The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provi a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, contact our Member S 572-7687. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, terms see the Glossary. You can view the Glossary at www.mctwf.org or call 1-800-572-7687 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	$1,000 Individual/$3,000 family network providers. $2,000 Individual/$6,000 family non-network providers.	Generally, you must pay all of the co deductible amount before this plan be family members on the plan, the over met before the plan begins to pay.
Are there services covered before you meet your deductible?	Yes. Preventive care/screening and primary, specialist, emergency room, or urgent care provider services as long as you use a network provider.	This plan covers some items and ser met the deductible amount. But a cop apply. "For example, this plan covers without cost sharing and before you m list of covered preventive services at https://www.healthcare.gov/coverage
Are there other deductibles for specific services?	No.	You don't have to meet deductibles f
What is the out-of-pocket limit for this plan?	For network providers, $5,000 Individual/$10,000 family for most medical services. For non-network providers, $10,000 Individual/$20,000 family for most medical services.	The out-of-pocket limit is the most yo ered services. If you have other famil overall family out-of-pocket limit mus
What is not included in the out-of-pocket limit?	Premiums, balance-billed charges, health care this plan doesn't cover, non-network coinsurance expenses.	Even though you pay these expenses out-of-pocket limit.
Will you pay less if you use	Yes. See www.mctwf.org or call 1-800-572-7687	This plan uses a provider network. Y provider in the plan's network. You w out-of-network provider, and you mig

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		Limitation
		Network Provider (You will pay the least)	Non-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	$30 copay/visit	40% coinsurance	None
	Specialist visit	$60 copay/visit	40% coinsurance	
	Preventive care	No charge	40% coinsurance	You may ha
	Screening	No charge	40% coinsurance	aren't preve
	Immunization	No charge	40% coinsurance	services you check what
If you have a test	Diagnostic test (x-ray, blood work)	20% coinsurance	40% coinsurance	None
	Imaging (CT/PET scans, MRIs)	20% coinsurance	40% coinsurance	Preauthoriza covered
If you need drugs to treat your illness or condition **More information about prescription drug coverage is available at www.caremark.com**	Generic drugs	$10 copay/prescription for up to 34 days supply (retail & mail order), $20 copay for 35-60 days' supply (retail & mail order), $30 copay for 61-90 days' supply (retail) and $20 copay 61-90 days' supply (mail order).	Difference between the charges and the allowed amount plus the applicable network copay.	Preauthoriz erwise not c formulary br exceeding a drugs within egories: Acn ADHD/Narc Anabolic St (brand nam (brand or ge 90 days per function tab preventions limitations *
	Preferred brand drugs	$20 copay/prescription for up to 34 days supply (retail & mail order), $40 copay for 35-60 days' supply (retail & mail order), $60 copay for 61-90 days' supply (retail) and $45 copay 61-90 days' supply (mail order).		
	Non-preferred brand drugs	$35 copay/prescription for up to 34 days supply (retail & mail order), $70 copay for 35-60 days' supply (retail & mail order), $105 copay for 61-90 days' supply (retail) and $80 copay 61-90 days' supply (mail order).		
	Specialty drugs	$20 copay/prescription for up to 34 days supply (retail & mail order), $40 copay for 35-60 days'		Prior author not covered

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exce
		Network Provider (You will pay the least)	Non-Network Provider (You will pay the most)	In
If you need immediate medical attention	Emergency room care	$150 copay/visit	$150 copay/visit	Copay waived if admitte limitations.
	Emergency medical transportation	20% coinsurance	20% coinsurance	*see section 3.15 in S
	Urgent care	$65 copay/visit	40% coinsurance	None
If you have a hospital stay	Facility fee(e.g. hospital room)	$250 copay/admission 20% coinsurance after copay.	$250 copay/admission 40% coinsurance after copay	None
	Physician fees	20% coinsurance	40% coinsurance	
	Surgeon fees	20% coinsurance	40% coinsurance	
If you need mental health, behavioral health, or substance abuse services.	Outpatient services	$25 copay/visit	40% coinsurance	None
	Inpatient services	$250 copay/admission 20% coinsurance after copay.	$250 copay/admission 40% coinsurance after copay	Prior authorization req
If you are pregnant	Office visits	20% coinsurance	40% coinsurance	None
	Childbirth/delivery professional services	20% coinsurance	40% coinsurance	
	Childbirth/delivery facility services	$250 copay/admission 20% coinsurance after copay.	$250 copay/admission 40% coinsurance after copay	
If you need help re-covering or have	Home health care	20% coinsurance	20% coinsurance	Prior authorization rec
	Rehabilitation services	20% coinsurance	40% coinsurance	None
	Habilitation services	20% coinsurance	40% coinsurance	
	Skilled nursing care	20% coinsurance	20% coinsurance	Prior authorization req

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exc
		Network Provider (You will pay the least)	Non-Network Provider (You will pay the most)	
If your child needs dental or eye care	Children's eye exam	No charge	Any Charge over $50	Limited to one exam
	Children's glasses	Basic Lenses - No charge	Lenses - any charge over $50 for single, $60 for bifocal, $70 for trifocal and $70 for lenticular	Limited to one vision
		Frames - any charge over $150	Frames - any charge over $75	
	Children's dental check-up	No charge	Any charge over the allowed amount	Limited to 2 oral exar

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

- Acupuncture
- Cosmetic surgery
- Infertility treatment
- Long-term care
- Routine foot care (tain systemic cond

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

- Bariatric surgery
- Chiropractic care up to 24 spinal manipulations per person annually. One mechanical traction per day only with spinal manipulation expenses. One "new patient" office visit every 36 months and one "established patient" office visit annually, per chiropractor.
- Dental care (Adult) up to annual per person maximum of $1,600 PPO or $1,500 Premier.
- Hearing aids up to $1,500 per person, per aid every 2 years.
- Non-emergency care when traveling outside the U.S. Contact 1-800-810-2583.
- Private-duty nursing days lifetime, 16 hrs. p 8 hrs. per day for 900
- Routine eye care (Ad one vision correction

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information partment of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272). Other coverage options may be available to you too, incl ance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318

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 com appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also 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 may also contact the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa/healthreform, nancial and Insurance Regulations at 1-877-999-6442.

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 on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost sharing amounts (de coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under dif 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	$1000
Specialist copayment	$60
Hospital (facility) copayment	$250
Other copayment/coinsurance	$30/20%

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	$12,800

In this example, Peg would pay:

Cost Sharing	
Deductibles	$1,087
Copayments	$100
Coinsurance	$2,001
What isn't covered	
Limits or exclusions	$60

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

The plan's overall deductible	$1000
Specialist copayment	$60
Hospital (facility) copayment	$250
Other copayment/coinsurance	$30/20%

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	$7,400

In this example, Joe would pay:

Cost Sharing	
Deductibles	$1,000
Copayments	$930
Coinsurance	$373
What isn't covered	
Limits or exclusions	$55

Mia's Simp
(in-network emergency c

The plan's overall ded	
Specialist copayment	
Hospital (facility) copa	
Other copayment/coin	

This EXAMPLE event inc
Emergency room care *(inc supplies)*
Diagnostic test *(x-ray)*
Durable medical equipmer
Rehabilitation services *(ph*

Total Example Cost	

In this example, Mia wo

Cost S	
Deductibles	
Copayments	
Coinsurance	
What isn't c	
Limits or exclusions	