TCIU LA MTA Health & Welfare Trust: Fee For Service Plan

Coverage Period: 01/01/2015 – 12/31/2015

Summary of Benefits and Coverage: What this Plan Covers & What it Costs **Coverage for:** Individual + Dependents | **Plan Type:** PPO

This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at www.tcu-mtawelfare.org or by calling 1-800-427-5342.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	**$50** per person **$150** per family	You must pay all the costs up to the **deductible** amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the **deductible** starts over (usually, but not always, January 1st). See the chart starting on page 2 for how much you pay for covered services after you meet the **deductible.**
Are there other deductibles for specific services?	Yes, **$250** Per Hospital Admission for NON-PPO Only; **$20** per person & **$60** per family for fee-for service 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.
Is there an out–of–pocket limit on my expenses?	Yes. **$1,000.**	The **out-of-pocket limit** is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for you care expenses.
What is not included in the out–of–pocket limit?	Deductibles, premiums (employee contribution) balance billed charges and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the **out-of-pocket limit.**
Is there an overall annual limit on what the plan pays?	No.	The chart starting on page 2 describes any limits on what the plan will pay for specific covered services, such as office visits.
Does this plan use a network of providers?	Yes. For a list of PPO Providers, see www.myfirsthealth.com or call 1-800-226-5116.	If you use an in-network doctor or other health care **provider,** this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network providers in their **network.** See the chart starting on page 2 for how this plan pays different kinds of **providers.**
Do I 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.
Are there services this plan doesn't cover?	Yes.	Some of the services this plan doesn't cover are listed on page 6. See your policy plan document for additional information about **excluded services.**

Questions: Call 1-800-427-5342 or visit us at www.tcu-mtawelfare.org.
If you aren't clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary at www.dol.gov/ebsa/pdf/SBCUniformGlossary.pdf or call 1-800-427-5342 to request a copy.

- **Copayments** are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.
- **Coinsurance** is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is $1,000, your **coinsurance** payment of 20% would be $200. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges $1,500 for an overnight stay and the **allowed amount** is $1,000, you may have to pay the $500 difference. (This is called **balance billing**.)
- This plan may encourage you to use PPO **providers** by charging you lower **deductibles**, **copayments** and **coinsurance** amounts.

Common Medical Event	Services You May Need	Your Cost If You Use a PPO Provider	Your Cost If You Use a NON-PPO Provider	Limitations & Exceptions
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	20% Coinsurance	20% Coinsurance + 100% of charges in excess of allowed amount	none
	Specialist visit	20% Coinsurance	20% Coinsurance + 100% of charges in excess of allowed amount	none
	Other practitioner office visit	20% Coinsurance	20% Coinsurance + 100% of charges in excess of allowed amount	none
	Preventive care/screening/immunization	20% Coinsurance	20% Coinsurance + 100% of charges in excess of allowed amount	A physical exam is limited to an intermediate office visit, CBC, urinalysis and EKG. Health Exams otherwise not covered unless incident to injury or sickness

Common Medical Event	Services You May Need	Your Cost If You Use a PPO Provider	Your Cost If You Use a NON-PPO Provider	Limitations & Exceptions
If you have a test	Diagnostic test (x-ray, blood work)	20% Coinsurance	20% Coinsurance + 100% of charges in excess of allowed amount	none
	Imaging (CT/PET scans, MRIs)	20% Coinsurance	20% Coinsurance + 100% of charges in excess of allowed amount	none
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available by calling 1-800-427-5342. For a list of Sav-Rx pharmacies go to www.savrx.com.	Generic and Brand drugs	20% coinsurance	Not covered.	Prescriptions must be filled at a Sav-Rx pharmacy in order to be covered. You pay 100% of the cost of drug and submit claim for reimbursement to the Fund Office. The Fund will reimburse 80% of the cost.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	No charge.	20% Coinsurance + 100% of charges in excess of allowed amount	none
	Physician/surgeon fees	20% Coinsurance	20% Coinsurance + 100% of charges in excess of allowed amount	none

Common Medical Event	Services You May Need	Your Cost If You Use a PPO Provider	Your Cost If You Use a NON-PPO Provider	Limitations & Exceptions
If you need immediate medical attention	Emergency room services	20% Coinsurance	20% Coinsurance + 100% of charges in excess of allowed amount	none
	Emergency medical transportation	20% Coinsurance	20% Coinsurance + 100% of charges in excess of allowed amount	none
	Urgent care	20% Coinsurance	20% Coinsurance + 100% of charges in excess of allowed amount	none
If you have a hospital stay	Facility fee (e.g., hospital room)	No charge.	20% Coinsurance + 100% of charges in excess of allowed amount	none
	Physician/surgeon fee	20% Coinsurance	20% Coinsurance + 100% of charges in excess of allowed amount	none

Common Medical Event	Services You May Need	Your Cost If You Use a PPO Provider	Your Cost If You Use a NON-PPO Provider	Limitations & Exceptions
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	20% Coinsurance	20% Coinsurance + 100% of charges in excess of allowed amount	none
	Mental/Behavioral health inpatient services	No charge	20% Coinsurance + 100% of charges in excess of allowed amount	None
	Substance use disorder outpatient services	20% Coinsurance	20% Coinsurance + 100% of charges in excess of allowed amount	none
	Substance use disorder inpatient services	No charge	20% Coinsurance + 100% of charges in excess of allowed amount	None
If you are pregnant	Prenatal and postnatal care	20% Coinsurance	20% Coinsurance + 100% of charges in excess of allowed amount	Well child care services covered up to 6 years old; includes maximum of 3 days hospitalization following delivery (96 hours for children born by cesarean section).
	Delivery and all inpatient services	No charge	20% Coinsurance + 100% of charges in excess of allowed amount	none

