



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, please contact Fund Administrator c/o HS&BA at (925) 833-7300. 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](http://www.dol.gov/ebsa/healthreform) or call 1-888-877-8363 to request a copy.

Important Questions	Answers	Why This Matters:
<b>What is the overall <a href="#">deductible</a>?</b>	\$200 individual / \$400 family	Generally, you must pay all of the costs from <a href="#">providers</a> up to the <a href="#">deductible</a> amount before this <a href="#">plan</a> begins to pay. If you have other family members on the <a href="#">plan</a> , each family member must meet their own individual <a href="#">deductible</a> until the total amount of <a href="#">deductible</a> expenses paid by all family members meets the overall family <a href="#">deductible</a> .
<b>Are there services covered before you meet your <a href="#">deductible</a>?</b>	Yes. <a href="#">Preventive care</a> .	This plan covers some items and services even if you haven't yet met the <a href="#">deductible</a> amount. But a <a href="#">copayment</a> or <a href="#">coinsurance</a> may apply. For example, this <a href="#">plan</a> covers certain <a href="#">preventive services</a> without <a href="#">cost-sharing</a> and before you meet your <a href="#">deductible</a> . See a list of covered <a href="#">preventive services</a> at <a href="https://www.healthcare.gov/coverage/preventive-care-benefits">https://www.healthcare.gov/coverage/preventive-care-benefits</a> .
<b>Are there other <a href="#">deductibles</a> for specific services?</b>	No.	You don't have to meet <a href="#">deductibles</a> for specific services.
<b>What is the <a href="#">out-of-pocket limit</a> for this <a href="#">plan</a>?</b>	For <a href="#">in-network providers</a> : \$1,500 individual / \$4,500 family For <a href="#">out-of-network providers</a> : \$5,000 individual / \$15,000 family <a href="#">Prescription drugs</a> : \$6,400 individual / \$11,300 family. This is a combined maximum for in-network and out-of-network generic and formulary drugs during a coverage period (calendar year).	The <a href="#">out-of-pocket limit</a> is the most you could pay in a year for covered services. If you have other family members in this <a href="#">plan</a> , they have to meet their own <a href="#">out-of-pocket limits</a> until the overall family <a href="#">out-of-pocket limit</a> has been met. This limit helps you plan for health care expenses.
<b>What is not included in the <a href="#">out-of-pocket limit</a>?</b>	<a href="#">Premiums</a> , <a href="#">balance-billing</a> charges, health care this <a href="#">plan</a> doesn't cover, charges in excess of annual maximum benefits, a penalty for failure to obtain <a href="#">pre-authorization</a> , dental and vision expenses, Non-PPO <a href="#">coinsurance</a> , and the cost between a chosen brand and generic equivalent do not count toward the <a href="#">out-of-pocket limit</a> .	Even though you pay these expenses, they don't count toward the <a href="#">out-of-pocket limit</a> .
<b>Will you pay less if you use a <a href="#">network provider</a>?</b>	Yes. See <a href="http://www.anthem.com/ca">www.anthem.com/ca</a> or call 1-888-877-8363 for a list of <a href="#">network providers</a> .	This <a href="#">plan</a> uses a <a href="#">provider network</a> . You will pay less if you use a <a href="#">provider</a> in the <a href="#">plan's network</a> . You will pay the most if you use an <a href="#">out-of-network provider</a> , and you might receive a bill from a <a href="#">provider</a> for the difference between the <a href="#">provider's</a> charge and what your <a href="#">plan</a> pays ( <a href="#">balance billing</a> ). Be aware, your <a href="#">network provider</a> might use an <a href="#">out-of-network provider</a> for some services (such as lab work). Check with your <a href="#">provider</a> before you get services.
<b>Do you need a <a href="#">referral</a> to see a <a href="#">specialist</a>?</b>	No.	You can see the <a href="#">specialist</a> you choose without a <a href="#">referral</a> .

[\* For more information about limitations and exceptions, see the plan or policy document at [www.hsba.com](http://www.hsba.com).]



