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, contact the Trust Fund Office at 1-800-527-4613. 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 1-800-527-4613 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	$0	See the Common Medical Events chart below for your costs for services this plan covers.
Are there services covered before you meet your deductible?	Not applicable	This plan does not have a deductible.
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?	Medical plan Contract providers: $600/individual, Medical plan Non-Contract providers: $1,800/individual (interchangeable) Prescription Drugs Network pharmacies: $2,000/individual	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?	**Medical plan:** premiums, balance-billing charges, skilled nursing facility, charges from Non-Contract providers, charges in excess of benefit maximums, expenses for vision or dental care (if elected), outpatient prescription drugs, and health care this plan doesn't cover. **Prescription Drugs:** premiums, balance-billing charges, charges from Non-Network pharmacies, medical expenses, expenses for vision or dental care (if elected), and drugs 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.anthem.com or call 1-800-274-7767 for a list of medical Contract providers. See www.mhn.com or call 1-800-977-7962 for a list of Contract mental health and substance abuse 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.

Important Questions	Answers	Why This Matters:
Do you need a referral to see a specialist?	No.	You can see the specialist you choose without a referral.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Contract Provider (You will pay the least)	Non-Contract 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, then 10% coinsurance	$20 copayment/visit, then 40% coinsurance	Benefits paid by this Plan are reduced by the amounts payable under Medicare Parts A and B even if the Medicare-eligible individual is not yet enrolled in Medicare.
	Specialist visit			
	Preventive care/screening/ Immunization	***Services mandated by Health Reform:*** No charge. ***Other services:*** No charge if allowed by Medicare.	40% coinsurance	Age and frequency guidelines apply to covered preventive care. You may have to pay for services that aren't preventive care. Ask your provider if the services needed are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	10% coinsurance	40% coinsurance	Professional/physician charges may be billed separately.
	Imaging (CT/PET scans, MRIs)	10% coinsurance	40% coinsurance	
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.UHCRetiree.com	Generic drugs (Formulary generic drugs)	**Retail:** $10 copayment/script. **Mail order:** $20 copayment/script	Not covered (limited exceptions for emergency prescriptions)	• Limited to a 30-day supply at retail and a 90-day supply for mail-order. 90-day supply at retail subject to three times the applicable retail copayment. • No charge for ACA-required generic preventive care drugs (such as contraceptives) or brand name drugs if a generic is medically inappropriate. • Some prescription drugs are subject to preauthorization (to avoid non-payment), quantity limits or step therapy requirements. • Certain preventive care drugs are payable at no charge with a prescription.
	Preferred brand drugs (Formulary brand)	**Retail:** $20 copayment/script. **Mail order:** $40 copayment/script		
	Non-preferred brand drugs (Non-formulary generic or Non-formulary brand drugs)	**Retail:** $40 copayment/script. **Mail order:** $80 copayment/script		
	Specialty drugs	Same copayments as retail formulary generic and retail formulary brand drugs copayments.	Not covered.	• Specialty drugs must be purchased through the United Healthcare EGWP. Call (888) 556-6648. • Limited to a 30-day supply.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Contract Provider (You will pay the least)	Non-Contract Provider (You will pay the most)	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	10% coinsurance	40% coinsurance plus any amount above the Plan's maximum payment of $350/day in the facility	None.
	Physician/surgeon fees	10% coinsurance	40% coinsurance	None.
If you need immediate medical attention	Emergency room care	$100 copayment/visit, then 10% coinsurance	$100 copayment/visit, then 10% coinsurance.	Professional/physician charges may be billed separately. Copayment waived if admitted.
	Emergency medical transportation	$50 copayment/trip, then 10% coinsurance	$50 copayment/trip, then 10% coinsurance	Professional/physician charges may be billed separately. Covered when the medical condition of the patient requires paramedic support, or service to the nearest hospital that can provide appropriate treatment.
	Urgent care	$20 copayment/visit, then 10% coinsurance	$20 copayment/visit, then 40% coinsurance	Professional/physician charges may be billed separately.
If you have a hospital stay	Facility fee (e.g., hospital room)	$250 copayment/ admission	40% coinsurance	None.
	Physician/surgeon fees	10% coinsurance	40% coinsurance	None.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$20 copayment/visit, then 10% coinsurance	$20 copayment/visit, then 40% coinsurance	Substance abuse treatment is covered for the Retiree only. You must pay 100% for substance abuse services of your dependents, even in-network.
	Inpatient services	$250 copayment/ admission	40% coinsurance	
If you are pregnant	Office visits	$20 copayment/visit, then 10% coinsurance	$20 copayment/visit, then 40% coinsurance	• Cost sharing does not apply for Contract Provider preventive services. • Maternity care may include tests and services described elsewhere in the SBC (i.e., ultrasound).
	Childbirth/delivery professional services	$250 copayment/admission	40% coinsurance	None.
	Childbirth/delivery facility services	10% coinsurance	40% coinsurance	

