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.ualocal434-mca-healthfund.com or call 1-800-535-6373. 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 1-800-535-6373 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. Medicare covered charges.	This plan covers some items and services without application of a deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost sharing and before you meet your deductible. See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits.
Are there other deductibles for specific services?	Yes. Prescription Drug: **$50**/person. If optional dental coverage elected: PPO Providers: **$75**/person and **$225**/family; Non-PPO Providers: **$100**/person and **$300**/family. 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?	Medical: PPO Providers: **$0**; Non-PPO Providers: unlimited. Prescription Drugs: **$2,000**/person; **$4,000**/family per calendar year.	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 limit until the overall family out-of-pocket limit has been met. No out-of-pocket limit applies to covered medical expenses from PPO Providers because the Plan reimburses 100% of Medicare approved charges after Medicare's payment.
What is not included in the out-of-pocket limit?	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. Prescription drug copays count toward the prescription drug out-of-pocket limit only.
Will you pay less if you use a network provider?	Yes. For information on providers participating in Medicare, see www.medicare.gov; for a list of network providers for prescription drugs, see www.optumrx.com or call 1-800-788-4863 and for dental care call the Fund Office at 1-800-535-6373.	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.

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
		Network Provider (You will pay the least)	Out-of-Network 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	No charge	All costs over Medicare allowed amount	Medicare and the Plan coordinate to pay the Medicare allowed amount; you pay remaining balance.
	Specialist visit	No charge	All costs over Medicare allowed amount	
	Preventive care/screening/ immunization	No charge	All costs over Medicare allowed amount	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.
If you have a test	Diagnostic test (x-ray, blood work)	No charge	All costs over Medicare allowed amount	Medicare and the Plan coordinate to pay the Medicare allowed amount; you pay remaining balance.
	Imaging (CT/PET scans, MRIs)	No charge	All costs over Medicare allowed amount	
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.optumrx.com or by calling 1-800-788-4863.	Generic drugs	Copay the greater of $5 or 15% of total cost of prescription	Copay the greater of $5 or 25% of total cost of prescription	Subject to prescription drug deductible. Covers up to a 34-day supply (retail); 90-day supply (mail order). Coverage for nicotine replacement therapy available through Quit for Life Smoking Cessation Program; if you enroll, Chantix and buproprion are covered at 100% up to two 90-day supplies per calendar year. ACA preventive care vaccinations are covered at 100% when received at Network Pharmacies. If you are enrolled in Medicare Part D, you will not have prescription drug coverage under the plan. Preauthorization may be required for certain drugs.
	Brand name drugs	25% coinsurance of total cost of prescription	35% coinsurance of total cost of prescription	
	Prescription proton pump inhibitors, other than prescription/legend omeprazole and non-sedating antihistamines	Copay of 50% of total cost of prescription	Copay of 60% of total cost of prescription	
	Over-the-counter Prilosec, loratadine, Prevacid, Zegerid, Allegra/Allegra-D and prescription omeprazole	No charge; prescription drug deductible does not apply	Not covered	Over-the-counter Prilosec, loratadine, Prevacid, Zegerid, and Allegra/Allegra-D require a prescription. If you are enrolled in Medicare Part D,

* For more information about limitations and exceptions, see the plan or policy document at www.ualocal434-mca-healthfund.com.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions*, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
				you will not have prescription drug coverage under the plan.
	Specialty drugs	25% coinsurance of total cost of prescription	35% coinsurance of total cost of prescription	Subject to prescription drug deductible. Preauthorization is required. Covers up to a 30-day supply. If you are enrolled in Medicare Part D, you will not have prescription drug coverage under the plan.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	No charge	All costs over Medicare allowed amount	Medicare and the Plan coordinate to pay the Medicare allowed amount; you pay remaining balance.
	Physician/surgeon fees	No charge	All costs over Medicare allowed amount	
If you need immediate medical attention	Emergency room care	No charge	All costs over Medicare allowed amount	Medicare and the Plan coordinate to pay the Medicare allowed amount; you pay remaining balance.
	Emergency medical transportation	No charge	All costs over Medicare allowed amount	
	Urgent care	No charge	All costs over Medicare allowed amount	
If you have a hospital stay	Facility fee (e.g., hospital room)	No charge	All costs over Medicare allowed amount	Medicare and the Plan coordinate to pay the Medicare allowed amount; you pay remaining balance.
	Physician/surgeon fees	No charge	All costs over Medicare allowed amount	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	No charge	All costs over Medicare allowed amount	Medicare and the Plan coordinate to pay the Medicare allowed amount; you pay remaining balance.
	Inpatient services	No charge	All costs over Medicare allowed amount	
If you are pregnant	Office visits	No charge	All costs over Medicare allowed amount	Medicare and the Plan coordinate to pay the Medicare allowed amount; you pay remaining balance. Cost sharing does not apply to certain preventive services. Depending on the type of services, coinsurance may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound).
	Childbirth/delivery professional services	No charge	All costs over Medicare allowed amount	
	Childbirth/delivery facility services	No charge	All costs over Medicare allowed amount	

