



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, call 1-877-441-1212. 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 1-877-441-1212 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 ?	Yes. Most covered services.	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain <u>preventive services</u> without cost sharing and before you meet your deductible . See a list of covered <u>preventive services</u> at https://www.healthcare.gov/coverage/preventive-care-benefits/ .
Are there other deductibles for specific services?	Yes, \$100 person / \$200 family combined deductible for registered graduate nurse expenses, blood products, naturopathic, alternative treatments and hearing care expenses. Deductible period is July 1 through June 30. 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.
What is the out-of-pocket limit for this plan ?	\$6,600 person / \$13,200 family for covered medical expenses.	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 for until the overall family out-of-pocket limit has been met.
What is not included in the out-of-pocket limit ?	Medical services you receive that are not covered by Medicare, naturopathy, hypnotherapy, acupuncture, services provided by a dietician, nutritionist, and hearing care.	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 ?	Not Applicable.	This plan does not use a provider network . You can receive covered services from any provider .
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
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	No charge if provider accepts Medicare assignment	Benefits for providers that do not accept Medicare assignment will be subject to <u>usual, customary and reasonable (UCR)</u> amounts. Alternative providers : registered certified hypnotherapists, acupuncturists, registered dietitians, certified nutritionists are limited to a maximum 50% coinsurance limited to \$50 per visit and \$300 per year and do not count toward the <u>out-of-pocket limit</u> . Services of alternative providers are eligible only if they are covered expenses under the plan .
	Specialist visit		
	Preventive care/screening/immunization	No charge if provider accepts Medicare assignment	You may have to pay for services that aren't preventive . Ask your provider if the services you need are preventive . Then check what your plan will pay for. Benefits for providers that do not accept Medicare assignment will be subject to UCR.
If you have a test	Diagnostic test (x-ray, blood work)	No charge if provider accepts Medicare assignment	Benefits for providers that do not accept Medicare assignment will be subject to <u>UCR</u> .
	Imaging (CT/PET scans, MRIs)		
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.optumrx.com .	Generic drugs	\$10 copay /prescription at retail \$20 copay / prescription for mail order	Covers up to a 30-day supply for a retail prescription and 31-90-day supply for a mail order prescription. Subject to Medicare drug formulary. This is a Medicare Part D prescription drug plan through United Healthcare.
	Preferred brand drugs	\$25 copay /prescription at retail \$40 copay / prescription for mail order	
	Non-preferred brand drugs	\$40 copay /prescription at retail \$60 copay / prescription for mail order	
	Specialty drugs	Same as generic/brand benefit	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	No charge if provider accepts Medicare assignment	Benefits for providers that do not accept Medicare assignment will be subject to UCR.
	Physician/surgeon fees		
If you need immediate medical attention	Emergency room care	No charge if provider accepts Medicare assignment	Benefits for providers that do not accept Medicare assignment will be subject to UCR.
	Emergency medical transportation		
	Urgent care		
If you have a hospital stay	Facility fee (e.g., hospital room)	No charge if provider accepts Medicare assignment	Benefits for providers that do not accept Medicare assignment will be subject to UCR.

