



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 301-733-2602. 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 by calling 301-733-2602 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible ?	\$100/individual or \$200/family Doesn't apply to prescription drugs, vision and dental benefits. Balance billing and excluded services do not count toward the deductible .	Generally, you must pay all of the costs from providers up to the deductible before this plan begins to pay. If you have other family members on the plan , each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible .
Are there services covered before you meet your deductible ?	Yes. Prescriptions, preventive care/screening or dental and vision for children are covered before you meet your deductible .	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 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 ?	\$1,500 individual / \$3,000 family (medical) \$3,000 individual (prescription drug)	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 until the overall family out-of-pocket limit has been met.
What is not included in the out-of-pocket limit ?	Premiums , balance billing charges, health care this plan doesn't cover, out-of-network coinsurance , deductibles and penalties for failure to obtain preauthorization for services.	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 1-800-235-5160 for a list of network providers . Out of State participants should visit www.bcbs.com	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
		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	10% coinsurance	30% coinsurance	None
	Specialist visit	10% coinsurance	30% coinsurance	None
	Preventive care/screening/immunization	No charge	30% coinsurance	Annual physicals are limited to one per year. 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)	10% coinsurance	30% coinsurance	None
	Imaging (CT/PET scans, MRIs)	10% coinsurance	30% coinsurance	None
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.caremark.com	Generic drugs	20% copay /prescription, with following minimum copays : \$5/prescription retail; \$15/prescription mail or CVS Store (maintenance choice)	20% copay /prescription, with following minimum copays : \$5/prescription retail; \$15/prescription mail or CVS Store, plus balance billing	If a brand name drug is purchased and a generic is available, you will pay the difference in cost between the brand and generic plus the generic copay . Limited to up to 30-day supply for retail and up to 90-day supply for mail order or CVS store. Maintenance drugs purchased at retail (other than CVS Store) limited to 30-day supply with 20% copay /prescription with the following minimums: \$20/prescription generic; \$45/prescription preferred and \$75/prescription non-preferred. The maximum annual prescription copay , per individual, is \$3,000. See the listing on page 4 for additional exclusions.
	Preferred brand drugs	20% copay /prescription, with following minimum copays : \$15/prescription retail; \$45/prescription mail or CVS Store (maintenance choice)	20% copay /prescription, with following minimum copays : \$15/prescription retail; \$45/prescription mail or CVS Store, plus balance billing	
	Non-preferred brand drugs	20% copay /prescription, with following minimum copays : \$25/prescription retail; \$75/prescription mail or CVS Store (maintenance choice)	20% copay /prescription, with following minimum copays : \$25/prescription retail; \$75/prescription mail or CVS Store, plus balance billing	
	Specialty drugs	20% copay /prescription, with following minimum copays : \$25/prescription retail; \$75/prescription mail or CVS Store (maintenance choice)	20% copay /prescription, with following minimum copays : \$25/prescription retail; \$75/prescription mail or CVS Store	

* For more information about limitations and exceptions, see the plan or policy document by calling 301-733-2602.

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 have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	10% coinsurance	30% coinsurance	None
	Physician/surgeon fees	10% coinsurance	30% coinsurance	None
If you need immediate medical attention	Emergency room care	10% coinsurance	30% coinsurance	Non-emergency services, or services for which emergency treatment was not required is covered at 0%.
	Emergency medical transportation	10% coinsurance	30% coinsurance	Ambulance service is covered when transported to or from a Hospital where medically necessary .
	Urgent care	10% coinsurance	30% coinsurance	None
If you have a hospital stay	Facility fee (e.g., hospital room)	10% coinsurance	30% coinsurance	Preauthorization is required. If you don't get preauthorization , benefits could be reduced by 60% of what the Fund otherwise would have paid. All hospital admissions are to be certified in advance (or, for emergency admissions, within 2 business days of admission) by American Health Holdings at 1-800-641-5566. Private room and board covered up to \$5 in excess of average Semi-Private Room.
	Physician/surgeon fees	10% coinsurance	30% coinsurance	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	10% coinsurance	30% coinsurance	None
	Inpatient services	10% coinsurance	30% coinsurance	None
If you are pregnant	Office visits	10% coinsurance	30% coinsurance	None
	Childbirth/delivery professional services	10% coinsurance	30% coinsurance	None
	Childbirth/delivery facility services	10% coinsurance	30% coinsurance	None

