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, call 1-800-JBT-HELP (1-800-528-4357) or see www.jointbenefittrust.com. 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 1-800-JBT-HELP to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	**$300**/person or **$750**/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, office visits, hospice services, hearing services, substance abuse services, and outpatient prescription drugs.	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-benefits/
Are there other deductibles for specific services?	**Yes. $50**/person or **$100/family** for dental. There are no other specific deductibles.	You must pay all of the costs for these services up to the specific deductible amount before this plan begins to pay for these services.
What is the out-of-pocket limit for this plan?	Medical plan network providers: $3,000/individual, $6,000/family; Prescription drugs (in-network): $3,600/individual, $7,200/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-billing charges, penalties for failure to obtain preauthorization, all services provided by out-of-network providers inside California except in the case of a true medical emergency, and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out-of-pocket limit.

Important Questions	Answers	Why This Matters:
Will you pay less if you use a network provider?	Yes. See www.anthem.com/ca or call 1-833-346-3365 for a list of medical network providers in the state of California. For Blue Card medical network providers outside of California, call 800-810-2583. Call Managed Health Network (MHN) at 1-800-528-0646 for mental health providers. Call Teamsters Alcohol/Drug Rehabilitation Program (TARP) at 1-800-522-8277 for substance abuse providers. Call Landmark Healthcare at 1-800-638-4557 for chiropractic providers. Call the Administrative Office at 1-800-528-4357 for the mammography network.	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 copayment/visit. Deductible does not apply.	Not covered.	None.
	Specialist visit	$20 copayment/visit. Deductible does not apply.	Not covered.	None.
	Preventive care/screening/ immunization	No charge. Deductible does not apply.	Not covered.	• You may have to pay for services that aren't preventive. Check with the Administrative Office regarding whether if the services needed are considered preventive. Then check what your plan will pay for. • Mammograms must be done through the Mammography network (rather than Anthem) in order to paid as a preventive service. Maximum Plan payment for a mammogram is $163/exam.

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 a test	Diagnostic test (x-ray, blood work)	20% coinsurance	Not covered.	Maximum Plan payment for a mammogram is $163/exam.
	Imaging (CT/PET scans, MRIs)	20% coinsurance	Not covered.	Preauthorization of certain diagnostic imaging and tests is required to avoid a penalty of nonpayment.
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.caremark.com	Formulary Generic drugs	Deductible does not apply. Retail pharmacy for 30 day supply: $10 copayment per fill; Mail Order for 90 day supply: $20 copayment per fill.	Not covered	• Preauthorization required for certain drugs (including opioids) or the plan will not pay for the prescription. • No charge for FDA-approved **formulary generic** contraceptives. No charge for **formulary brand name** contraceptives if a formulary generic is medically inappropriate. No charge for **non-formulary contraceptive** if *both* a formulary generic *and* formulary brand contraceptive are medically inappropriate. • Copayments are waived for certain generic drugs for patients who participate in the Chronic Disease Management Program.
	Formulary Brand drugs (Preferred brand drugs)	Deductible does not apply. Retail pharmacy for 30 day supply: $20 copayment per fill; Mail Order for 90 day supply: $40 copayment per fill.	Not covered	
	Non-formulary drugs (Non-preferred brand drugs and Non-preferred generic drugs)	Not covered	Not covered	You pay 100% for these drugs, even in-network.
	Specialty drugs	Deductible does not apply. $40 copayment per fill through mail order.	Not covered	Preauthorization required for certain Specialty Drugs or the plan will not pay for the prescription.

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)	20% coinsurance	Not covered.	Preauthorization is required for certain procedures.
	Physician/surgeon fees	20% coinsurance	Not covered.	None.
If you need immediate medical attention	Emergency room care	10% coinsurance if you are admitted directly to a hospital. 20% coinsurance if you are not admitted to a hospital.	Medical emergency: 10% coinsurance if you are admitted directly to a hospital; 20% coinsurance if you are not admitted to a hospital. Non-emergency: Not covered.	If the definition of "emergency" is met, services provided by out-of-network providers are payable at the In-Network level.
	Emergency medical transportation	20% coinsurance	Medical emergency: 20% coinsurance Non-emergency: Not covered.	None.
	Urgent care	10% coinsurance if you are admitted directly to a hospital. 20% coinsurance if you are not admitted to a hospital.	Not covered.	None.
If you have a hospital stay	Facility fee (e.g., hospital room)	10% coinsurance	Not covered.	• Elective hospital admission requires preauthorization to avoid a 50% reduction in your benefit. • Maximum Plan payment is $35,000 for a single routine total hip or knee replacement.
	Physician/surgeon fees	20% coinsurance	Not covered.	None.

