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,visit www.scdairyfund.org or call 866-481-5841. 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.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	$100 person /$300 family. Amounts used to satisfy the deductible in last quarter can also be used to satisfy next year's 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?	No.	You will have to meet the deductible before the plan pays for any services.
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?	Medical: $1,000 per person / $8,000 per family. Prescription: $1,300 per person / $4,000 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.
What is not included in the out-of-pocket limit?	Premiums, balance-billed charges (including balance billing for the Fund's mandatory generic program) (unless balance billing is prohibited), deductibles, penalties for failure to pre-certify 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. Visit www.bluecrossca.com to view the list of PPO providers or call the Fund office at (562) 463-5033 or (866)481-5841 and request a directory.	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.

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	20% coinsurance	40% of allowed amount + balance	After deductible
	Specialist visit	20% coinsurance	40% of allowed amount + balance	After deductible
	Preventive care/screening/ immunization	No charge	Not covered	Non-preventative physical exams for employees, spouses/domestic partners are allowed up to $500 per visit.
If you have a test	Diagnostic test (x-ray, blood work)	20% coinsurance	40% of allowed amount + balance	After deductible. X-rays ordered by a chiropractor limited to one set per year
	Imaging (CT/PET scans, MRIs)	20% coinsurance. No charge for preventative imaging.	40% of allowed amount + balance	You may be balance billed if you use a non-PPO provider.
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.savrx.com or call 1-800-228-3108.	Generic drugs	$5.75 copay per prescription for Retail; $11.50 copay for Mail Order	If you live more than 15 miles from a network pharmacy, the Fund will reimburse 75% of the cost.	Maximum day supply – 30-day retail; 90-day mail. Mail order mandatory for maintenance medications. Preferred & non-preferred brand drugs are only covered when a generic is not available or with letter of medical necessity from your physician. If brand is requested without physician request, copay will be difference between cost of brand and generic medication. Out-of-network coinsurance applies if you live15 or more miles from a Sav-Rx pharmacy.
	Preferred brand drugs	$11.50 copay per prescription for Retail; $23.00 copay for Mail Order		
	Non-preferred brand drugs	$28.75 copay per prescription for Retail; $40.25 copay for Mail Order		
	Specialty drugs	Same copays apply (Generic, Preferred brand or Non-preferred Brand)		Prior authorization required – 30-day supply
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance	40% of allowed amount + balance	After deductible. For non-PPO, 20% coinsurance if you live more than 20 miles from PPO provider.
	Physician/surgeon fees	20% coinsurance	40% of allowed amount +	After deductible.

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)	
			balance	
If you need immediate medical attention	Emergency room care	20% coinsurance	20% of allowed amount + balance	After deductible.
	Emergency medical transportation	20% coinsurance	20% of allowed amount + balance	After deductible.
	Urgent care	20% coinsurance	40% of allowed amount + balance	After deductible.
If you have a hospital stay	Facility fee (e.g., hospital room)	No charge	40% of allowed amount + balance	After deductible. Inpatient certification required by Anthem Blue Cross, 800-274-7767. Otherwise benefit payments will be reduced by 50%. For non-PPO, 20% coinsurance if you live more than 20 miles from PPO provider.
	Physician/surgeon fees	20% coinsurance	40% of allowed amount + balance	After deductible.
If you need mental health, behavioral health, or substance abuse services. For help, contact HMC Healthworks at 1-800-431-5036.	Outpatient services	No charge	40% of allowed amount + balance	Not subject to deductible. Precertification requirements for certain services such as ECT, Psych testing and Neuropsych testing. For non-PPO, 20% coinsurance if you live more than 20 miles from PPO provider.
	Inpatient services	No charge	40% of allowed amount + balance	Not subject to deductible. Precertification requirements for certain services such as ECT, Psych testing and Neuropsych testing. For non-PPO, 20% coinsurance if you live more than 20 miles from PPO provider.
If you are pregnant	Office visits	20% coinsurance. No charge for preventive services.	40% of allowed amount + balance	After deductible
	Childbirth/delivery facility services	20% coinsurance	40% of allowed amount + balance	After deductible
If you need help recovering or have other special health needs	Home health care	20% coinsurance	20% of allowed amount + balance	After deductible
	Rehabilitation services	20% coinsurance	40% of allowed amount + balance	After deductible

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)	
	Habilitation services	Not covered	Not covered	None
	Skilled nursing care	20% coinsurance	40% of allowed amount + balance	After deductible
	Durable medical equipment	20% coinsurance	20% of allowed amount + balance	After deductible
	Hospice services	20% coinsurance	20% of allowed amount + balance	Not subject to deductible
If your child needs dental or eye care	Children's eye exam	$5 copay	Up to $45 reimbursed	Provided through Vision Service Plan (VSP). Limited to one exam every 12 months. Lenses - 1 pair every 12 months, only if needed. Frames are limited to one set every 24 months, only if needed. The allowance for frames is $120.00; out-of-network benefits are scheduled.
	Children's glasses	No charge; $120 frame allowance (glasses or contact lenses)	Up to $47 reimbursed; subject to balance billing.	
	Children's dental check-up	Dental HMO – No charge Dental PPO – No charge	Dental HMO – Not covered Dental PPO – No charge up to the allowance in fee schedule; subject to balance billing.	Provided by Liberty Dental through a separate trust fund. Employee selects either the dental HMO or the dental PPO.

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
- Genetic counseling
- Hearing Aids
- Infertility Treatment
- Long term care
- Non-Emergency Care when traveling outside the U.S.
- Private Duty Nursing
- Weight loss programs
- 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 - Refer to Vision Service Plan (VSP) 1-800-877-7195	• Routine Dental Care – Adult – Refer to Dental Plans through the Teamsters Miscellaneous Security Trust Fund

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 Health and Human Services Center for Consumer Information and Insurance Oversight, 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: the Administrative Office of the Southern California Dairy Industry Security Fund at 1200 Wilshire Blvd., Fifth Floor, Los Angeles, CA 90017-1906, or call 1-866-481-5841.

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 1-866-481-5841.

[Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-866-481-5841.

[Chinese (中文): 如果需要中文的帮助，请拨打这个号码 1-866-481-5841.

[Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-866-481-5841.

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	$100
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	$12,700

In this example, Peg would pay:

Cost Sharing	
Deductibles	$100
Copayments	$0
Coinsurance	$900
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	$1,060

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

The plan's overall deductible	$100
Specialist *[cost sharing]*	20%
Hospital (facility) *[cost sharing]*	$0
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	$5,600

In this example, Joe would pay:

Cost Sharing	
Deductibles	$100
Copayments	$0
Coinsurance	$900
What isn't covered	
Limits or exclusions	$55
The total Joe would pay is	$1,055

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

The plan's overall deductible	$100
Specialist *[cost sharing]*	20%
Hospital (facility) *[cost sharing]*	$0
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	$2,800

In this example, Mia would pay:

Cost Sharing	
Deductibles	$100
Copayments	$0
Coinsurance	$540
What isn't covered	
Limits or exclusions	$300
The total Mia would pay is	$940

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