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)	
<b>If you visit a health care <a href="#">provider's</a> office or clinic</b>	Primary care visit to treat an injury or illness	10% <a href="#">coinsurance</a>	30% <a href="#">coinsurance</a>	See Plan Booklet for What is Not Covered. Telehealth or virtual visits are also a covered benefit at no cost to member
	<a href="#">Specialist</a> visit	10% <a href="#">coinsurance</a>	30% <a href="#">coinsurance</a>	
	<a href="#">Preventive care/screening/immunization</a>	No charge	30% <a href="#">coinsurance</a>	You may have to pay for services that aren't preventive. Ask your <a href="#">provider</a> if the services needed are preventive. Then check what your <a href="#">plan</a> will pay for.
<b>If you have a test</b>	<a href="#">Diagnostic test</a> (x-ray, blood work)	10% <a href="#">coinsurance</a>	30% <a href="#">coinsurance</a>	Some <a href="#">preventive</a> screening (such as lab and imaging) may be at a different cost share.
	Imaging (CT/PET scans, MRIs)	10% <a href="#">coinsurance</a>	30% <a href="#">coinsurance</a>	Some <a href="#">preventive</a> screening (such as lab and imaging) may be at a different cost share.
	COVID-19 Test	No charge	No charge	No <a href="#">Preauthorization</a> required. Cost share shown will remain in effect until Secretary of HHS determines that the public health emergency has expired.
<b>If you need drugs to treat your illness or condition</b> More information about <a href="#">prescription drug coverage</a> is available at <a href="http://www.OptumRx.com">www.OptumRx.com</a>	Generic drugs	\$5 <a href="#">copayment</a> (retail) \$10 <a href="#">copayment</a> (mail order)	Must pay full cost of prescription and file a claim with OptumRx.	Retail: Covers a reasonable supply no more than 34-days, except in the treatment of chronic or permanent illness, in which case the supply will cover 100 days. Mail Order: 90-day supply for chronic or permanent illness.
	Preferred brand drugs	\$20 <a href="#">copayment</a> (retail) \$40 <a href="#">copayment</a> (mail order)		
	Non-preferred brand drugs	\$45 <a href="#">copayment</a> (retail) \$90 <a href="#">copayment</a> (mail order)		
	<a href="#">Specialty drugs</a>	10% <a href="#">coinsurance</a> , not to exceed \$100 per prescription.	Not covered	<a href="#">Pre-authorization</a> is required.
<b>If you have outpatient surgery</b>	Facility fee (e.g., ambulatory surgery center)	10% <a href="#">coinsurance</a>	30% <a href="#">coinsurance</a>	None.
	Physician/surgeon fees	10% <a href="#">coinsurance</a>	30% <a href="#">coinsurance</a>	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 immediate medical attention	<a href="#">Emergency room care</a>	10% <u>coinsurance</u>	10% <u>coinsurance</u>	Must receive treatment within 24 hours of accident.
	<a href="#">Emergency medical transportation</a>	10% <u>coinsurance</u>	30% <u>coinsurance</u>	None.
	<a href="#">Urgent care</a>	10% <u>coinsurance</u>	30% <u>coinsurance</u>	None.
If you have a hospital stay	Facility fee (e.g., hospital room)	10% <u>coinsurance</u>	30% <u>coinsurance</u> , not to exceed a semi-private room rate at a Contract Hospital	If <u>pre-authorization</u> is not obtained from Anthem Blue Cross benefits will be reduced by 10%. In some instances, services provided by an out-of-network provider at an in-network facility may be payable at the in-network coinsurance.
	Physician/surgeon fees	10% <u>coinsurance</u>	30% <u>coinsurance</u>	None.
If you need mental health, behavioral health, or substance abuse services	Mental/Behavioral health outpatient services	10% <u>coinsurance</u>	30% <u>coinsurance</u>	None.
	Mental/Behavioral health inpatient services	10% <u>coinsurance</u>	30% <u>coinsurance</u>	<u>Coinsurance</u> will be 10% for emergency care at a non-participating <u>provider</u> until you can be transferred to a participating facility. <u>Coinsurance</u> will be 30% if you remain at a non-participating facility. If <u>pre-authorization</u> is not obtained benefits will be reduced by 10% for non-emergency admissions.
	Substance use disorder outpatient services	10% <u>coinsurance</u>	30% <u>coinsurance</u>	Coverage through Teamsters Assistance Program.
	Substance use disorder inpatient services	10% <u>coinsurance</u>	30% <u>coinsurance</u>	Coverage through Teamsters Assistance Program.  If <u>pre-authorization</u> is not obtained benefits will be reduced by 10% for non-emergency admissions.

[\* For more information about limitations and exceptions, see the plan or policy document at [www.hsba.com](http://www.hsba.com).]

