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 the Fund Office at 1-888-490-8800. 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 or call 1-888-490-8800 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	$200/individual or $500/family. Doesn't apply to prescription drugs. Balance billing, excluded services **deductibles** for specific services (i.e. dental), do not count toward the **deductible**.	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 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	For covered Employees, an Annual Physical is covered before the deductible. For all other services, you will have to meet the **deductible** before the plan pays for any services.
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?	Not applicable.	This **plan** does not have an **out-of-pocket limit** on your expenses.
What is not included in the out-of-pocket limit?	Not applicable.	This **plan** does not have an **out-of-pocket limit** on your expenses.
Will you pay less if you use a network provider?	Yes. See https://individual.carefirst.com/ or call 1-800-810-2583.	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 **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	20% coinsurance*	50% co-insurance*	--None--
	Specialist visit	20% coinsurance*	50% co-insurance	--None--
	Preventive care/screening/ immunization	$0 – Annual physical for Employees 20% coinsurance* all other preventive care/screening/ immunization	50% co-insurance*	Annual physicals: one/year. Flu shots: one/ year; pneumonia shots: one/ lifetime; shingles vaccine: one/ lifetime. Benefits are available for mammograms as follows: From age 35 through 39: one mammogram. From age 40 through 49: one mammogram/ every other year. Age 50 and over: one mammogram / 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)	20% coinsurance*	50% co-insurance*	--None--
	Imaging (CT/PET scans, MRIs)	20% coinsurance*	50% co-insurance*	Preauthorization is required for outpatient diagnostic imaging. Contact American Health Holdings at the number printed on your Identification Card to obtain preauthorization.
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.caremark.com	Generic drugs	$0 copay retail $0 copay mail	Same as participating plus balance billing.	Retail orders: 30-day supply; Mail/CVS orders: 90-day supply. Over-the-counter and certain non-formulary brand name drugs are not covered by CVS/Caremark. In order to receive these drugs, you must obtain preauthorization by contacting CVS/Caremark at (866) 282-8503 or www.caremark.com. Mail order CVS is mandatory for maintenance medications after 2 retail fill limit.
	Preferred brand drugs	$20 copay retail $45 copay mail	Same as participating plus balance billing.	
	Non-preferred brand drugs	$35 copay retail $75 copay mail	Same as participating plus balance billing.	
	Specialty drugs	30% coinsurance**	Same as participating plus balance billing.	

[*There are no co-insurance charges for the first $4,000 in covered benefits and no co-insurance charges after $12,000 in covered benefits for in-network services.
For more information about limitations and exceptions, see the plan or policy document at www.ourbenefitoffice.com/asbestosworkerslocal24/benefits.]
[**30% coinsurance applies only to specialty drugs that are covered under the PrudentRx Solution program; however, members that complete the PrudentRx enrollment will not be subject to the 30% coinsurance. Specialty drugs not covered by the Prudent Rx Solution program are subject to a $20 copay for retail and $45 copay for mail scripts.]

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)	20% coinsurance*	50% coinsurance*	Preauthorization is required for certain outpatient procedures. Contact American Health Holdings at the number printed on your Identification Card to obtain preauthorization. 20% coinsurance applies to out-of-network ancillary services at an in-network facility.
	Physician/surgeon fees	20% coinsurance*	50% coinsurance*	Assistant surgeons covered up to 25% of fee.
If you need immediate medical attention	Emergency room care	20% coinsurance* $100 copayment/visit	20% coinsurance* $100 copayment	The copayment of $100 will be waived if the visit to the ER was for a life threatening illness, was for an injury that requires immediate medical attention, or the patient is admitted to the hospital directly from the ER.
	Emergency medical transportation	20% coinsurance*	20% coinsurance*	Ambulance service is covered when transported to a local Hospital.
	Urgent care	20% coinsurance*	50% coinsurance*	20% coinsurance* applies to emergency services received at an out-of-network facility.
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance*	50% coinsurance*	Hospital charges for *semi-private room and board* and covered inpatient services for as long as hospitalization is medically required. Hospital charges for private room and board will be covered when medically necessary. 20% coinsurance applies to out-of-network ancillary services at an in-network facility.
	Physician/surgeon fees	20% coinsurance*	50% coinsurance*	--None--
If you need mental health, behavioral	Outpatient services	20% coinsurance*	50% coinsurance*	20% coinsurance applies to out-of-network ancillary services at an in-network facility.
	Inpatient services	20% coinsurance*	50% coinsurance*	

