



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 (855) 505-0462. 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 (855) 505-0462 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible ?	Annual \$100 Individual / \$200 Family	You must pay all of the costs from providers up to the deductible amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the deductible starts over (usually, but not always January 1). See the chart starting on page 2 for how much you pay for covered services after you meet the deductible .
Are there services covered before you meet your deductible ?	Yes.	Preventive care services do not require you to meet the deductible .
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 ?	Medical: \$600/IND; \$1,200 FAM Rx: \$5,800/IND/\$11,600 FAM	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 and health care this plan doesn't cover.	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 (800) 235-5160 for a list of in-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 full cost if you use an out-of-network provider . 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 . You will pay less if you choose a preferred provider specialist.

 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*
		In-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	20% up to \$2,500, \$0 thereafter	20% up to \$2,500, \$0 thereafter	Charges above allowed amount are your responsibility
	Specialist visit	20% up to \$2,500, \$0 thereafter	20% up to \$2,500, \$0 thereafter	Charges above allowed amount are your responsibility
	Preventive care/screening/immunization	\$0	\$0 up to allowed amount	Immunizations as recommended by the Department of Health & Human Services
If you have a test	Diagnostic test (x-ray, blood work)	20% up to \$2,500, \$0 thereafter	20% up to \$2,500, \$0 thereafter	Charges above allowed amount are your responsibility
	Imaging (CT/PET scans, MRIs)	20% up to \$2,500, \$0 thereafter	20% up to \$2,500, \$0 thereafter	Charges above allowed amount are your responsibility
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.caremark.com .	Generic drugs	Retail - \$15 copay /prescription Mail - \$30 copay /prescription	Not covered	Retail: Up to a 30-day supply; 31-90 day supply mandatory mail order
	Preferred brand drugs	Retail - \$35 copay /prescription Mail - \$70 copay /prescription	Not covered	Limited list of injectable drugs, Contact Express Scripts @ (877) 282-2881 or at www.express-scripts.com
	Non-preferred brand drugs	Retail - \$50 copay /prescription Mail - \$100 copay /prescription	Not covered	
	Specialty drugs	Varies by drug – see above copays	Not covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% up to \$2,500, \$0 thereafter	20% up to \$2,500, \$0 thereafter	
	Physician/surgeon fees	20% up to \$2,500, \$0 thereafter	20% up to \$2,500, \$0 thereafter	
If you need immediate medical attention	Emergency room care	20% up to \$2,500, \$0 thereafter	20% up to \$2,500, \$0 thereafter	Covered ONLY for accidental injury within 48 hours or life-threatening illness within 12 hours of onset of illness
	Emergency medical transportation	20% up to \$2,500, \$0 thereafter	20% up to \$2,500, \$0 thereafter	Charges above allowed amount are your responsibility

