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 call 1-800-872-8979. 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.teamsterbenefits.com or call 1-800-872-8979 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	**$300**/person or **$900**/family Does not apply to prescription drugs, vision hardware, or office visits, routine preventive care, diagnostic lab/imaging/tests, and vision exams at PPO network providers. Copayments, coinsurance and balance-billed charges 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 meet the overall family **deductible.**
Are there services covered before you meet your deductible?	PPO network office visits, preventive care, prescription drugs, routine dental and vision care.	This **plan** covers some items and services even if you haven't 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?	**No.**	You don't have to meet **deductibles** for specific services, but see the chart starting on page 2 for other costs for services this plan covers
What is the out-of-pocket limit for this plan?	The annual PPO / Non-PPO out-of-pocket (OOP) limit includes: Medical deductible, medical coinsurance, medical office visit copays, and prescription drugs out of pocket for a combined total of: **$6,850 per person** **$13,700 per family** Medical Deductible: **$300 per person; $900 per 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.

Important Questions	Answers	Why This Matters:
	Medical coinsurance / office visit copays: **$2,295 per person; $4,290 per family** Prescription Drugs out of pocket: **$4,255 per person; $8,510 per family**	
What is not included in the out-of-pocket limit?	Premiums, non-network PPO charges, balance-billed charges, penalties for failure to obtain pre-certification, 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 participating providers, see www.premera.com or call 1-800-713-5373. You can also call the Trust office at 1-800-872-8979.	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 don't need a referral to see a specialist.	You can see the **specialist** you choose without permission from this plan.

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	$25 copay/visit	None. Copayment waived for Teladoc only; all other virtual visits covered at regular copayment and coinsurance, as applicable
	Specialist visit	$25 copay/visit	$25 copay/visit.	None. Copayment waived for Teladoc only; all other virtual visits covered at regular copayment and coinsurance, as applicable.
	Other practitioner office visit	$25 copay/visit	$25 copay/visit	Acupuncture and massage therapy are not covered.
	Preventive care/screening/ immunization	No charge	No charge, unless the charges are over the Usual & Customary Amount	Adults: as specified by ACA Children: routine wellness visits as recommended by the American Academy of Pediatrics. Immunizations: as recommended by the

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)	
				Center for Disease Control and Prevention.
If you have a test	Diagnostic test (x-ray, blood work)	20% of PPO Allowed Charges, Deductible, 20% co-insurance	20% of Usual & Customary Amount, Deductible, 20% coinsurance	None.
	Imaging (CT/PET scans, MRIs)	20% of PPO Allowed Charges, Deductible, 20% co-insurance	20% of Usual & Customary Amount, Deductible, 20% coinsurance	Pre-authorization is required for some imaging services.
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.[insert].com	Generic drugs	$5 copay/prescription	Not covered	Covers up to a 30-day supply at a retail pharmacy; 90-day supply through mail order. If a specialty drug is administered by a provider or facility other than a licensed pharmacy, then the applicable deductible and coinsurance will apply based on the network status of the provider.
	Preferred brand drugs	$25 copay/prescription	Not covered	
	Non-preferred brand drugs	$40 copay/prescription (Physician Request) $40 copay/ prescription, plus the difference in the cost between Brand Name drug and Generic drug cost (Participant Request)	Not covered	
	Specialty drugs	$75 copay/prescription	Not covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance after the deductible	Deductible, 20% of Usual & Customary Amount	Pre-authorization is required for some outpatient surgeries.
	Physician/surgeon fees	20% coinsurance after the deductible	Deductible, 20% of Usual & Customary Amount	
If you need immediate medical attention	Emergency room care	20% coinsurance after the deductible	Deductible, 20% of Usual & Customary Amount	None.
	Emergency medical transportation	Plan pays $100, Deductible, 20% coinsurance	Plan pays $100, Deductible, 20% of Usual & Customary Amount	None.
	Urgent care	$25 copay/visit	$25 copay/visit	None.
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance after the deductible	Deductible, 20% of Usual & Customary Amount	Pre-authorization required for Inpatient Facility services other than those provided to a

