



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](http://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](http://www.roadcarriers707.com) or call 516-560-8500 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall <u>deductible</u> ?	None for in-network service; \$250/individual, \$500/family for out-of-network service.	Generally, when the deductible applies, you must pay all of the costs from <u>providers</u> up to the <u>deductible</u> 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 <u>deductible</u> ?	No deductible for in-network service; no deductible for hospital, emergency room, ambulance services, prescriptions, dental, vision or hearing aids out-of-network.	This <u>plan</u> covers some items and services even if you haven't yet met the <u>deductible</u> amount. But a <u>copayment</u> or <u>coinsurance</u> may apply.
Are there other <u>deductibles</u> for specific services?	Yes. \$50 per individual/\$100 per family for dental services. There are no other specific deductibles.	You must pay all of the costs for these services up to the specific <u>deductible</u> amount before this <u>plan</u> begins to pay for these services.
What is the <u>out-of-pocket limit</u> for this <u>plan</u> ?	If in-network \$2,000/individual, \$4,000/family; If out-of-network \$2,500 / individual, \$5,000/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 in this <u>plan</u> , they have to meet their own <u>out-of-pocket limits</u> until the overall family <u>out-of-pocket limit</u> has been met.
What is not included in the <u>out-of-pocket limit</u> ?	Deductibles, co-payments, balance-billed 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> .
Will you pay less if you use a <u>network provider</u> ?	Yes. See <a href="http://www.empireblue.com">www.empireblue.com</a> or call 1-800-810-BLUE for a list of participating providers.	This <u>plan</u> uses a <u>provider network</u> . You will pay less if you use a <u>provider</u> in the <u>plan's network</u> . You will pay the most if you use an <u>out-of-network provider</u> , and you might receive a bill from a <u>provider</u> for the difference between the <u>provider's charge</u> and what your <u>plan</u> pays ( <u>balance billing</u> )
Do you need a <u>referral</u> to see a <u>specialist</u> ?	No.	You can see the <u>specialist</u> you choose without a <u>referral</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*
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care <a href="#">provider's</a> office or clinic	Primary care visit to treat an injury or illness	\$20 copay/visit and 20% coinsurance.	30% coinsurance.	-----none-----
	<a href="#">Specialist</a> visit	\$20 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, except participants diagnosed with skin cancer the plan year limit is \$1,500. Other maximum limits on visits may apply.
	<a href="#">Preventive care/screening/immunization</a>	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	<a href="#">Diagnostic test</a> (x-ray, blood work)	\$25 copay, then 20% coinsurance.	30% coinsurance.	-----none-----
	Imaging (CT/PET scans, MRIs)	\$25 copay, then 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.roadcarriers707.com](http://www.roadcarriers707.com).  
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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)	
<b>If you need drugs to treat your illness or condition</b> More information about <a href="#">prescription drug coverage</a> is available at <a href="http://www.myallegiantrx.com">www.myallegiantrx.com</a>	Generic drugs	\$10 copay/item (retail); \$20 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	\$50 copay/item (retail) plus price spread; \$100 copay/item plus price spread (mail order).	Not covered.	Same. Price spread is the difference between the cost of the preferred brand drug and non-preferred brand drug.
	<a href="#">Specialty drugs</a>	Same as for preferred brand drugs.	Not covered.	Same.
<b>If you have outpatient surgery</b>	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.
	<a href="#">Emergency room care</a>	\$100 copay/visit.	\$100 copay/visit.	Copay waived if admitted.

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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)	
<b>If you need immediate medical attention</b>	<a href="#">Emergency medical transportation</a>	20% coinsurance.	20% coinsurance.	-----none-----
	<a href="#">Urgent care</a>	\$20 copay/visit.	30% coinsurance.	-----none-----
<b>If you have a hospital stay</b>	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.
<b>If you need mental health, behavioral health, or substance abuse services</b>	Outpatient services	1-5 visits \$10 co-pay each; additional visits \$20 co-pay each.	30% coinsurance.	For in-network benefits, no copay is required for attendance at group session appointments. Instead,
	Inpatient services	20% coinsurance.	30% coinsurance.	Treatment must be precertified.
<b>If you are pregnant</b>	Office visits	\$20 copay/visit.	30% coinsurance.	-----none-----
	Childbirth/delivery professional services	20% coinsurance.	30% coinsurance.	-----none-----
	Childbirth/delivery facility services	20% coinsurance.	30% coinsurance.	-----none-----
<b>If you need help recovering or have other special health needs</b>	<a href="#">Home health care</a>	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. A prescription is required to be sent to the Fund Office describing the plan of treatment for patient.
	<a href="#">Rehabilitation services</a>	\$20 copay/visit.	30% coinsurance.	Coverage is limited to 24 visits per plan year for physical/occupational therapy. A prescription is required to be sent to the Fund Office describing the plan of treatment for patient.
	<a href="#">Habilitation services</a>	\$20 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. A prescription is required to be sent to the Fund

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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)	
				Office describing the plan of treatment for patient.
	<a href="#">Skilled nursing care</a>	20% coinsurance.	30% coinsurance.	Precertification is required. Coverage is limited to 30 days/plan year.
	<a href="#">Durable medical equipment</a>	20% coinsurance.	30% coinsurance.	Precertification is required. Coverage for orthotics for the feet is limited to two pairs/lifetime up to \$500 max.
	<a href="#">Hospice services</a>	20% coinsurance.	30% coinsurance.	Precertification is required. Coverage is limited to 210 day inpatient maximum.
	ABA Therapy	\$20 copay/visits	30% coinsurance	Pre-authorization is not required. However, a prescription is required to be sent to the Fund Office describing the plan of treatment for patient. Coverage is limited to 30 visits per plan year.
If your child needs dental or eye care	Eye exam	No charge.	\$20 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. Out-of-network coverage is subject to a \$75 maximum per individual (combined with eye exam) every two plan years.
	Dental check-up	\$50 deductible for individual/\$100 family per plan year of scheduled amount for covered services. No charge after deductible is met.	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 may be limited by schedule. Coverage for orthodontics is limited to \$3,000 per individual per lifetime.

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### 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: [NYS, HHS, DOL, and/or other applicable agency contact information]. 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](http://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 1-516-560-8500.

#### 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 1-800-366-3707.

—————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 <a href="#">plan's</a> overall <a href="#">deductible</a>	\$0
■ <a href="#">Specialist</a> [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*)

<b>Total Example Cost</b>	<b>\$12,731</b>
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#### In this example, Peg would pay:

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

### Managing Joe's type 2 Diabetes

(a year of routine in-network care of a well-controlled condition)

■ The <a href="#">plan's</a> overall <a href="#">deductible</a>	\$0
■ <a href="#">Specialist</a> [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*)

<b>Total Example Cost</b>	<b>\$7,391</b>
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#### In this example, Joe would pay:

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

### Mia's Simple Fracture

(in-network emergency room visit and follow up care)

■ The <a href="#">plan's</a> overall <a href="#">deductible</a>	\$0
■ <a href="#">Specialist</a> [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*)

<b>Total Example Cost</b>	<b>\$1,925</b>
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#### In this example, Mia would pay:

Cost Sharing	
Deductibles	\$713
Copayments	\$
Coinsurance	\$
What isn't covered	
Limits or exclusions	\$
<b>The total Mia would pay is</b>	<b>\$713</b>