**Truck Drivers and Helpers Local 355 Health and Welfare Fund Plan 30 - 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, contact 1-866-621-7974. 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 www.healthcare.gov/sbc-glossary.com or call 1-866-621-7974 to request a copy.

| Important Questions | Answers | Why This Matters: |
|---|---|---|
| **What is the overall deductible?** | **$300 Individual / $600 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 policy, the overall family deductible must be met before the plan begins to pay. |
| **Are there services covered before you meet your deductible?** | **Yes** | This plan covers some items and services even if you haven't yet met the deductible amount (i.e. office visits, prescription drugs). For those services a copayment may apply. |
| **Are there other deductibles for specific services?** | **$50 Individual / $100 Family for Dental services. There are no other specific deductibles.** | You must pay all of the costs for non-preventive dental services up to the specific deductible amount before the plan begins to pay for dental services. |
| **What is the out-of-pocket limit for this plan?** | **Medical**<br>**$5,000 Individual/$10,000 Family**<br>**Rx $1,850 Ind / $3,700 Family** | The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members on the policy, the overall family out-of-pocket limit must be met before the plan begins to pay. |
| **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**. For a list of preferred providers, visit www.carefirst.com or call **1-800-235-5160**. | This plan uses a preferred provider network. You will pay the most if you use a non-preferred 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. 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 |
|---|---|---|---|---|
| | | Preferred 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% coinsurance | 20% coinsurance plus balance over allowed amount | Out of Network charges above allowed amount are your responsibility |
| | Specialist visit | 20% coinsurance | 20% coinsurance plus balance over allowed amount | Out of Network charges above allowed amount are your responsibility |
| | Preventive care/screening/ immunization | $0 | 20% coinsurance plus balance over allowed amount | Immunizations as recommended by the Department of Health & Human Services |
| **If you have a test** | Diagnostic test (x-ray, blood work) | 20% coinsurance | 20% coinsurance plus balance over allowed amount | Out of Network charges above allowed amount are your responsibility |
| | Imaging (CT/PET scans, MRIs) | 20% coinsurance | 20% coinsurance plus balance over allowed amount | Out of Network 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.express-scripts.com | Generic drugs | $10 copayment/month $20 copayment for 90 days through mail order | N/A | You can receive a 3-month supply for single copay through mail order or at Walgreens. Mail order / Walgreens mandatory after 2 fills for maintenance medications. Mandatory generic program. |
| | Preferred brand drugs | $25 copayment/month $50 copayment for 90 days through mail order | N/A | You can receive a 3-month supply for single copay through mail order or at Walgreens. Mail order / Walgreens mandatory after 2 fills for maintenance medications. . Mandatory generic program. |
| | Non-preferred brand drugs | $25 copayment/month $50 copayment for 90 days through mail order | N/A | You can receive a 3-month supply for single copay through mail order or at Walgreens. Mail order / Walgreens mandatory after 2 fills for |

| Common Medical Event | Services You May Need | What You Will Pay | | Limitations, Exceptions, & Other Important Information |
|---|---|---|---|---|
| | | Preferred Provider (You will pay the least) | Out-of-Network Provider (You will pay the most) | |
| | | | | maintenance medications.<br>. Mandatory generic program. |
| | Specialty drugs | Varies | N/A | Contact Accredo at 1-866-759-1557 |
| **If you have outpatient surgery** | Facility fee (e.g., ambulatory surgery center) | 20% coinsurance | 20% coinsurance based on allowed amount | Out of Network charges above allowed amount are your responsibility |
| | Physician/surgeon fees | 20% coinsurance | 20% coinsurance based on allowed amount | Out of Network charges above allowed amount are your responsibility |
| **If you need immediate medical attention** | Emergency room care | $50 copayment if true emergency<br>$150 copayment if non-emergency | $50 copayment if true emergency<br>$150 copayment if non-emergency | Services must be received within 12 hours of onset of accidental injury or life-threatening illness for coverage as true emergency |
| | Emergency medical transportation | 20% coinsurance | 20% coinsurance | Out of Network charges above allowed amount are your responsibility |
| | Urgent care – office visit only | 20% coinsurance | 20% coinsurance based on allowed amount | Out of Network charges above allowed amount are your responsibility |
| **If you have a hospital stay** | Facility fee (e.g., hospital room) | 20% coinsurance | 20% coinsurance based on allowed amount | Pre-authorization **required –** call American Health Holdings @ **1-800-641-5566.** |
| | Physician/surgeon fees | 20% coinsurance | 20% coinsurance based on allowed amount | Out of Network charges above allowed amount are your responsibility |
| **If you need mental health, behavioral health, or substance abuse services** | Outpatient services | 20% coinsurance | 20% coinsurance based on allowed amount | Substance abuse treatment not covered |
| | Inpatient services | 20% coinsurance | 20% coinsurance based on allowed amount | Pre-authorization **required –** call American Health Holdings @ **1-800-641-5566.**<br>Substance abuse treatment not covered. |
| **If you are pregnant** | Office visits | 20% coinsurance | 20% coinsurance based on allowed amount | Out of Network charges above allowed amount are your responsibility. |
| | Childbirth/delivery professional services | Not Covered | N/A | Members and spouses only. Out of Network charges above allowed amount are your responsibility. |
| | Childbirth/delivery facility | Not Covered | N/A | Members and spouses only. Out of Network |

