



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 <u>plan</u> covers.
Are there services covered before you meet your deductible?	Not applicable	This <u>plan</u> does not have a <u>deductible</u> .
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 limit</u> for this <u>plan</u>?	Medical <u>plan</u> Contract <u>providers</u> : \$600/individual, Medical plan Non-Contract <u>providers</u> : \$1,800/individual (interchangeable) Prescription Drugs <u>Network</u> pharmacies: \$2,000/individual, \$4,000/family	The <u>out-of-pocket limit</u> is the most you could pay in a year for covered services. If you have other family members in this <u>plan</u> , they have to meet their own <u>out-of-pocket limits</u> until the overall family <u>out-of-pocket limit</u> has been met.
What is not included in the <u>out-of-pocket limit</u>?	Medical plan: <u>premiums</u> , <u>balance-billing</u> charges, <u>skilled nursing</u> facility, charges from Non-Contract <u>providers</u> , charges in excess of benefit maximums, expenses for vision or dental care (if elected), outpatient <u>prescription drugs</u> , and health care this <u>plan</u> doesn't cover. Prescription Drugs: <u>premiums</u> , <u>balance-billing</u> charges, charges from <u>Non-Network</u> pharmacies, medical expenses, expenses for vision or dental care (if elected), and drugs this <u>plan</u> 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.anthem.com or call 1-800-274-7767 for a list of medical Contract <u>providers</u> . See www.mhn.com or call 1-800-977-7962 for a list of Contract mental health and substance abuse <u>providers</u> .	This <u>plan</u> uses a <u>provider network</u> . You will pay less if you use a <u>provider</u> in the <u>plan's network</u> . You will pay the most if you use an <u>out-of-network provider</u> , and you might receive a bill from a <u>provider</u> for the difference between the <u>provider's</u> charge and what your <u>plan</u> pays (<u>balance billing</u>). Be aware your <u>network provider</u> might use an <u>out-of-network provider</u> for some services

Important Questions	Answers	Why This Matters:
		(such as lab work). Check with your <u>provider</u> before you get services.
Do you need a <u>referral</u> to see a <u>specialist</u> ?	No.	You can see the <u>specialist</u> you choose without a <u>referral</u> .

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 <u>provider's</u> office or clinic	Primary care visit to treat an injury or illness	\$20 <u>copayment</u> /visit, then 10% <u>coinsurance</u>	\$20 <u>copayment</u> /visit, then 40% <u>coinsurance</u>	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.
	<u>Specialist</u> visit			
	<u>Preventive care/screening/</u> Immunization	Services mandated by Health Reform: No charge. Other services: No charge if allowed by Medicare.	40% <u>coinsurance</u>	Age and frequency guidelines apply to covered <u>preventive care</u> . You may have to pay for services that aren't <u>preventive care</u> . Ask your <u>provider</u> if the services needed are <u>preventive</u> . Then check what your <u>plan</u> will pay for.
If you have a test	<u>Diagnostic test</u> (x-ray, blood work)	10% <u>coinsurance</u>	40% <u>coinsurance</u>	Professional/physician charges may be billed separately.
	Imaging (CT/PET scans, MRIs)	10% <u>coinsurance</u>	40% <u>coinsurance</u>	
If you need drugs to treat your illness or condition More information about <u>prescription drug coverage</u> is available at www.UHCRetiree.com	Generic drugs (<u>Formulary</u> generic drugs)	Retail: \$10 <u>copayment</u> /script. Mail order: \$20 <u>copayment</u> /script	Not covered (limited exceptions for emergency prescriptions)	<ul style="list-style-type: none"> 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 <u>copayment</u>. 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 <u>preauthorization</u> (to avoid non-payment), quantity limits or step therapy requirements. Certain <u>preventive care</u> drugs are payable at no charge with a prescription. <u>Specialty drugs</u> must be purchased through the United Healthcare EGWP. Call (888) 556-6648.
	Preferred brand drugs (<u>Formulary</u> brand)	Retail: \$20 <u>copayment</u> /script. Mail order: \$40 <u>copayment</u> /script		
	Non-preferred brand drugs (Non- <u>formulary</u> generic or Non- <u>formulary</u> brand drugs)	Retail: \$40 <u>copayment</u> /script. Mail order: \$80 <u>copayment</u> /script		
	<u>Specialty drugs</u>	Same <u>copayments</u> as retail <u>formulary</u> generic	Not covered.	