* For more information about limitations and exceptions, see the plan or policy document at www.ualocal434-mca-healthfund.com.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions*, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need help recovering or have other special health needs **If you need help recovering or have other special health needs (continued)**	Home health care	No charge	All costs over Medicare allowed amount	Coverage is limited to 40 visits per year. Medicare and the Plan coordinate to pay the Medicare allowed amount; you pay remaining balance.
	Rehabilitation services	No charge	All costs over Medicare allowed amount	Medicare and the Plan coordinate to pay the Medicare allowed amount; you pay remaining balance.
	Habilitation services	No charge	All costs over Medicare allowed amount	
	Skilled nursing care	No charge	All costs over Medicare allowed amount	Medicare and the Plan coordinate to pay the Medicare allowed amount, plan covers 30 days beyond the 100 days covered by Medicare on a customary, usual and reasonable basis at 100%, you pay remaining balance.
	Durable medical equipment	No charge	All costs over Medicare allowed amount	Medicare and the Plan coordinate to pay the Medicare allowed amount; you pay remaining balance.
	Hospice services	No charge	All costs over Medicare allowed amount	
If your child needs dental or eye care	Children's eye exam	If elected, all charges in excess of $50	If elected, all charges in excess of $50	Covered only if elected; coverage limited to one exam per year.
	Children's glasses	If elected, all charges in excess of: $30 per single lens, $40 per bifocal lens, $50 per trifocal lens, $80 per lenticular lens, and $50 for frames	If elected, all charges in excess of: $30 per single lens, $40 per bifocal lens, $50 per trifocal lens, $80 per lenticular lens, and $50 for frames	Covered only if elected; coverage is limited to one pair of glasses or contact lenses in lieu of glasses every 2 years. Your cost for contact lenses is all charges in excess of $80.
	Children's dental check-up	If elected, no charge; dental deductible does not apply	If elected, 30% coinsurance; dental deductible does not apply	Covered only if elected; coverage limited to 2 check-ups/year and $1,500/year at PPO Providers and $1,000/year at Non-PPO Providers.

* For more information about limitations and exceptions, see the plan or policy document at www.ualocal434-mca-healthfund.com.

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.)

- Acupuncture
- Bariatric surgery
- Cosmetic surgery, unless for reconstructive surgery due to bodily injury, infection or other disease of the involved part; or congenital disease or anomaly of a covered dependent child that resulted in a functional defect
- Hearing aids
- Infertility treatment
- Non-emergency care when traveling outside the U.S.
- Private duty nursing
- Routine foot care
- Weight loss programs, except morbid obesity screenings

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

- Chiropractic care, up to 20 visits per calendar year
- Dental care (adult), if elected, up to maximums noted above
- Long-term care hospitals
- Routine eye care (adult), if elected, up to maximums noted above

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 the Department of Labor's Employee Benefits Security Administration is 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 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 Plan at 1-800-535-6373 or 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? **No**

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.

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

* For more information about limitations and exceptions, see the plan or policy document at www.ualocal434-mca-healthfund.com.

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**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$50
Copayments	$0
Coinsurance	$10
What isn't covered	
Limits or exclusions	$20
The total Peg would pay is	**$80**

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**

In this example, Joe would pay:

Cost Sharing	
Deductibles*	$50
Copayments	$0
Coinsurance	$1,060
What isn't covered	
Limits or exclusions	$0
The total Joe would pay is	**$1,110**

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**

In this example, Mia would pay:

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

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* This plan has other deductibles for specific services included in this coverage example. See "Are there other deductibles for specific services?" row above.
Note: You may file for reimbursement for some of these expenses, as permitted by the plan's health reimbursement account program.

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