| Common Medical Event | Services You May Need | What You Will Pay | | Limitations, Exceptions, & Other Important Information |
|---|---|---|---|---|
| | | Preferred Provider (You will pay the least) | Out-of-Network Provider (You will pay the most) | |
| | services | | | charges above allowed amount are your responsibility. |
| **If you need help recovering or have other special health needs** | Home health care | 20% coinsurance | 20% coinsurance based on allowed amount | Out of Network charges above allowed amount are your responsibility |
| | Rehabilitation services | 20% coinsurance | 20% coinsurance based on allowed amount | Pre-authorization **required –** call American Health Holdings @ **1-800-641-5566.** Occupational/ Speech/ Physical therapies/ Chiropractic and Acupuncture – combined 75 visit annual limit. |
| | Habilitation services | Not Covered | Not Covered | |
| | Skilled nursing care | 20% coinsurance | 20% coinsurance based on allowed amount | 100 days per disability |
| | Durable medical equipment | 20% coinsurance | 20% coinsurance based on allowed amount | Medical equipment over $500 must be pre-approved by the plan. |
| | Hospice services | 20% coinsurance | 20% coinsurance based on allowed amount | Palliative care only – maximum of 6 months. Pre-authorization **required –** call American Health Holdings @ **1-800-641-5566.** |
| **If your child needs dental or eye care** | Children's eye exam | Amount above annual allowance | Amount above annual allowance | Plan pays up to $225/person each calendar year for exam/glasses combined. If under age 19, annual maximum does not apply when medically necessary. |
| | Children's glasses | Amount above annual allowance | Amount above annual allowance | |
| | Children's dental check-up | $0 | Amount above plan allowance | Every 6 months. |

## 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.)**

- Cosmetic Surgery
- Dental Care (separate plan)
- Infertility treatment
- Long-term care
- Private duty nursing
- Routine eye care (separate plan)
- Weight loss programs

| Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.) | | |
|---|---|---|
| • Acupuncture and chiropractic care (combined with Physical/Speech/Occupational therapy 75 annual visit maximum) | • Bariatric surgery (medically necessary)<br>• Hearing aids (every 5 years, maximum $300 per ear) | • Non-emergency care outside U.S.<br>• Routine foot care |

**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 1-866-621-7974. You may also contact the Department of Labor Employee Benefits Security Administration at 1-866-444-3272 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 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 443-573-3632 or 1-866-621-7974. You may also contact the U.S. Department of Labor, Benefits Security Administration (1-866-444-3272 or www.dol.gov/ebsa ) or the U.S. Department of Health and Human Services (1-877-267-2323 X61565 or www.cciio.cms.gov )

**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.

*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 | $300 |
| Specialist *[cost sharing]* | 20% |
| Hospital (facility) *[cost sharing]* | 20% |
| Other *[cost sharing]* | $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** | **$12,738** |
|---|---|

**In this example, Peg would pay:**

| *Cost Sharing* | |
|---|---|
| Deductibles | $300 |
| Copayments | $40 |
| Coinsurance | $2,041 |
| *What isn't covered* | |
| Limits or exclusions | $2,454 |
| **The total Peg would pay is** | **$4,835** |

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

| | |
|---|---|
| The plan's overall deductible | $300 |
| Specialist *[cost sharing]* | 20% |
| Hospital (facility) *[cost sharing]* | 20% |
| Other *[cost sharing]* | $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** | **$7,400** |
|---|---|

**In this example, Joe would pay:**

| *Cost Sharing* | |
|---|---|
| Deductibles | $300 |
| Copayments | $635 |
| Coinsurance | $558 |
| *What isn't covered* | |
| Limits or exclusions | $55 |
| **The total Joe would pay is** | **$1,575** |

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

| | |
|---|---|
| The plan's overall deductible | $300 |
| Specialist *[cost sharing]* | 20% |
| Hospital (facility) *[cost sharing]* | 20% |
| Other *[cost sharing]* | $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** | **$1,941** |
|---|---|

**In this example, Mia would pay:**

| *Cost Sharing* | |
|---|---|
| Deductibles | $300 |
| Copayments | $150 |
| Coinsurance | $274 |
| *What isn't covered* | |
| Limits or exclusions | $0 |
| **The total Mia would pay is** | **$724** |

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