The Summary of Benefits and Coverage (SBC) document will help you understand your health plan. The SBC shows you how you and the plan share the cost for covered health care services. This document is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, please refer to the **plan**'s summary plan description (the "SPD") available at www.roadcarriers707.com or by calling 516-560-8500. 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.roadcarriers707.com or call 516-560-8500 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	None for in-network service; $200/individual, $400/family for out-of-network service.	Generally, when the deductible applies, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay.
Are there services covered before you meet your deductible?	No deductible for in-network service; no deductible for hospital, emergency room, ambulance services, prescriptions, dental, vision or hearing aids out-of-network.	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply.
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?	If in-network $2,000/individual, $4,000/family; If out-of-network $2,500 / individual, $5,000/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?	Deductibles, premiums, balance-billed 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.empireblue.com or call 1-800-810-BLUE for a list of participating 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 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)
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	$15 copay/visit.	30% coinsurance.	----------none----------
	Specialist visit	$15 copay/visit.	30% coinsurance.	For acupuncture, coverage is limited to 6 visits per plan year. For podiatry, coverage is limited to 24 visits per plan year. For a dermatologist or chiropractor visit, coverage is limited to $500 per plan year. Other maximum limits on visits may apply.
	Preventive care/screening/ immunization	No charge.	30% coinsurance.	Mammograms are covered once per plan year for women age 40 and older. You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	20% coinsurance.	30% coinsurance.	----------none----------
	Imaging (CT/PET scans, MRIs)	20% coinsurance.	30% coinsurance.	Precertification is required for MRIs, CAT scans and PET scans.

* For more information about limitations and exceptions, see the SPD at www.roadcarriers 707.com.

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 need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.myallegiantrx.com	Generic drugs	$5 copay/item (retail); $10 copay/item (mail order).	Not covered.	Covers up to a 30 day supply (retail prescription) or 90 day supply (mail order prescription). Certain drugs are subject to step therapy or quantity limitations. Preauthorization is required for certain narcotics, drugs that treat ED, drugs that cost more than $1,000 (retail) or $3,500 (mail order), and compound drugs costing more than $250. Semaglutide medications are excluded from the Plan for any off-label use, such as weight loss. Certain factors must be met to obtain medications in this classification. Continuous Glucose Monitoring Devices (CGMs) are covered for individuals who meet criteria determined by the Trustees. For a list of criteria you must meet, contact the Fund office
	Preferred brand drugs	$25 copay/item (retail); $50 copay/item (mail order).	Not covered.	Same.
	Non-preferred brand drugs	$40 copay/item (retail) plus price spread; $80 copay/item plus price spread (mail order).	Not covered.	Same. Price spread is the difference between the amount charged for a preferred brand drug and the amount charged for a non-preferred brand drug
	Specialty drugs	Same as for preferred brand drugs.	Not covered.	Same.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance.	30% coinsurance.	----------none----------
	Physician/surgeon fees	20% coinsurance.	30% coinsurance.	Precertification may be required for certain nonemergency or other surgery.
If you need immediate medical attention	Emergency room care	$100 copay/visit.	$100 copay/visit.	Copay waived if admitted.
	Emergency medical transportation	20% coinsurance.	20% coinsurance.	----------none----------

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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)	
	Urgent care	$15 copay/visit.	30% coinsurance.	----------none----------
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance.	30% coinsurance.	Precertification is required (failure to precertify results in 50% coinsurance up to $2,500).
	Physician/surgeon fees	20% coinsurance.	30% coinsurance.	Precertification may be required for certain nonemergency or other surgery.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	1-5 visits $10 co-pay each; additional visits $15 co-pay each.	30% coinsurance.	----------none----------
	Inpatient services	20% coinsurance.	30% coinsurance.	Treatment must be precertified.
If you are pregnant	Office visits	$15 copay/visit.	30% coinsurance.	----------none----------
	Childbirth/delivery professional services	20% coinsurance.	30% coinsurance.	----------none----------
	Childbirth/delivery facility services	20% coinsurance.	30% coinsurance.	----------none----------
If you need help recovering or have other special health needs	Home health care	20% coinsurance	30% coinsurance.	Coverage is limited to 100 visits/ plan year.Payments and maximum limits are reduced if home care is not in lieu of hospitalization.
	Rehabilitation services	$15 copay/visit.	30% coinsurance.	Coverage is limited to 24 visits per plan year for physical/occupational therapy.
	Habilitation services	$15 copay/visit.	30% coinsurance.	For correcting maldevelopment of proper speech patterns in a child, coverage is limited to 30 treatments/ plan year after government benefits are exhausted. Speech therapy for habilitation is limited to two years.
	Skilled nursing care	20% coinsurance.	30% coinsurance.	Precertification is required. Coverage is limited to 60 days/plan year.
	Durable medical equipment	20% coinsurance.	30% coinsurance.	Precertification is required. Coverage for orthotics for the feet is limited to two pairs/lifetime up to $500 max.
	Hospice services	20% coinsurance.	30% coinsurance.	Precertification is required. Coverage is limited to 210 day inpatient maximum.

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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	Eye exam	No charge.	$15 reimbursed by Vision Care provider.	Out-of-network coverage is subject to a $75 maximum per individual (combined with glasses) every two plan years.
	Glasses	No charge.	$50 eye glasses, $75 contact lenses reimbursed by Vision Care provider.	For in-network, coverage is limited to only frame and one pair single standard, bifocal or trifocal lens per year. Out-of-network coverage is subject to a $75 maximum per individual (combined with eye exam)
	Dental check-up	No charge.	After deductible, reimbursed at Dental provider fee schedule. Member pays balance.	Additional dental services are covered only if listed in Appendix A of SPD. One exam allowed each 6 months. Coverage for orthodontics is limited to $3,000 per individual per lifetime.

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
- Infertility treatment
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Weight loss programs (unless medically necessary)

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

- Acupuncture
- Bariatric surgery (if medically necessary)
- Chiropractic care
- Dental care (adult)
- Hearing aids
- Private-duty nursing
- Routine eye care (Adult)
- Routine foot care

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: [insert State, HHS, DOL, and/or other applicable agency contact information]. Other coverage options may be available to you too, including buying

* For more information about limitations and exceptions, see the SPD at www.roadcarriers 707.com.

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 SPD also provides 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: Road Carriers Local 707 Welfare Fund at 516-560-8500.

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 516-560-8500.

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

FOR ADDITIONAL BENEFIT INFORMATION AND PHONE NUMBERS:

DAVIS VISION/VISION WORKS – 1-800-283-9374

DENTAL – DDS – 1-800-255-5681

RX PRESCRIPTIONS – OPTUM RX – 1-866-888-0103

* For more information about limitations and exceptions, see the SPD at www.roadcarriers 707.com.

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 *[cost sharing]*	$15
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	**$12,731**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$1,000
Copayments	$
Coinsurance	$
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$1,060**

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 *[cost sharing]*	$15
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	**$7,391**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$790
Copayments	$210
Coinsurance	$
What isn't covered	
Limits or exclusions	$55
The total Joe would pay is	**$1,055**

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

The plan's overall deductible	$0
Specialist *[cost sharing]*	$15
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	**$1,925**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$713
Copayments	$
Coinsurance	$
What isn't covered	
Limits or exclusions	$
The total Mia would pay is	**$713**