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.tcu-mtawelfare.org or call 800-427-5342. 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 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 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?	$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, 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. 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 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
		PPO Provider (You will pay the least)	NON-PPO 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	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. You may be balance billed if you use a non-PPO provider.
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 (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% 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 by calling 1-800-427-5432.	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.

[* For more information about limitations and exceptions, see the plan or policy document at [www.insert.com].]

Common Medical Event	Services You May Need	What You Will Pay PPO Provider (You will pay the least)	What You Will Pay NON-PPO Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	No charge.	20% coinsurance	You may be balance billed if you use a non-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 transportation	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 non-PPO provider.
	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 substance abuse services	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 (e.g., 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 use a non-PPO provider.
	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	Home health care	20% coinsurance	20% coinsurance	Excludes custodial care and homemaker services. You may be balance billed if you use a non-PPO provider.

Common Medical Event	Services You May Need	What You Will Pay PPO Provider (You will pay the least)	What You Will Pay NON-PPO Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information
needs	Rehabilitation services	20% coinsurance	20% coinsurance	Excludes educational and vocational training. You may be balance billed if you use a non-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 use a non-PPO provider.
	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-PPO provider.
If your child needs dental or eye care	Children's eye exam	Not covered	Not covered	Coverage available under separate VSP Choice Plan or VSP Signature Plan.
	Children's glasses	Not covered	Not covered	
	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
- Habilitation services
- Infertility treatment
- Long-term care
- Private duty nursing
- 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,
- Non-emergency care when traveling outside the U.S.
- Routine eye care (Adult) (benefits available under separate VSP plan)

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)		
• Chiropractic care (must be medically necessary)	maximum of $500 per device)	• 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 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 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 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	$12,700

In this example, Peg would pay:	
Cost Sharing	
Deductibles	$50
Copayments	$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 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	$5,600

In this example, Joe would pay:	
Cost Sharing	
Deductibles	$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 plan's overall deductible $50
- Specialist coinsurance 20%
- Hospital (facility) cost sharing $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	$2,800

In this example, Mia would pay:	
Cost Sharing	
Deductibles	$50
Copayments	$0
Coinsurance	$550
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	$600

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