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)	
	Physician/surgeon fees	20% coinsurance after the deductible	Deductible, 20% of Usual & Customary Amount	newborn.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	20% coinsurance after the deductible	Deductible, 20% of Usual & Customary Amount	None. Copayment waived for Teladoc only; all other virtual visits covered at regular copayment and coinsurance, as applicable
	Inpatient services	20% coinsurance after the deductible	Deductible, 20% of Usual & Customary Amount	Pre-authorization required.
If you are pregnant	Office visits	20% coinsurance after the deductible	Deductible, 20% of Usual & Customary Amount	Preventive care only is covered for pregnancy of dependent children.
	Childbirth/delivery professional services	20% coinsurance after the deductible	Deductible, 20% of Usual & Customary Amount	Labor and delivery charges are not covered for dependent children.
	Childbirth/delivery facility services	20% coinsurance after the deductible	Deductible, 20% of Usual & Customary Amount	Labor and delivery charges are not covered for dependent children.
If you need help recovering or have other special health needs	Home health care	Plan pays 100%	Plan pays 100% of Usual & Customary Amount	Pre-authorization required. Up to 130 visits per person per calendar year. Must be provided by a home health agency which is licensed by the state or Medicare-certified.
	Rehabilitation services	20% coinsurance after the deductible	Deductible, 20% of Usual & Customary Amount	Outpatient care for physical therapy services limited to 40 visits per person per calendar year with a 20-visit limit per condition.
	Habilitation services	20% coinsurance after the deductible	Deductible, 20% of Usual & Customary Amount	None.
	Skilled nursing care	20% coinsurance after the deductible	Deductible, 20% of Usual & Customary Amount	Up to 120 days per person per calendar year. Pre-certification required.
	Durable medical equipment	20% coinsurance after the deductible	Deductible, 20% of Usual & Customary Amount	Pre-authorization recommended if equipment over $2,000 to buy or $250 per month to rent.
	Hospice services	Plan pays 100%	Plan pays 100% of Usual & Customary Amount	Services must be provided by an agency that is licensed by the state or Medicare-certified. Respite Care is limited to 14 days.
If your child needs dental or eye care	Children's eye exam	Children's eye exam	10% co-insurance	10% co-insurance
	Children's glasses	Children's glasses	Plan pays 100% up to $60 per Frame	Plan pays 100% up to $60 per Frame
	Children's dental check-up	Children's dental check-up	Plan pays 90% of Usual & Customary Amount	None.

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
- Hearing aids
- Infertility treatment
- Long-term care
- Massage Therapy
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing
- Routine foot care

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

- Chiropractic care
- 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: U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa/healthreform, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cciio.cms.gov. 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 on how 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: Inland Empire Teamsters Trust, PO Box 5433, Spokane WA 99205, 1-800-872-8979. You may also contact the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa/healthreform.

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 (Española): Para obtener asistencia end Español, llame al 1-800-872-8979
Tagalog (Tagalog): Kung Kalanga ninyo ang tulong as Tagalog tumawag sa 1-800-872-8979
Chinese (中文): 如果需要中文的帮助，请拨打这个号码 1-800-872-8979.
Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-800-872-8979.

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	$300
Specialist *[cost sharing]*	20%
Hospital (facility) *[cost sharing]*	20%
Other *[cost sharing]*	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	**$7,540**
In this example, Peg would pay:	
Cost Sharing	
Deductibles	$300
Copayments	$0
Coinsurance	$1,448
What isn't covered	
Limits or exclusions	$150
The total Peg would pay is	**$1,898**

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

The plan's overall deductible	$300
Specialist *[cost sharing]*	20%
Hospital (facility) *[cost sharing]*	20%
Other *[cost sharing]*	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	**$5,400**
In this example, Joe would pay:	
Cost Sharing	
Deductibles	$300
Copayments	$75
Coinsurance	$945
What isn't covered	
Limits or exclusions	$80
The total Joe would pay is	**$1,400**

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

The plan's overall deductible	$300
Specialist *[cost sharing]*	20%
Hospital (facility) *[cost sharing]*	20%
Other *[cost sharing]*	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	**$2,020**
In this example, Mia would pay:	
Cost Sharing	
Deductibles	$300
Copayments	$100
Coinsurance	$244
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$644**

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