	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.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$25 copay/office visit	Not Covered	Outpatient programs and covered, elective inpatient services require preauthorization to avoid a reduction to payment of 50% coinsurance.
	Inpatient services	$300 copay/day up to $900 per admission.	Not covered	
If you are pregnant	Office visits	No Charge	Not Covered	Cost sharing does not apply to certain preventive services. Maternity care may
	Childbirth/delivery professional	Hospitalist Program	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)	
	services	(mandatory if admitted to Las Vegas area hospital): No charge. Surgeon & other physicians: $150 copay/admission		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 facility services	$300 copay/day up to $900 per admission	Not Covered	
If you need help recovering or have other special health needs	Home health care	No charge	Not Covered	Preauthorization is required. If you don't get preauthorization, benefits could be reduced by 50% of the total cost of the service.
	Rehabilitation services	$25 copay/visit	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.
	Habilitation services	$25 copay/visit	Not Covered	
	Skilled nursing care	$400 admission deductible	Not Covered.	Preauthorization is required. 100 days/calendar year maximum.
	Durable medical equipment	No charge	Not Covered	For purchase or rental at plan's option. Purchases are limited to a single type of DME, including repair and replacement, every 3 years. Member pays for cost of services if prior authorization is not obtained.
	Hospice services	No Charge	Not Covered	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 based on 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 Coverage
- Long Term Care
- Non-emergency care when traveling outside the U.S.
- Private Duty Nursing
- Routine Foot Care
- 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 $1,500 copay/ bariatric surgery; no coverage for non-spousal dependents)
- Chiropractic Care
- 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: 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	$50
Hospital (facility) copayment	$300
Other copayment	$150

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	$1,200
Coinsurance	$0
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$1,260**

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	$50
Hospital (facility) copayment	$300
Other copayment	$150

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	$1,800
Coinsurance	$0
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$1,820**

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

The plan's overall deductible	$0
Specialist copayment	$50
Hospital (facility) copayment	$300
Other copayment	$150

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	$755
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$755**

*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.