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. This is only a summary. For more information about your coverage, or to get a copy of the Summary Plan Description, contact the Fund Office at 410-884-1406 or visit the website at https://www.ourbenefitoffice.com/ConstructionWorkersTrustFund/Benefits/. 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 410-884-1406 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	$100 per person/$300 per family	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, the overall family deductible must be met before the plan begins to pay.
Are there services covered before you meet your deductible?	Yes. Preventive care is covered before you meet your deductible.	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?	No.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	$300 per person/$6,900 per family for medical; $10,500 per family for prescription drugs.	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, the overall family out-of-pocket limit must be met.
What is not included in the out-of-pocket limit?	Charges above plan maximums, deductibles, balance-billing charges, health care this plan doesn't cover, penalties for failure to obtain preauthorization.	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.carefirst.com or call 410-884-1406 for a list of network 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.
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	20% coinsurance	None
	Specialist visit	20% coinsurance	None
	Preventive care/screening/ immunization	No charge for network provider; deductible does not apply; 20% coinsurance for out-of-network provider	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)	20% coinsurance	None
	Imaging (CT/PET scans, MRIs)	20% coinsurance	
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/34-day supply (retail) $20 copay/90-day supply of maintenance drugs	Maintenance drugs must be obtained through CVS Caremark mail order program. Preauthorization may be required for some drugs, or not covered. No copay for generic contraceptives. If generic drug is available and you obtain a brand name drug, you pay the additional costs.
	Preferred brand drugs	$25 copay/34-day supply (retail) $50 copay/90-day supply of maintenance drugs	
	Non-preferred brand drugs	$50 copay/34-day supply (retail) $100 copay/90-day supply of maintenance drugs	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance	None
	Physician/surgeon fees	20% coinsurance	None
If you need immediate medical attention	Emergency room care	20% coinsurance	Not covered unless emergency medical situation.
	Emergency medical transportation	20% coinsurance	Not covered unless emergency medical situation; air ambulance only covered if medically necessary.
	Urgent care	20% coinsurance	None
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance	Preauthorization is required, or not covered; no more than 60 days per 365 day period, combined with skilled nursing care days.
	Physician/surgeon fees	20% coinsurance	None

[* For more information about limitations and exceptions, see the plan or policy document at https://www.ourbenefitoffice.com/ConstructionWorkersTrustFund/Benefits/]

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 need mental health, behavioral health, or substance abuse services	Outpatient services	20% coinsurance	None
	Inpatient services	20% coinsurance	Preauthorization is required, or not covered.
If you are pregnant	Office visits	20% coinsurance	Not covered for dependent children, except for preventive services. Cost sharing does not apply to certain preventive services. Maternity care may include tests and services described elsewhere in the SBC (e.g., ultrasound).
	Childbirth/delivery professional services	20% coinsurance	
	Childbirth/delivery facility services	20% coinsurance	
If you need help recovering or have other special health needs	Home health care	20% coinsurance	Maximum of 100 visits per 365 day period
	Rehabilitation services	20% coinsurance	Maximum 40 visits per calendar year for outpatient physical therapy
	Habilitation services	Not covered	
	Skilled nursing care	20% coinsurance	Preauthorization is required, or not covered; maximum of 60 days per 365 day period, combined with hospital days.
	Durable medical equipment	20% coinsurance	None
	Hospice services	20% coinsurance	Preauthorization is required for inpatient hospice services, or not covered; no more than 60 inpatient days per 365 day period, combined with hospital and skilled nursing care days; outpatient hospice services are covered under home health care.
If your child needs dental or eye care	Children's eye exam	All charges over $30	$150 per calendar year combined limit
	Children's glasses	All charges over $75 for single vision All charges over $120 for contact lenses	
	Children's dental check-up	No charge	Charges above allowed amount not covered.

[* For more information about limitations and exceptions, see the plan or policy document at https://www.ourbenefitoffice.com/ConstructionWorkersTrustFund/Benefits/]

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your Summary Plan Description for more information and a list of any other excluded services.)

- Cosmetic Surgery
- Habilitation Services
- Hearing Aids
- Infertility Treatment
- Long Term Care
- Private-Duty Nursing
- Weight Loss Programs

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

- Acupuncture (if prescribed by a physician)
- Bariatric Surgery
- Chiropractic Care
- Dental Care (Adult)
- Non-emergency care when traveling outside the United States
- Routine Eye Care
- Routine Foot Care

[* For more information about limitations and exceptions, see the plan or policy document at https://www.ourbenefitoffice.com/ConstructionWorkersTrustFund/Benefits/]

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. For more information on your rights to continue coverage, contact the Plan at 410-884-1406. You may also contact the U.S. Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or visit 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 Summary Plan Description booklet also provides 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 410-884-1406 or by mail at Construction Workers Trust Fund, 7130 Columbia Gateway Dr., Suite A, Columbia, MD 21046. You may also contact the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or visit www.dol.gov/ebsa/healthreform.

Additionally, a consumer assistance program can help you file your appeal or grievance. Contact: Maryland Office of the Attorney General, Health Education and Advocacy Unit, 200 St. Paul Place, 16th Floor, Baltimore, MD 21202, 1-877-261-8807.

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 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 410-884-1406.

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 https://www.ourbenefitoffice.com/ConstructionWorkersTrustFund/Benefits/]

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	$100
Specialist coinsurance	20%
Hospital (facility) coinsurance	20%
Other coinsurance	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	**$12,700**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$100
Copayments	$0
Coinsurance	$300
What isn't covered	
Limits or exclusions	$0
The total Peg would pay is	**$400**

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

The plan's overall deductible	$200
Specialist coinsurance	20%
Hospital (facility) coinsurance	20%
Other coinsurance	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	**$5,600**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$100
Copayments	$0
Coinsurance	$300
What isn't covered	
Limits or exclusions	$0
The total Joe would pay is	**$400**

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

The plan's overall deductible	$200
Specialist coinsurance	20%
Hospital (facility) coinsurance	20%
Other coinsurance	20%

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	$100
Copayments	$0
Coinsurance	$300
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$400**

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