

 **Truck Drivers and Helpers Local 355 Health and Welfare Fund Plan E - 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:
<u>What is the overall deductible?</u>	\$300 Individual / \$600 Family	Generally, you must pay all of the costs from providers up to the <u>deductible</u> amount before this plan begins to pay. If you have other family members on the policy, the overall family <u>deductible</u> must be met before the <u>plan</u> begins to pay.
<u>Are there services covered before you meet your deductible?</u>	Yes	This <u>plan</u> covers some items and services even if you haven't yet met the <u>deductible</u> amount (i.e. office visits, prescription drugs). For those services a <u>copayment</u> may apply.
<u>Are there other deductibles for specific services?</u>	\$50 Individual / \$100 Family for Dental services. There are no other specific deductibles.	You must pay all of the costs for <u>non-preventive</u> dental services up to the specific <u>deductible</u> amount before the plan begins to pay for dental services.
<u>What is the out-of-pocket limit for this plan?</u>	Medical \$5,000 Individual/\$10,000 Family Rx \$1,850 Ind / \$3,700 Family	The <u>out-of-pocket limit</u> is the most you could pay in a year for covered services. If you have other family members on the policy, the overall family <u>out-of-pocket limit</u> must be met before the <u>plan</u> begins to pay.
<u>What is not included in the out-of-pocket limit?</u>	Premiums, balance-billing charges and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u> .
<u>Will you pay less if you use a network provider?</u>	Yes. For a list of preferred providers, visit www.carefirst.com or call 1-800-235-5160.	This <u>plan</u> uses a <u>preferred provider</u> network. You will pay the most if you use a <u>non-preferred provider</u> , and you might receive a bill from a <u>provider</u> for the difference between the <u>provider's</u> charge and what your <u>plan</u> pays (balance billing). Be aware, your <u>network provider</u> might use an <u>out-of-network provider</u> for some services (such as lab work). Check with your <u>provider</u> before you get services.
<u>Do you need a referral to see a specialist?</u>	No.	You can see the <u>specialist</u> you choose without a referral. You will pay less if you choose a <u>preferred provider specialist</u> .

 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 <u>provider's</u> office or clinic	<u>Primary care</u> visit to treat an injury or illness	\$20	\$20 plus balance over allowed amount	Out of Network charges above allowed amount are your responsibility
	<u>Specialist</u> visit	\$20	\$20 plus balance over allowed amount	Out of Network charges above allowed amount are your responsibility
	<u>Preventive care/screening/immunization</u>	\$0	\$20 plus balance over allowed amount	Immunizations as recommended by the Department of Health & Human Services
If you have a test	<u>Diagnostic test</u> (x-ray, blood work)	\$0 for first \$300/year 20% <u>coinsurance</u> thereafter	\$0 for first \$300/year 20% <u>coinsurance</u> thereafter	Out of Network charges above allowed amount are your responsibility
	<u>Imaging</u> (CT/PET scans, MRIs)	\$0 for first \$300/year 20% <u>coinsurance</u> thereafter	\$0 for first \$300/year 20% <u>coinsurance</u> thereafter	Out of Network charges above allowed amount are your responsibility
If you need drugs to treat your illness or condition More information about <u>prescription drug coverage</u> is available at www.express-scripts.com.com	<u>Generic drugs</u>	\$10 <u>copayment</u> /month \$20 <u>copayment</u> 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.
	<u>Preferred brand drugs</u>	\$25 <u>copayment</u> /month \$50 <u>copayment</u> 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.
	<u>Non-preferred brand drugs</u>	\$25 <u>copayment</u> /month \$50 <u>copayment</u> 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.
	<u>Specialty drugs</u>	Varies	N/A	Contact Accredo at 1-866-759-1557

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 have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% <u>coinsurance</u>	20% <u>coinsurance</u> based on allowed amount	Out of Network charges above allowed amount are your responsibility
	Physician/surgeon fees	20% <u>coinsurance</u>	20% <u>coinsurance</u> based on allowed amount	Out of Network charges above allowed amount are your responsibility
If you need immediate medical attention	Emergency room care	\$50 <u>copayment</u> if true emergency \$150 <u>copayment</u> if non-emergency	\$50 <u>copayment</u> if true emergency \$150 <u>copayment</u> 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% <u>coinsurance</u>	20% <u>coinsurance</u>	
	Urgent care – office visit only	\$20	\$15 plus balance over 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% <u>coinsurance</u>	20% <u>coinsurance</u> based on allowed amount	Pre-authorization required – call American Health Holdings @ 1-800-641-5566 . Semi-private room rate/up to 180 days per disability.
	Physician/surgeon fees	20% <u>coinsurance</u>	20% <u>coinsurance</u> 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% <u>coinsurance</u>	20% <u>coinsurance</u> based on allowed amount	Out of Network charges above allowed amount are your responsibility
	Inpatient services	20% <u>coinsurance</u>	20% <u>coinsurance</u> based on allowed amount	Pre-authorization required – call American Health Holdings @ 1-800-641-5566 . Semi-private room rate/up to 180 days per disability.
If you are pregnant	Office visits	20% <u>coinsurance</u>	20% <u>coinsurance</u> based on allowed amount	Out of Network charges above allowed amount are your responsibility.
	Childbirth/delivery professional services	20% <u>coinsurance</u>	20% <u>coinsurance</u> based on allowed amount	Members and spouses only. Out of Network charges above allowed amount are your responsibility.
	Childbirth/delivery facility services	20% <u>coinsurance</u>	20% <u>coinsurance</u> based on allowed amount	Members and spouses only. Out of Network charges above allowed amount are your responsibility.
If you need help	Home health care	20% <u>coinsurance</u>	20% <u>coinsurance</u> based on	

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)	
recovering or have other special health needs			allowed amount	
	Rehabilitation services	20% <u>coinsurance</u>	20% <u>coinsurance</u> 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% <u>coinsurance</u>	20% <u>coinsurance</u> based on allowed amount	100 days per disability
	Durable medical equipment	20% <u>coinsurance</u>	20% <u>coinsurance</u> based on allowed amount	Medical equipment over \$500 must be pre-approved by the <u>plan</u> .
	Hospice services	\$0	\$0	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 <u>plan</u> 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)
- Hearing aids (every 5 years, maximum \$5,000)
- Non-emergency care outside U.S.
- 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 443-573-3635 or 1-888-805-7996. 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.

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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	\$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
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In this example, Peg would pay:

Cost Sharing	
Deductibles	\$300
Copayments	\$80
Coinsurance	\$2,480
What isn't covered	
Limits or exclusions	\$60
The total Peg would pay is	\$2,920

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
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In this example, Joe would pay:

Cost Sharing	
Deductibles	\$300
Copayments	\$835
Coinsurance	\$372
What isn't covered	
Limits or exclusions	\$55
The total Joe would pay is	\$1,563

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
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In this example, Mia would pay:

Cost Sharing	
Deductibles	\$300
Copayments	\$210
Coinsurance	\$215
What isn't covered	
Limits or exclusions	\$0
The total Mia would pay is	\$725

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