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, www.tcu-mtawelfare.org or call 800-427-5342. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible,

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 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
Are there services covered before you meet your	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	$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 out-of-pocket limit?	Deductibles, the $250 per admission non-PPO hospital copayment, prescription drug expenses, premiums, balance billing charges,	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.myfirsthealth.com or call 1-800-226-5516 for a list of network providers.	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
Do you need a referral to see a	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: PPO Provider (You will pay the	What You Will Pay: NON-PPO Provider (You will	Limitations, Exceptions, & Other Important Information
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	20% coinsurance	20% coinsurance	If you use a non-PPO provider, you may be balance billed for charges above the allowed amount.
	Specialist visit	20% coinsurance	20% coinsurance	You may be balance billed if you use a non- PPO provider.
	Preventive care/screening/ immunization	20% coinsurance	20% coinsurance	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.
If you have a test	Diagnostic test (x-ray, blood work)	20% coinsurance	20% coinsurance	Covered only in connection with an Injury or Sickness or as provided under the physical examination (CBC, urinalysis and EKG, treadmill test is excluded) or well childcare benefit. You may be balance billed if you
	Imaging (CT/PET scans, MRIs)	20% coinsurance	20% coinsurance	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	Generic and Brand drugs	20% coinsurance	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.
If you have	Facility fee (e.g.,	No charge.	20% coinsurance	You may be balance billed if you use a

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

Common Medical Event	Services You May Need	What You Will Pay: PPO Provider (You will pay the	What You Will Pay: NON-PPO Provider (You will	Limitations, Exceptions, & Other Important Information
				PPO provider.
	Habilitation services	Not covered	Not covered	None
	Skilled nursing care	20% coinsurance	20% coinsurance	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
	Durable medical equipment	20% coinsurance	20% coinsurance	You may be balance billed if you use a non- PPO provider.
	Hospice services	20% coinsurance	20% coinsurance	Plan pays only if certified by physician and preauthorized by Trust. You may be balance billed if you use a non-
If your child needs dental or eye care	Children's eye exam	Not covered	Not covered	Coverage available under separate VSP Choice Plan or
	Children's glasses	Not covered	Not covered	
	Children's dental check-up	Not covered	Not covered	Coverage available under the 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

- Cosmetic surgery
- Dental Care (Adult) (coverage available under separate Fee-for-Service Dental Plan or United Concordia Dental HMO)
- Infertility treatment
- Long-term care
- Private duty nursing
- Routine eye care (Adult) (benefits available under separate VSP plan)
- 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)
- Hearing aids (one device/ear every 5 years, maximum of $500 per device)
- Non-emergency care when traveling
- Routine foot care (if medically necessary).

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 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 TCU-LA MTA Health & Welfare Fund at 13191 Crossroads Parkway North Suite 205, City of Industry, CA 91746-3434, or call 1-800-427-5342.

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 1-800-427-5342.
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，请请打请个号请 1-800-427-5342.
Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-800-427-5342.

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	**$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	**$12,73**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$50
Copayments	$0
Coinsurance	$950
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	**$50**
Specialist coinsurance	**20%**
Hospital (facility) cost sharing	**$0**
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	**$738**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$50
Copayments	$0
Coinsurance	$950
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	**$50**
Specialist coinsurance	**20%**
Hospital (facility) cost	**$0**
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	**$192**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$50
Copayments	$0
Coinsurance	$385
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	$435

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