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 are pregnant	Office visits	10% <u>coinsurance</u>	30% <u>coinsurance</u>	Some <u>preventive</u> or diagnostic services may be covered as such
	Childbirth/delivery professional services	10% <u>coinsurance</u>	30% <u>coinsurance</u>	Benefits limited to Participant and covered spouse only (no coverage for pregnant dependent children).
	Childbirth/delivery facility services	10% <u>coinsurance</u>	30% <u>coinsurance</u>	<u>Pre-authorization</u> required only if hospital stay is more than 48 hours for normal delivery or 96 hours for a Cesarean delivery. The <u>plan</u> will reimburse up to \$750 for midwifery expenses incurred from a pregnancy. In some instances, services provided by an out-of-network provider at an in-network facility may be payable at the in-network coinsurance.
If you need help recovering or have other special health needs	<a href="#">Home health care</a>	10% <u>coinsurance</u>	30% <u>coinsurance</u>	If authorized by Medical Review Organization as part of the Case Management Program and the care is certified by Attending Physician to be Medically Necessary.
	<a href="#">Rehabilitation services</a>	10% <u>coinsurance</u>	30% <u>coinsurance</u>	Services provided by Physical Therapists
	<a href="#">Habilitation services</a>	10% <u>coinsurance</u>	30% <u>coinsurance</u>	None.
	<a href="#">Skilled nursing care</a>	10% <u>coinsurance</u>	30% <u>coinsurance</u>	Professional services provided by a Graduate Registered Nurse.
	<a href="#">Durable medical equipment</a>	10% <u>coinsurance</u>	30% <u>coinsurance</u>	Rental of <u>durable medical equipment</u> for therapeutic treatment.
	<a href="#">Hospice services</a>	10% <u>coinsurance</u>	30% <u>coinsurance</u>	None.
If your child needs dental or eye care	Children's eye exam	No Charge	Not Covered	Limited to one exam every 12 months
	Children's glasses	No Charge for lens every 12 months and frames every 24 months	Not Covered	Coverage for frames limited to \$120. Coverage for lens ranges between \$50 and \$125 depending on lens type.
	Children's dental check-up	No Charge	No Charge	Cleaning once every 6 months.

[\* For more information about limitations and exceptions, see the plan or policy document at [www.hsba.com](http://www.hsba.com).]

## 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
- Bariatric surgery
- Cosmetic surgery (except for expenses incurred after an accident and necessary for the repair or alleviation of damage resulting from that accident; a lifetime maximum of \$10,000 applies)
- Hearing aids
- Infertility treatment
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Routine foot care
- Weight Loss Program (Obesity Management)

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

- Chiropractic care
- Dental care (Adult) is payable up to \$2,000/year under the Anthem Dental PPO Plan
- Private-duty nursing
- Telemedicine
- Routine eye care (Adult)

**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 Labor's 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: Fund Office at (415) 986-6276 or 1-888-877-8363. You may also contact the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or [www.dol.gov/ebsa/healthreform](http://www.dol.gov/ebsa/healthreform). Additionally, a consumer assistance program can help you file your appeal. Contact 1-866-466-2219 (California residents only).

### 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 1-888-877-8363.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-888-877-8363.

Chinese (中文): 如果需要中文的帮助, 请拨打这个号码1-888-877-8363.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijigo holne' 1-888-877-8363.

————— *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 <a href="#">plan's</a> overall <a href="#">deductible</a>	\$200
■ <a href="#">Specialist coinsurance</a>	10%
■ <a href="#">Hospital (facility) coinsurance</a>	10%
■ Other <a href="#">coinsurance</a>	10%

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>\$12,700</b>
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In this example, Peg would pay:

Cost Sharing	
<a href="#">Deductibles</a>	\$200
<a href="#">Copayments</a>	\$10
<a href="#">Coinsurance</a>	\$1,200
What isn't covered	
Limits or exclusions	\$60
<b>The total Peg would pay is</b>	<b>\$1,470</b>

### Managing Joe's type 2 Diabetes

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

■ The <a href="#">plan's</a> overall <a href="#">deductible</a>	\$200
■ <a href="#">Specialist coinsurance</a>	10%
■ <a href="#">Hospital (facility) coinsurance</a>	10%
■ Other <a href="#">coinsurance</a>	10%

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>\$5,600</b>
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In this example, Joe would pay:

Cost Sharing	
<a href="#">Deductibles</a>	\$200
<a href="#">Copayments</a>	\$700
<a href="#">Coinsurance</a>	\$200
What isn't covered	
Limits or exclusions	\$20
<b>The total Joe would pay is</b>	<b>\$1120</b>

### Mia's Simple Fracture

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

■ The <a href="#">plan's</a> overall <a href="#">deductible</a>	\$200
■ <a href="#">Specialist coinsurance</a>	10%
■ <a href="#">Hospital (facility) coinsurance</a>	10%
■ Other <a href="#">coinsurance</a>	10%

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>\$2,800</b>
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In this example, Mia would pay:

Cost Sharing	
<a href="#">Deductibles</a>	\$200
<a href="#">Copayments</a>	\$10
<a href="#">Coinsurance</a>	\$300
What isn't covered	
Limits or exclusions	\$0
<b>The total Mia would pay is</b>	<b>\$510</b>