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 https://www.healthcare.gov/sbc-glossary/ or call 1-800-433-6692 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	$200 individual / $400 family	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. Preventive care.	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-beneifits/.
Are there other deductibles for specific services?	No.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	For in-network providers: $1,500 individual / $4,500 family For out-of-network providers: $5,000 individual / $15,000 family Prescription drugs: $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 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. For medical plan participating providers, once you or your family have met the out-of-pocket limit, which includes the deductible, the plan will pay 100% of participating provider medical expenses incurred for the remainder of the plan year.
What is not included in the out-of-pocket limit?	The deductible for non-PPO providers, premiums, balance billing charges except where prohibited by law, charges in excess of annual maximum benefits, a penalty for failure to obtain preauthorization, dental and vision expenses, non-PPO coinsurance, and the cost between a chosen brand and generic equivalent do not count toward the out-of-pocket limit.	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. See www.anthem.com/ca or www.bcbs.com (outside of CA) or call the Fund Office for a list of participating providers in the Anthem Blue Cross network in CA or 1-888-877-8363	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.
Do you need a referral to see a specialist?	No.	You can see the specialist you choose without a referral.

[* For more information about limitations and exceptions, see the plan or policy document at norcalsoftdrink.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)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	10% coinsurance	30% coinsurance	The plan will not pay more than 70% coinsurance for non-emergency services provided by a non-PPO provider at a PPO facility. If you consent to the non-PPO billing rates, you are responsible for the difference. See Plan Booklet for What Is Not Covered. Telehealth or virtual visits are also a covered benefit at no cost to member.
	Specialist visit	10% coinsurance	30% coinsurance	
	Preventive care/screening/ immunization	No charge	30% coinsurance	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	Diagnostic test (x-ray, blood work)	10% coinsurance	30% coinsurance	Some preventive screening (such as lab and imaging) may be at a different cost share.
	COVID-19 Test	No charge	No charge	No preauthorization required. Cost share shown will remain in effect until Secretary of HHS determines that the public health emergency has expired.
	Imaging (CT/PET scans, MRIs)	10% coinsurance	30% coinsurance	Some preventive screening (such as lab and imaging) may be at a different cost share.
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.OptumRx.com	Generic drugs	$5 copayment (retail) $10 copayment (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 copayment (retail) $40 copayment (mail order)		
	Non-preferred brand drugs	$45 copayment (retail) $90 copayment (mail order)		
	Specialty drugs	Injectable drugs: 10% coinsurance, not to exceed $100 per prescription. Other specialty drugs: subject to standard copays shown above.	Not covered	Preauthorization is required.

[* For more information about limitations and exceptions, see the plan or policy document at norcalsoftdrink.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 have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	10% coinsurance	30% coinsurance	The plan will not pay more than 70% coinsurance for non-emergency services provided by a non-PPO provider at a PPO facility. If you consent to the non-PPO billing rates, you are responsible for the difference.
	Physician/surgeon fees	10% coinsurance	30% coinsurance	
If you need immediate medical attention	Emergency room care	10% coinsurance	10% coinsurance	Must receive treatment within 24 hours of accident. You will have to pay 30% coinsurance for emergency services at a non-PPO facility if (1) you did not have an emergency medical condition; or (2) you receive emergency services for treatment of an emergency medical condition from a non-PPO provider or non-PPO emergency facility and consent to the non-PPO billing rate for certain post-stabilization services.
	Emergency medical transportation	10% coinsurance	30% coinsurance	None.
	Urgent care	10% coinsurance	30% coinsurance	None.
If you have a hospital stay	Facility fee (e.g., hospital room)	10% coinsurance	30% coinsurance not to exceed the semi-private room rate at a PPO hospital	If preauthorization 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% coinsurance	30% coinsurance	The plan will not pay more than 70% coinsurance for non-emergency services provided by a non-PPO provider at a PPO facility. If you consent to the non-PPO billing rates, you are responsible for the difference.

[* For more information about limitations and exceptions, see the plan or policy document at norcalsoftdrink.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 need mental health, behavioral health, or substance abuse services	Mental/behavioral health outpatient services	10% coinsurance	30% coinsurance	The plan will not pay more than 70% coinsurance for non-emergency services provided by a non-PPO provider at a PPO facility. If you consent to the non-PPO billing rates, you are responsible for the difference.
	Mental/behavioral health inpatient services	10% coinsurance	30% coinsurance	The plan will not pay more than 70% coinsurance for non-emergency services provided by a non-PPO provider at a PPO facility. If you consent to the non-PPO billing rates, you are responsible for the difference. If preauthorization is not obtained, benefits will be reduced by 10% for non-emergency admissions.
	Substance use disorder outpatient services	10% coinsurance	30% coinsurance	Coverage through Teamsters Assistance Program.
	Substance use disorder inpatient services	10% coinsurance	30% coinsurance	Coverage through Teamsters Assistance Program. If preauthorization is not obtained, benefits will be reduced by 10% for non-emergency admissions.
If you are pregnant	Office visits	10% coinsurance	30% coinsurance	Some preventive or diagnostic services may be covered at no charge.
	Childbirth/delivery professional services	10% coinsurance	30% coinsurance	Benefits limited to Participant and covered spouse only (no coverage for pregnant dependent children). Preauthorization required only if hospital stay is more than 48 hours for normal delivery or 96 hours for a Cesarean delivery. The plan will reimburse up to $750 for midwifery expenses incurred during 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.
	Childbirth/delivery facility services	10% coinsurance	30% 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)	
If you need help recovering or have other special health needs	Home health care	10% coinsurance	30% coinsurance	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.
	Rehabilitation services	10% coinsurance	30% coinsurance	Services provided by Physical Therapists
	Habilitation services	10% coinsurance	30% coinsurance	None.
	Skilled nursing care	10% coinsurance	30% coinsurance	Professional services provided by a Graduate Registered Nurse.
	Durable medical equipment	10% coinsurance	30% coinsurance	Rental of durable medical equipment for therapeutic treatment.
	Hospice services	10% coinsurance	30% coinsurance	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.

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
- Telemedicine
- Dental care (Adult) is payable up to $2,000/year under the Anthem Dental PPO Plan
- Private-duty nursing
- 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. 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: 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. 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, kwiijigo holne' 1-888-877-8363.

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

[* For more information about limitations and exceptions, see the plan or policy document at norcalsoftdrink.com.]

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 coinsurance	**10%**
Hospital (facility) coinsurance	**10%**
Other coinsurance	**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)*

Total Example Cost	**$12,700**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$200
Copayments	$10
Coinsurance	$1,200
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$1,470**

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 coinsurance	**10%**
Hospital (facility) coinsurance	**10%**
Other coinsurance	**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)*

Total Example Cost	**$5,600**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$200
Copayments	$700
Coinsurance	$200
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$1,120**

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

The plan's overall deductible	**$200**
Specialist coinsurance	**10%**
Hospital (facility) coinsurance	**10%**
Other coinsurance	**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)*

Total Example Cost	**$2,800**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$200
Copayments	$10
Coinsurance	$300
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$510**

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