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	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 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 Network Provider (You will pay the least)	What You Will Pay Out-of-Network Provider (You will pay the most)	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	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	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	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	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	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 Network Provider (You will pay the least)	What You Will Pay Out-of-Network Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information
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 70%
	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

* 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 Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information
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 $1,000 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

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

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, kwiijigo holne' 301-733-2602.]

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 by calling 301-733-2602.

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**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$100
Copayments	$0
Coinsurance	$1,260
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$1,300**

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**

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	**$650**

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**

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.