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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)	
health, or substance abuse services				
If you are pregnant	Office visits	20% coinsurance*	50% coinsurance*	--None--
	Childbirth/delivery professional services	20% coinsurance*	50% coinsurance*	--None--
	Childbirth/delivery facility services	20% coinsurance*	50% coinsurance*	--None--
If you need help recovering or have other special health needs	Home health care	20% coinsurance*	50% coinsurance*	Preauthorization required.
	Rehabilitation services	20% coinsurance*	50% coinsurance*	Occupational therapy or rehabilitation is covered when provided following illness or injury.
	Habilitation services	20% coinsurance*	50% coinsurance*	Occupational therapy or rehabilitation is covered when provided following illness or injury.
	Skilled nursing care	20% coinsurance*	50% coinsurance*	45-day limit, unless the Fund's medical consultant or case management agent determines that the alternative to extended treatment at the facility will be more costly to the Fund.
	Durable medical equipment	20% coinsurance*	50% coinsurance*	Preauthorization required. Wheelchair benefits are limited to rental for up to 90 days or purchase no more often than once per five years.
	Hospice services	20% coinsurance*	50% coinsurance*	Coverage is provided for a terminally ill patient with a prognosis of no more than six months to live. Additional six-month benefit periods are covered if the patient remains alive and submits a Physician's certification.

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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 your child needs dental or eye care	Children's eye exam	$0	$0	Professional fees, materials and lenses are available once each calendar year, if necessary. Benefits subject to standard medical protocols and reasonable and customary limitations. This plan utilizes NVA for vision services.
	Children's glasses	20% coinsurance*	20% coinsurance*	Frames and lenses once every two years. Benefits subject to standard medical protocols and reasonable and customary limitations. This plan utilizes NVA for vision services.
	Children's dental check-up	20% coinsurance*	20% coinsurance*	Routine exams limited to two per year. Benefits subject to standard medical protocols and reasonable and customary limitations.

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 (with limited exceptions)
- Long-term care
- Routine foot care
- Weight loss programs
- Private-duty Nursing

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

- Acupuncture (if provided by a Physician or licensed acupuncturist)
- Adult dental care (limited to $2,000 per person per calendar year)
- Bariatric surgery (when approved by Fund Medical Consultant)
- Chiropractic care
- Hearing aids (limited to $4,000 per person every 3-years)
- Medically necessary infertility treatment (limited to $10,000 per lifetime including prescriptions)
- Non-emergency care when traveling outside the US
- Routine adult eye care (limited to $250 per person per calendar year)

Your Rights to Continue Coverage: For information on your rights to continue coverage, contact the Plan at 1 (888) 490-8800. There are agencies that can help if you want to continue your coverage after it ends. You may also contact your State Insurance department, the US Department of Labor, Employee Benefits Security Administrations at 1 (866) 444-3272 or www.dol.gov/ebsa. 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,

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contact: Asbestos Workers Local 24 Medical Fund, 7130 Columbia Gateway Drive, Suite A, Columbia, MD 21046. Telephone: 1 (888) 490-8800, or the US Department of Labor, Employee Benefits Security Administrations at 1 (866) 444-3272 or www.dol.gov/ebsa.

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	$200
Specialist *[cost sharing]*	20%
Hospital (facility) *[cost sharing]*	20%
Other *[cost sharing]*	20%

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	$200
Copayments	$0
Coinsurance*	$1,600
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$1,860**

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

The plan's overall deductible	$200
Specialist *[cost sharing]*	20%
Hospital (facility) *[cost sharing]*	20%
Other *[cost sharing]*	20%

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	$200
Copayments	$500
Coinsurance*	$180
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$900**

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

The plan's overall deductible	$200
Specialist *[cost sharing]*	20%
Hospital (facility) *[cost sharing]*	20%
Other *[cost sharing]*	20%

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	$200
Copayments	$0
Coinsurance*	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$200**

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

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