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	Outpatient services	• Mental Health Private Counseling: Visits 1-5: No charge; Visits 6-10: $10 copayment/visit; Visits 11+: $20 copayment/visit; • Mental Health Group Counseling: No charge • Substance Abuse services: No charge, deductible does not apply	Not covered.	None.
	Inpatient services	Mental Health: No charge Substance Abuse services: No charge, deductible does not apply	Not covered.	Elective admission for mental health and residential treatment program admission requires preauthorization by MHN to avoid a 50% reduction in your benefit. Elective admission for substance abuse services requires preauthorization by TARP.
If you are pregnant	Office visits	No Charge, deductible does not apply	Not covered.	• Cost sharing does not apply for preventive services (well-woman pre-conception or prenatal care). • Maternity care may include tests and services described somewhere else in the SBC (i.e., ultrasound). • Prenatal care (other than certain preventive screenings) and childbirth/delivery is not covered for dependent children. • Preauthorization required only if hospital stay is more than 48 hours for vaginal delivery or 96 hours for C-section.
	Childbirth/delivery professional services	20% coinsurance	Not covered.	
	Childbirth/delivery facility services	10% coinsurance	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)	
If you need help recovering or have other special health needs	Home health care	20% coinsurance	Not covered.	Preauthorization of home health care services is required.
	Rehabilitation services	Inpatient 10% coinsurance Outpatient 20% coinsurance	Not covered.	Preauthorization is required for inpatient admission and outpatient physical therapy after 20 visits. If you fail to get your inpatient admission preauthorized, benefits could be reduced by 50%.
	Habilitation services	Not covered.	Not covered.	You pay 100% of this service, even in-network.
	Skilled nursing care	10% coinsurance	Not covered.	Preauthorization of skilled nursing facility admission is required to avoid a 50% reduction in your benefit.
	Durable medical equipment	20% coinsurance	Not covered.	Preauthorization is required for durable medical equipment costing over $1,000.
	Hospice services	No charge, deductible does not apply.	Not covered.	Covered if life expectancy is less than 6 months.
If your child needs dental or eye care	Children's eye exam	Covered under a separate vision plan.	Covered under a separate vision plan.	Contact the Administrative Office for information regarding your vision plan.
	Children's glasses			
	Children's dental check-up	Covered under a separate dental plan.	Covered under a separate dental plan.	If you work for an employer other than Olam contact the Administrative Office for information regarding your dental plan. If you are an Olam employee, contact Olam for information regarding your dental plan.

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.)

- Cosmetic surgery
- Dental care (provided under a separate dental plan)
- Habilitation services
- Hearing Aid (Dependents)
- Infertility treatment
- Long-term care
- Non-emergency care when traveling outside the U.S. (excluding Mexico)
- Non-Formulary Drugs (Non-preferred brand drugs and Non-preferred generic drugs)
- Private-duty nursing
- Routine foot care
- Weight loss programs (except as required by the health reform law)
- Routine eye care (covered under a separate vision plan)

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)		
• Acupuncture (Preauthorization is required after 20th visit per year)	• Bariatric surgery • Chiropractic care ($680/person annual maximum for care received from Landmark and Anthem providers combined)	• Hearing Aid (Employee only) $500/ear every 3 years

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: the 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: the Administrative Office at 1-800-JBT-HELP (1-800-528-4357) or see www.jointbenefittrust.com. 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.

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 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 1-800-JBT-HELP (1-800-528-4357).
Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-JBT-HELP (1-800-528-4357).
Chinese (中文): 如果需要中文的帮助，请拨打这个号码 1-800-JBT-HELP (1-800-528-4357).

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	$300
Specialist coinsurance	$20
Hospital (facility) coinsurance	
▪ In-Patient	10%
▪ Out-Patient	20%
Other coinsurance	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	**$12,800**
In this example, Peg would pay:	
Cost Sharing	
Deductibles	$300
Copayments	$30
Coinsurance	$1,330
What isn't covered	
Limits or exclusions	$10
The total Peg would pay is	**$1,670**

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 copayment	$20
Hospital (facility) coinsurance	
▪ In-Patient	10%
▪ Out-Patient	20%
Other coinsurance	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	**$7,400**
In this example, Joe would pay:	
Cost Sharing	
Deductibles	$300
Copayments	$720
Coinsurance	$310
What isn't covered	
Limits or exclusions	$30
The total Joe would pay is	**$1,360**

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

The plan's overall deductible	$300
Specialist copayment	$20
Hospital (facility) coinsurance	
▪ In-Patient	10%
▪ Out-Patient	20%
Other coinsurance	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	**$1,900**
In this example, Mia would pay:	
Cost Sharing	
Deductibles	$300
Copayments	$80
Coinsurance	$260
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$640**

NOTE: These numbers assume the patient does not participate in the plan's Chronic Disease Management Program. If you participate in the plan's Chronic Disease Management Program, you may be able to reduce your cost. For more information about the Chronic Disease Management Program, please contact the Administrative Office at 1-800-JBT-HELP (1-800-528-4357) or see www.jointbenefittrust.com.

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