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	Home health care	10% coinsurance	30% coinsurance	Preauthorization is required. Covered if in lieu of hospitalization and approved in advance by Fund Office. Extended Care facility covered if begins within 14 days following at least 3 consecutive days of hospital confinement. Care that is primarily custodial in nature is not covered.
	Rehabilitation services	10% coinsurance	30% coinsurance	None
	Habilitation services	10% coinsurance	30% coinsurance	None
	Skilled nursing care	10% coinsurance	30% coinsurance	None
	Durable medical equipment	10% coinsurance	30% coinsurance	None
	Hospice services	10% coinsurance	30% coinsurance	None
If your child needs dental or eye care	Children's eye exam	\$0	\$0	Coverage limited to two exams/year. Benefits subject to standard medical protocols and limitations.
	Children's glasses	\$0	\$0	Coverage limited to one pair of frames and lenses/year.
	Children's dental check-up	\$0	\$0	Coverage limited to two exams/year.

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](#).)

- Bariatric Surgery
- Compound medications, certain formulary brand name drugs, certain topical analgesic
- Cosmetic surgery
- Infertility treatment
- Long-term Care
- Weight loss programs

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

- Acupuncture
- Chiropractic Care (limited to \$800 payment per calendar year)
- Dental Care (Adult) (calendar year maximum applies – see Summary Plan Description)
- Hearing aids (limited to \$1,700 per pair per person every 5 years)
- Non-emergency care when traveling outside the U.S.
- Private duty nursing
- Routine Eye Care (Adult) (calendar year maximum applies – see Summary Plan Description)
- Routine Foot Care

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: Employee Benefits Security Administration, Department of Labor at (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: Hagerstown Teamsters and Motor Carriers Health and Welfare Fund, 10312 Remington Drive, Hagerstown, MD 21740 or call 301-733-2602. Additionally, a consumer assistance program can help you file your [appeal](#). Contact the Maryland Office of the Attorney General, Health Education and Advocacy Unit at (877) 261-8807 or <https://www.oag.state.md.us/Consumer/HEAU.htm>. 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 301-733-2602.]

[Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 301-733-2602.]

[Chinese (中文): 如果需要中文的帮助, 请拨打这个号码 301-733-2602.]

[Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijigo holne' 301-733-2602.]

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	\$100
■ Specialist coinsurance	10%
■ Hospital (facility) coinsurance	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	\$12,700
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In this example, Peg would pay:

Cost Sharing	
Deductibles	\$100
Copayments	\$0
Coinsurance	\$1,100
What isn't covered	
Limits or exclusions	\$60
The total Peg would pay is	\$1,260

Managing Joe's Type 2 Diabetes

(a year of routine in-network care of a well-controlled condition)

■ The plan's overall deductible	\$100
■ Specialist coinsurance	10%
■ Hospital (facility) coinsurance	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	\$5,600
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In this example, Joe would pay:

Cost Sharing	
Deductibles	\$100
Copayments	\$0
Coinsurance	\$550
What isn't covered	
Limits or exclusions	\$20
The total Joe would pay is	\$680

Mia's Simple Fracture

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

■ The plan's overall deductible	\$100
■ Specialist coinsurance	10%
■ Hospital (facility) coinsurance	10%
■ Other coinsurance	10%

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	\$100
Copayments	\$0
Coinsurance	\$270
What isn't covered	
Limits or exclusions	\$0
The total Mia would pay is	\$370

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