Common Medical Event	Services You May Need	What You Will Pay	Limitations, Exceptions, & Other Important Information
	Physician/surgeon fees		
If you need mental health, behavioral health, or substance abuse services	Outpatient services	No charge if provider accepts Medicare assignment	Benefits for providers that do not accept Medicare assignment will be subject to UCR.
	Inpatient services		
If you are pregnant	Office visits	No charge if provider accepts Medicare assignment	Benefits for member and spouse only except for certain preventive screenings. No childbirth/delivery coverage for dependent daughter. <u>Cost-sharing</u> does not apply for <u>preventive services</u> . Depending on the type of services, a <u>copayment</u> or <u>coinsurance</u> may apply. Benefits for providers that do not accept Medicare assignment will be subject to <u>UCR</u> .
	Childbirth/delivery professional services		
	Childbirth/delivery facility services		
If you need help recovering or have other special health needs	Home health care	No charge if provider accepts Medicare assignment	Limited to 130 visits per calendar year. Benefits for providers that do not accept Medicare assignment will be subject to <u>UCR</u> .
	Rehabilitation services	No charge if provider accepts Medicare assignment	Outpatient physical, occupational and speech therapy limited to 20 visits per condition per calendar year if unrelated to a mental health condition. Benefits for providers that do not accept Medicare assignment will be subject to <u>UCR</u> .
	Habilitation services	No charge if provider accepts Medicare assignment	Outpatient physical, occupational and speech therapy limited to 20 visits per calendar year if unrelated to a mental health condition. Benefits for providers that do not accept Medicare assignment will be subject to <u>UCR</u> .
	Skilled nursing care	No charge if provider accepts Medicare assignment	Limited to 100 days per condition. Benefits for providers that do not accept Medicare assignment will be subject to <u>UCR</u> .
	Durable medical equipment	No charge if provider accepts Medicare assignment	Benefits for providers that do not accept Medicare assignment will be subject to <u>UCR</u> .
	Hospice services	No charge if provider accepts Medicare assignment	Limited to a maximum of 6 months of combined inpatient and outpatient hospice care. Benefits for providers that do not accept Medicare assignment will be subject to <u>UCR</u> .

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
If your child needs dental or eye care		PPO Provider	Non-Preferred Provider	
	Children's eye exam	\$20 copay for exam and/or glasses	Fees in excess of benefit schedule	Vision coverage provided through Vision Service Plan (www.vsp.com). Limited to one exam once every 12 months and set of lenses every 12 months and one frame or contact lenses every 24 months. Charges from a non-VSP doctor must be paid in full and member must file a claim.
	Children's glasses	\$20 copay for exam and/or glasses	Lenses and frames – fees in excess of benefit schedule	
	Children's dental check-up	Not Covered		Retirees must elect dental through Delta Dental at time of retirement or at annual open enrollment.

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](#).)

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| <ul style="list-style-type: none">• Cosmetic Surgery (except to repair injury or congenital defect)• Dental Care (Adult)• Infertility Treatment• Long-term Care | <ul style="list-style-type: none">• Childbirth/delivery expenses for pregnant dependent children.• Routine Foot Care• Services that could be covered by Medicare (only applies to persons eligible to enroll in Medicare, but failed to do so) | <ul style="list-style-type: none">• Services or treatment which is not medically necessary or is experimental or investigational• Weight Loss Programs-except pre-requisite to bariatric surgery• Work related injury or illness |
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Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your [plan](#) document.)

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|---|--|---|
| <ul style="list-style-type: none">• Acupuncture• Bariatric Surgery (must meet all plan requirements)• Chiropractic Care (limit to 20 visits per year) | <ul style="list-style-type: none">• Hearing Aids (for retired employees only)• Non-emergency care when traveling outside the U.S. | <ul style="list-style-type: none">• Private-Duty Nursing (if medically necessary)• Routine Eye Care (Adult -through VSP) |
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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 Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform and 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: Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform. You may also contact the Trust Administration Office at 1-877-441-1212.

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 1-877-441-1212.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-877-441-1212.

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

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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	\$0
■ Specialist coinsurance	0%
■ Hospital (facility) coinsurance	0%
■ Other coinsurance	0%

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
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In this example, Peg would pay:

Cost Sharing	
Deductibles	\$0
Copayments	10
Coinsurance	\$0
What isn't covered	
Limits or exclusions	\$60
The total Peg would pay is	\$70

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 coinsurance	0%
■ Hospital (facility) coinsurance	0%
■ Other coinsurance	0%

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
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In this example, Joe would pay:

Cost Sharing	
Deductibles	\$0
Copayments	\$500
Coinsurance	\$0
What isn't covered	
Limits or exclusions	\$20
The total Joe would pay is	\$520

Mia's Simple Fracture

(in-network emergency room visit and follow up care)

■ The plan's overall deductible	\$0
■ Specialist coinsurance	0%
■ Hospital (facility) coinsurance	0%
■ Other coinsurance	0%

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
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In this example, Mia would pay:

Cost Sharing	
Deductibles	\$0
Copayments	\$10
Coinsurance	\$0
What isn't covered	
Limits or exclusions	\$0
The total Mia would pay is	\$10

The [plan](#) would be responsible for the other costs of these EXAMPLE covered services.