Common Medical Event	Services You May Need	Your Cost If You Use a PPO Provider	Your Cost If You Use a NON-PPO Provider	Limitations & Exceptions
If you need help recovering or have other special health needs	Home health care	20% Coinsurance	20% Coinsurance + 100% of charges in excess of allowed amount	none
	Rehabilitation services	20% Coinsurance	20% Coinsurance + 100% of charges in excess of allowed amount	none
	Habilitation services	Not covered	Not covered	None
	Skilled nursing care	20% Coinsurance	20% Coinsurance + 100% of charges in excess of allowed amount	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 per disability.
	Durable medical equipment	20% Coinsurance	20% Coinsurance + 100% of charges in excess of allowed amount	None
	Hospice service	20% Coinsurance	20% Coinsurance + 100% of charges in excess of allowed amount	Plan pays only if certified by a physician and pre-authorized by Trust
If your child needs dental or eye care	Eye exam	Please contact the Fund Office for information about the vision plans offered through VSP.		
	Glasses	Please contact the Fund Office for information about the vision plans offered through VSP.		

Common Medical Event	Services You May Need	Your Cost If You Use a PPO Provider	Your Cost If You Use a NON-PPO Provider	Limitations & Exceptions
	Dental check-up	1st 12 months, 10% Coinsurance; thereafter, no charge to allowed amount. Alternatively, you can elect coverage under the United Concordia Dental HMO plan.		You are responsible for all charges above the allowed amount. Pediatric dental benefits are for children up to 18 years of age (effective February 1, 2014, up to 19 years of age).

Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy or plan document for other excluded services.)

- Cosmetic Surgery
- Habilitation Services
- Infertility Treatment
- Long Term Care
- Private duty nursing
- Reversal or attempted reversal of sterilization
- Weight loss programs

Other Covered Services (This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)

- Acupuncture (unless administered as surgery)
- Bariatric Surgery
- Chiropractic Care
- Dental Care (adult) (to a maximum of $2,000 per person per calendar year)
- Hearing Aids (maximum benefit of $500 per device, one per ear every 5 years)
- Non-emergency care when traveling outside the U.S.
- Routine eye care (adult) (benefits available under VSP visions plans, limitations apply)
- Routine foot care

Your Rights to Continue Coverage:

If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a **premium**, which may be significantly higher than the premium you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply.

For more information on your rights to continue coverage, contact the plan at (800) 427-5342. You may also contact your state insurance department, the US Department of Labor, Employee Benefits Security Administration at (866) 444-3272 or www.dol.gov/ebsa, or the US Department of Health and Human Services at (877) 267-2323 x61565 or www.cciio.cms.gov.

Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to **appeal** or file a **grievance**. For questions about your rights, this notice, or assistance, you can contact: 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. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cciio.cms.gov.

Does this Coverage Provide Minimum Essential Coverage?

The Affordable Care Act requires most people to have health care coverage that qualifies as "minimum essential coverage." **This plan or policy does provide minimum essential coverage.**

Does this Coverage Meet the Minimum Value Standard?

The Affordable Care Act establishes a minimum value standard of benefits of a health plan. The minimum value standard is 60% (actuarial value). **This health coverage does meet the minimum value standard for the benefits it provides.**

Language Access Services:

Para obtener asistencia en Español, llame al 1-800-427-5342.

To see examples of how this plan might cover costs for a sample medical situation, see the next page.

About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.

This is not a cost estimator.

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

Having a baby
(normal delivery)

- **Amount owed to providers:** $7,540
- **Plan pays** $6350
- **Patient pays** $1190

Sample care costs:

Hospital charges (mother)	$2,700
Routine obstetric care	$2,100
Hospital charges (baby)	$900
Anesthesia	$900
Laboratory tests	$500
Prescriptions	$200
Radiology	$200
Vaccines, other preventive	$40
Total	**$7,540**

Patient pays:

Deductibles	$50
Copays	$0
Coinsurance	$950
Limits or exclusions	$190
Total	**$1,190**

Managing type 2 diabetes
(routine maintenance of a well-controlled condition)

- **Amount owed to providers:** $5,400
- **Plan pays** $4180
- **Patient pays** $1220

Sample care costs:

Prescriptions	$2,900
Medical Equipment and Supplies	$1,300
Office Visits and Procedures	$700
Education	$300
Laboratory tests	$100
Vaccines, other preventive	$100
Total	**$5,400**

Patient pays:

Deductibles	$50
Copays	$0
Coinsurance	$950
Limits or exclusions	$220
Total	**$1,220**

Questions and answers about the Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

- Costs don't include **premiums**.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network **providers**. If the patient had received care from out-of-network **providers**, costs would have been higher.

What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how **deductibles**, **copayments**, and **coinsurance** can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

Does the Coverage Example predict my own care needs?

✘ **No.** Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

Does the Coverage Example predict my future expenses?

✘ **No.** Coverage Examples are **not** cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your **providers** charge, and the reimbursement your health plan allows.

Can I use Coverage Examples to compare plans?

✓ **Yes.** When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

Are there other costs I should consider when comparing plans?

✓ **Yes.** An important cost is the **premium** you pay. Generally, the lower your **premium**, the more you'll pay in out-of-pocket costs, such as **copayments**, **deductibles**, and **coinsurance**. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.