The Summary of Benefits and Coverage (SBC) document will help you choose a health <u>plan</u>. The SBC shows you how you and the <u>plan</u> would share the cost for covered health care services. NOTE: Information about the cost of this <u>plan</u> (called the <u>premium</u>) 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 <u>www.tcu-mtawelfare.org</u> or call 800-427-5342. For general definitions of common terms, such as <u>allowed amount</u>, <u>balance billing</u>, <u>coinsurance</u>, <u>copayment</u>, <u>deductible</u>, <u>provider</u>, or other <u>underlined</u> terms, see the Glossary. You can view the Glossary at https://www.healthcare.gov/sbc-qlossary or call 1-800-278-3296 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	\$50/individual or \$150/family	Generally, you must pay all of the costs from <u>providers</u> up to the <u>deductible</u> amount before this <u>plan</u> begins to pay. If you have other family members on the <u>plan</u> , each family member must meet their own individual <u>deductible</u> until the total amount of <u>deductible</u> expenses paid by all family members meets the overall family <u>deductible</u> .
Are there services covered before you meet your deductible?	No.	You will have to meet the <u>deductible</u> before the <u>plan</u> pays for any services.
Are there other deductibles for specific services?	No.	You don't have to meet <u>deductibles</u> for specific services.
What is the <u>out-of-pocket</u> <u>limit</u> for this <u>plan</u> ?	\$1,000/individual.	The out-of-pocket limit is the most you could pay in a year for covered services.
What is not included in the <u>out-of-pocket limit</u> ?	Deductibles, the \$250 per admission non-PPO hospital copayment, prescription drug expenses, premiums, balance billing charges, and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u> .
Will you pay less if you use a <u>network provider</u> ?	Yes. See www.myfirsthealth.com or call 1-800-226-5516 for a list of	

	What You Will Pay		Limitations Everations 9 Other
Services You May Need	PPO Provider (You will pay the least)	NON-PPO Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information
Primary care visit to treat an injury or illness	20% <u>coinsurance</u>	20% <u>coinsurance</u>	If you use a non-PPO <u>provider</u> , you may be <u>balance billed</u> for charges above the <u>allowed amount</u> .
Specialist visit	20% <u>coinsurance</u>	20% <u>coinsurance</u>	You may be <u>balance billed</u> if you use a non- PPO <u>provider</u> .
Preventive care/screening/ immunization	20% <u>coinsurance</u>	20% <u>coinsurance</u>	Physical exam is limited to an intermediate office visit, CBC, urinalysis, and EKG (treadmill test excluded). Health exams otherwise not covered unless incident to Injury or Sickness. You may be balance billed if you use a non-PPO provider.
Diagnostic test (x-ray, blood work)	20% <u>coinsurance</u>	20% <u>coinsurance</u>	Covered only in connection with an Injury or Sickness or as provided under the physical examination (includes CBC, urinalysis, and EKG; excludes treadmill test) or well childcare benefit. You may be balance billed if you use a non-PPO provider.
Imaging (CT/PET scans, MRIs)	20% <u>coinsurance</u>	20% <u>coinsurance</u>	You may be <u>balance billed</u> if you use a non-PPO <u>provider</u> .
Generic and brand drugs	20% <u>coinsurance</u>	Not covered	Prescriptions must be filled at a Sav-Rx pharmacy, and you must present your Sav-Rx card at the pharmacy or no coverage. You pay for your prescription, then submit your claim and receipt to the Administrative Office for reimbursement.
	Primary care visit to treat an injury or illness Specialist visit Preventive care/screening/immunization Diagnostic test (x-ray, blood work) Imaging (CT/PET scans, MRIs)	Primary care visit to treat an injury or illness Specialist visit Preventive care/screening/immunization Diagnostic test (x-ray, blood work) Diagnog (CT/PET scans, MRIs) PPO Provider (You will pay the least) 20% coinsurance 20% coinsurance 20% coinsurance 20% coinsurance 20% coinsurance	Services You May Need PPO Provider (You will pay the least) NON-PPO Provider (You will pay the most) Primary care visit to treat an injury or illness 20% coinsurance 20% coinsurance Specialist visit 20% coinsurance 20% coinsurance Preventive care/screening/immunization 20% coinsurance 20% coinsurance Diagnostic test (x-ray, blood work) 20% coinsurance 20% coinsurance Imaging (CT/PET scans, MRIs) 20% coinsurance 20% coinsurance