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Contract Provider (You will pay the least)	Non-Contract Provider (You will pay the most)	
If you need help recovering or have other special health needs	Home health care	10% coinsurance	40% coinsurance	None.
	Rehabilitation services	10% coinsurance	40% coinsurance	None.
	Habilitation services	10% coinsurance	40% coinsurance	
	Skilled nursing care	55% coinsurance	65% coinsurance	Cost sharing does not count toward the medical out-of-pocket limit. Limited to 55 days/calendar year.
	Durable medical equipment	10% coinsurance	40% coinsurance	None
	Hospice services	No charge	No charge	Covered for patients with less than 6-month life expectancy.
If your child needs dental or eye care	Children's eye exam	Not covered	Not covered	If you elect vision coverage, it will be available under a separate vision plan.
	Children's glasses	Not covered	Not covered	
	Children's dental check-up	Not covered	Not covered	If you elect dental coverage, it will be available under a separate 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 (Adult, child) (available under separate dental plan)
- Infertility treatment
- Long-term care
- Non-emergency care when traveling outside U.S.
- Private-duty nursing
- Routine eye care (Adult, child) (available under separate vision plan).
- Substance abuse treatment for Dependents
- Weight loss programs (except as required by the health reform law)

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

- Acupuncture
- Bariatric surgery
- Chiropractic care
- Hearing aids ($2,000/device/ear; every 3 years)
- Routine foot care (Orthotics limited to a $200 max per calendar year. Coverage for Contract providers only and only for the employee.)

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 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 Trust Fund Office at 1-800-527-4613. 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

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 1-800-527-4613.
Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-527-4613.
Chinese (中文): 如果需要中文的帮助， **请拨打这个号码** 1-800-527-4613.
Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-800-527-4613.

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

IMPORTANT:

The results of the following coverage examples for this Medicare Plan shown on the next page assume the following:

(1) Medicare is the primary payer and that participants are enrolled in Medicare Part A and B.
(2) The plan uses the coordination method to integrate with Medicare.
(3) The allowed amounts used in the examples are assumed to be the same as allowed under Medicare.
(4) The Plan only pays the eligible portion of covered services that Medicare does not pay.

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** **$0**
- **Specialist copay/coinsurance** **$20/10%**
- **Hospital (facility) copay/coinsurance** **$250/10%**
- **Other coinsurance** **10%**

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	$0
Copayments	$200
Coinsurance	$410
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$670**

Managing Joe's type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

- **The plan's overall deductible** **$0**
- **Specialist copay/coinsurance** **$20/10%**
- **Hospital (facility) copay/coinsurance** **$250/10%**
- **Other coinsurance** **10%**

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	$0
Copayments	$900
Coinsurance	$80
What isn't covered	
Limits or exclusions	$230
The total Joe would pay is	**$1,210**

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

- **The plan's overall deductible** **$0**
- **Specialist copay/coinsurance** **$20/10%**
- **Hospital (facility) copay/coinsurance** **$250/10%**
- **Other copayment (emergency room)** **$100**

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	$0
Copayments	$460
Coinsurance	$150
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$610**

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