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)	
		and retail <u>formulary</u> brand drugs <u>copayments</u> .		<ul style="list-style-type: none"> Limited to a 30-day supply.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	10% <u>coinsurance</u>	40% <u>coinsurance</u> plus any amount above the Plan's maximum payment of \$350/day in the facility	None.
	Physician/surgeon fees	10% <u>coinsurance</u>	40% <u>coinsurance</u>	None.
If you need immediate medical attention	<u>Emergency room care</u>	\$100 <u>copayment</u> /visit, then 10% <u>coinsurance</u>	\$100 <u>copayment</u> /visit, then 10% <u>coinsurance</u> .	Professional/physician charges may be billed separately. Copayment waived if admitted.
	<u>Emergency medical transportation</u>	\$50 <u>copayment</u> /trip, then 10% <u>coinsurance</u>	\$50 <u>copayment</u> /trip, then 10% <u>coinsurance</u>	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.
	<u>Urgent care</u>	\$20 <u>copayment</u> /visit, then 10% <u>coinsurance</u>	\$20 <u>copayment</u> /visit, then 40% <u>coinsurance</u>	Professional/physician charges may be billed separately.
If you have a hospital stay	Facility fee (e.g., hospital room)	\$250 <u>copayment</u> /admission	40% <u>coinsurance</u>	None.
	Physician/surgeon fees	10% <u>coinsurance</u>	40% <u>coinsurance</u>	None.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	\$20 <u>copayment</u> /visit, then 10% <u>coinsurance</u>	\$20 <u>copayment</u> /visit, then 40% <u>coinsurance</u>	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 <u>copayment</u> /admission	40% <u>coinsurance</u>	
If you are pregnant	Office visits	\$20 <u>copayment</u> /visit, then 10% <u>coinsurance</u>	\$20 <u>copayment</u> /visit, then 40% <u>coinsurance</u>	<ul style="list-style-type: none"> <u>Cost sharing</u> does not apply for Contract <u>Provider preventive services</u>. Maternity care may include tests and services described elsewhere in the SBC (i.e., ultrasound).
	Childbirth/delivery professional services	\$250 <u>copayment</u> /admission	40% <u>coinsurance</u>	None.

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)	
	Childbirth/delivery facility services	10% <u>coinsurance</u>	40% <u>coinsurance</u>	
If you need help recovering or have other special health needs	<u>Home health care</u>	10% <u>coinsurance</u>	40% <u>coinsurance</u>	None.
	<u>Rehabilitation services</u>	10% <u>coinsurance</u>	40% <u>coinsurance</u>	None.
	<u>Habilitation services</u>	10% <u>coinsurance</u>	40% <u>coinsurance</u>	
	<u>Skilled nursing care</u>	55% <u>coinsurance</u>	65% <u>coinsurance</u>	<u>Cost sharing</u> does not count toward the medical <u>out-of-pocket limit</u> . Limited to 55 days/calendar year.
	<u>Durable medical equipment</u>	10% <u>coinsurance</u>	40% <u>coinsurance</u>	None
	<u>Hospice services</u>	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 <u>plan</u> .
	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 <u>plan</u> .

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 <u>excluded services</u> .)		
<ul style="list-style-type: none"> • Cosmetic surgery • Dental care (Adult, child) (available under separate dental <u>plan</u>) • Infertility treatment 	<ul style="list-style-type: none"> • Long-term care • Non-emergency care when traveling outside U.S. • Private duty nursing 	<ul style="list-style-type: none"> • Routine eye care (Adult, child) (available under separate vision <u>plan</u>). • 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.)		
<ul style="list-style-type: none"> • Acupuncture • Bariatric surgery 	<ul style="list-style-type: none"> • Chiropractic care • Hearing aids (\$2,000/device/ear; every 3 years) 	<ul style="list-style-type: none"> • Routine foot care (Orthotics limited to a \$200 max per calendar year. Coverage for Contract <u>providers</u> 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, ☐ ☐ ☐ ☐ ☐ ☐ ☐ 1-800-527-4613.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijigo 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:

<i>Cost Sharing</i>	
Deductibles	\$0
Copayments	\$200
Coinsurance	\$410
<i>What isn't covered</i>	
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:

<i>Cost Sharing</i>	
Deductibles	\$0
Copayments	\$900
Coinsurance	\$80
<i>What isn't covered</i>	
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:

<i>Cost Sharing</i>	
Deductibles	\$0
Copayments	\$460
Coinsurance	\$150
<i>What isn't covered</i>	
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.