		What Yo	u Will Pay	Limitations Evacations & Other
Common Medical Event	Services You May Need	PPO Provider (You will pay the least)	NON-PPO Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information
If you have outpatient	Facility fee (e.g., ambulatory surgery center)	No charge.	20% <u>coinsurance</u>	You may be <u>balance billed</u> if you use a non- PPO provider.
surgery	Physician/surgeon fees	20% <u>coinsurance</u>	20% <u>coinsurance</u>	You may be <u>balance billed</u> if you use a non- PPO <u>provider</u> .
	Emergency room care	20% <u>coinsurance</u>	20% <u>coinsurance</u>	You may be <u>balance billed</u> if you use a non- PPO <u>provider</u> .
If you need immediate medical attention	Emergency medical transportation	20% <u>coinsurance</u>	20% <u>coinsurance</u>	You may be <u>balance billed</u> if you use a non- PPO <u>provider</u> .
	Urgent care	20% <u>coinsurance</u>	20% <u>coinsurance</u>	You may be <u>balance billed</u> if you use a non- PPO <u>provider</u> .
If you have a hospital	Facility fee (e.g., hospital room)	No charge	\$250 <u>copay</u> per admission plus 20% <u>coinsurance</u>	Heart, heart/lung, and liver transplants are not covered. You may be <u>balance billed</u> if you use a non-PPO <u>provider</u> .
stay	Physician/surgeon fees	20% <u>coinsurance</u>	20% <u>coinsurance</u>	Heart, heart/lung, and liver transplants are not covered. You may be <u>balance billed</u> if you use a non-PPO <u>provider</u> .
If you need mental health, behavioral	Outpatient services	20% <u>coinsurance</u>	20% <u>coinsurance</u>	You may be <u>balance billed</u> if you use a non- PPO <u>provider</u> .
health, or substance abuse services	Inpatient services	No charge	20% <u>coinsurance</u>	You may be <u>balance billed</u> if you use a non- PPO <u>provider</u> .
	Office visits	20% <u>coinsurance</u>	20% <u>coinsurance</u>	Maternity care may include tests and
	Childbirth/delivery professional services	No charge	20% <u>coinsurance</u>	services described elsewhere in the SBC (e.g., ultrasound).
If you are pregnant				Dependent child maternity care and delivery charges are not covered.
	Childbirth/delivery facility services		20% <u>coinsurance</u>	Any expenses related to a surrogacy arrangement or pregnancy of a surrogate mother are not covered. You may be <u>balance billed</u> if you use a non-PPO <u>provider</u> .
If you need help recovering or have other special health	Home health care	20% <u>coinsurance</u>	20% <u>coinsurance</u>	Excludes custodial care and homemaker services. You may be <u>balance billed</u> if you use a non-PPO <u>provider</u> .

 $^{[^*\} For\ more\ information\ about\ limitations\ and\ exceptions,\ see\ the\ \underline{plan}\ or\ policy\ document\ at\ [www.insert.com].]$

		What You Will Pay		Limitations, Exceptions, & Other
Common Medical Event	Services You May Need	PPO Provider (You will pay the least)	NON-PPO Provider (You will pay the most)	Important Information
needs	Rehabilitation services	20% <u>coinsurance</u>	20% <u>coinsurance</u>	Excludes educational and vocational training. You may be <u>balance billed</u> if you use a non-PPO provider.
	Habilitation services	Not covered	Not covered	None
	Skilled nursing care	20% <u>coinsurance</u>	20% <u>coinsurance</u>	Plan only pays nursing care facility confinements if first hospitalized for minimum of 7 days, confined within 14 days of hospital discharge, and recommended by physician. Maximum of 180 days for each condition or related cause. You may be balance billed if you use a non-PPO provider.
	Durable medical equipment	20% <u>coinsurance</u>	20% <u>coinsurance</u>	You may be <u>balance billed</u> if you use a non- PPO <u>provider</u> .
	Hospice services	20% <u>coinsurance</u>	20% <u>coinsurance</u>	Plan pays only if certified by physician and preauthorized by Trust. You may be balance billed if you use a non-PPO provider.
	Children's eye exam	Not covered	Not covered	Coverage available under separate VSP
If your child needs dental or eye care	Children's glasses	Not covered	Not covered	Choice Plan or VSP Signature Plan.
	Children's dental check-up	Not covered	Not covered	Coverage available under Fee-for-Service Dental Plan or United Concordia Dental HMO 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