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information*
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
	Urgent care	20% up to \$2,500, \$0 thereafter	20% up to \$2,500, \$0 thereafter	Charges above allowed amount are your responsibility None
If you have a hospital stay	Facility fee (e.g., hospital room)	20% up to \$2,500, \$0 thereafter	20% up to \$2,500, \$0 thereafter	Preauthorization required prior to hospital admission. In an emergency or life-threatening situation, notify Conifer Health Solutions @1-866-308-7335. If you don't get preauthorization , benefits could be denied for non-certified hospital expenses.
	Physician/surgeon fees	20% up to \$2,500, \$0 thereafter	20% up to \$2,500, \$0 thereafter	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	20% up to \$2,500, \$0 thereafter	20% up to \$2,500, \$0 thereafter	None
	Inpatient services	20% up to \$2,500, \$0 thereafter	20% up to \$2,500, \$0 thereafter	Preauthorization required prior to hospital admission. In an emergency or life-threatening situation, notify American Health Holdings (AHH) within 24 hours of admission. If you don't get preauthorization , benefits could be denied for non-certified hospital expenses.
If you are pregnant	Office visits	20% up to \$2,500, \$0 thereafter	20% up to \$2,500, \$0 thereafter	Pre-natal care only for dependent children. Charges above allowed amount are your responsibility.
	Childbirth/delivery professional services	20% up to \$2,500, \$0 thereafter	20% up to \$2,500, \$0 thereafter	Member and spouses only. Charges above allowed amount are your responsibility.
	Childbirth/delivery facility services	20% up to \$2,500, \$0 thereafter	20% up to \$2,500, \$0 thereafter	Member and spouses only. Charges above allowed amount are your responsibility. Preauthorization required prior to hospital admission. In an emergency or life-threatening situation, notify Conifer Health Solutions @1-866-308-7335 within 24 hours of admission. If you don't get preauthorization , benefits could be denied for non-certified hospital expenses.
If you need help recovering or have other special health needs	Home health care	20% up to \$2,500, \$0 thereafter	20% up to \$2,500, \$0 thereafter	Charges above allowed amount are your responsibility
	Rehabilitation services	20% up to \$2,500, \$0 thereafter	20% up to \$2,500, \$0 thereafter	Annual limit of 50 visits combined for PT/ OT/ Speech therapy and Chiropractic Treatment.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information*
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
	Habilitation services	Not Covered	Not Covered	
	Skilled nursing care	20% up to \$2,500, \$0 thereafter	20% up to \$2,500, \$0 thereafter	Charges above allowed amount are your responsibility
	Durable medical equipment	20% up to \$2,500, \$0 thereafter	20% up to \$2,500, \$0 thereafter	Charges above allowed amount are your responsibility
	Hospice services	20% up to \$2,500, \$0 thereafter	20% up to \$2,500, \$0 thereafter	Preauthorization required – call Conifer Health Solutions @1-866-308-7335.
If your child needs dental or eye care	Children’s eye exam	\$0	\$0 up to allowed amount	Charges above allowed amount are your responsibility
	Children’s glasses	\$10 copay	\$130 allowance single vision	Charges above allowed amount are your responsibility
	Children’s dental check-up	\$0 up to allowed amount	Amount above plan allowance	Charges above allowed amount are your responsibility

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.)
<ul style="list-style-type: none"> • Bariatric surgery • Cosmetic surgery • Dental Care (separate plan) • Infertility treatment • Long-term care • Private duty nursing
Other Covered Services (Limitations may apply to these services. This isn’t a complete list. Please see your plan document.)
<ul style="list-style-type: none"> • Acupuncture • Hearing aids – Minor Children 21 years of age or younger • Non-emergency care when traveling outside the US

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: Department of Labor’s Employee Benefits Security Administration at (866) 444-EBSA (3272) or <https://www.dol.gov/ebsa/contactEBSA/consumerassistance.html>. 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 Fund Office at (888) 490-8800 or Department of Labor’s Employee Benefits Security Administration at 1-866-444-EBSA (3272) <https://www.dol.gov/ebsa/healthreform>. **The Fund does not have a grievance procedure. All disputes under the Plan are processed through the appeals procedure described in the Summary Plan Description.

Does this plan provide Minimum Essential Coverage? Yes

If you don't have [Minimum Essential Coverage](#) for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

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 (888) 490-8800.

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

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](#) \$10
- [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	\$12,100
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In this example, Peg would pay:

<i>Cost Sharing</i>	
Deductibles	\$0
Copayments	\$0
Coinsurance	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$60
The total Peg would pay is	\$60

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](#) \$10
- [Hospital \(facility\) coinsurance](#) \$0
- Other (Rx) [copayments](#) \$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	\$5,000
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In this example, Joe would pay:

<i>Cost Sharing</i>	
Deductibles	\$0
Copayments	\$400
Coinsurance	\$0
<i>What isn't covered</i>	
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](#) \$0
- [Specialist coinsurance](#) \$0
- [Hospital \(facility\) copayments](#) \$250
- 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	\$2,200
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In this example, Mia would pay:

<i>Cost Sharing</i>	
Deductibles	\$0
Copayments	\$200
Coinsurance	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$0
The total Mia would pay is	\$200