Infertility treatment

Private duty nursing

Habilitation services

Long-term care

Weight loss programs

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

- Acupuncture (unless administered as surgery)
- Bariatric surgery (must have BMI of 40 or greater)

- Dental Care (Adult) (coverage available under separate Fee-for-Service Dental Plan or United Concordia Dental HMO)
 Hearing aids (one device/ear every 5 years,
- outside the U.S.Routine eye care (Adult) (benefits
 - Routine eye care (Adult) (benefits available under separate VSP plan)

Non-emergency care when traveling

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

Chiropractic care (must be <u>medically</u> necessary)

maximum of \$500 per device)

Routine foot care (if <u>medically necessary</u>).

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 <u>plan</u> for a denial of a <u>claim</u>. This complaint is called a <u>grievance</u> or <u>appeal</u>. For more information about your rights, look at the explanation of benefits you will receive for that medical <u>claim</u>. Your <u>plan</u> documents also provide complete information on how to submit a <u>claim</u>, <u>appeal</u>, or a <u>grievance</u> for any reason to your <u>plan</u>. For more information about your rights, this notice, or assistance, contact: the Administrative Office of the TCU-LA MTA Health & Welfare Fund at 1200 Wilshire Blvd., Fifth Floor, Los Angeles, CA 90017-1906, or by calling 1-800-427-5342.

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 1-800-427-5342.

[Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-427-5342.

[Chinese (中文): 如果需要中文的帮助,请拨打这个号码 1-800-427-5342.

[Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-800-427-5342.

To see examples of how this <u>plan</u> 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 <u>plan</u> might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your <u>providers</u> charge, and many other factors. Focus on the <u>cost sharing</u> amounts (<u>deductibles</u>, <u>copayments</u>, and <u>coinsurance</u>) and <u>excluded services</u> under the <u>plan</u>. Use this information to compare the portion of costs you might pay under different health <u>plans</u>. 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 <u>plan's</u> overall <u>deductible</u>	\$50
■ Specialist coinsurance	20%
■ Hospital (facility) cost sharing	\$0
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	\$12,700	
In this example, Peg would pay:		
Cost Sharing		
<u>Deductibles</u>	\$50	
<u>Copayments</u>	\$0	
Coinsurance	\$2,530	
What isn't covered		
Limits or exclusions	\$60	
The total Peg would pay is	\$2,640	

Managing Joe's Type 2 Diabetes

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

■ The <u>plan's</u> overall <u>deductible</u>	\$50
■ <u>Specialist coinsurance</u>	20%
■ Hospital (facility) cost sharing	\$0
Other <u>coinsurance</u>	20%

This EXAMPLE event includes services like:

<u>Primary care physician</u> office visits (including disease education)

Diagnostic tests (blood work)

Prescription drugs

<u>Durable medical equipment</u> (glucose meter)

Total Example Cost	\$5,600	
In this example, Joe would pay:		
Cost Sharing		
<u>Deductibles</u>	\$50	
Copayments	\$0	
Coinsurance	\$1,110	
What isn't covered		
Limits or exclusions	\$55	
The total Joe would pay is	\$1,215	

Mia's Simple Fracture

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

■ The <u>plan's</u> overall <u>deductible</u>	\$50
■ Specialist coinsurance	20%
■ Hospital (facility) cost sharing	\$0
Other <u>coinsurance</u>	20%

This EXAMPLE event includes services like:

Emergency room care (including medical supplies)

<u>Diagnostic test</u> (*x-ray*)

<u>Durable medical equipment</u> (crutches)

Rehabilitation services (physical therapy)

Total Example Cost	\$2,800	
In this example, Mia would pay:		
Cost Sharing		
<u>Deductibles</u>	\$50	
Copayments	\$0	
Coinsurance	\$550	
What isn't covered		
Limits or exclusions	\$0	
The total Mia would pay is	\$600	