Daryl Thomason Trucking Health & Wellness Plan: PPO Coverage Period: 03/01/2014 to 12/31/2014

Summary of Benefits and Coverage: What this Plan Covers & What it Costs **Coverage for:** Employee and Family | **Plan Type:** PPO

This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at www.epstpa.com or by calling 1-800-749-2631.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	For participating providers: $1500 person/$3000 family; For non-participating providers: $6350 person/$12700 family;	You must pay all the costs up to the **deductible** amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the **deductible** starts over (usually, but not always, January 1st). See the chart starting on page 2 for how much you pay for covered services after you meet the **deductible**.
Are there other deductibles for specific services?	$500 Prescription Drug Deductible, excluding generics	You must pay all the costs up to the **deductible** amount before this plan begins to pay for these services.
Is there an out–of–pocket limit on my expenses?	For participating providers $2250 person/$4500 family; For non-participating providers $6350 person / $12700 family	The **out-of-pocket limit** is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.
What is not included in the out–of–pocket limit?	Premiums, Deductibles, balance-billed charges, health care this plan doesn't cover, prescription drug benefits & pre-cert penalties	Even though you pay these expenses, they don't count toward the **out-of-pocket limit**.
Is there an overall annual limit on what the plan pays?	No	The chart starting on page 2 describes any limits on what the plan will pay for *specific* covered services, such as office visits.
Does this plan use a network of providers?	Yes. See **www.healthsmart.com or call 1-800-687-0500** for a list of participating providers	If you use an in-network doctor or other health care provider, this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network provider for some services. Plans use the term in-network, preferred, or participating for providers in their network. See the chart starting on page 2 for how this plan pays different kinds of providers.
Do I need a referral to see a specialist?	No. You don't need a referral to see a specialist.	You can see the specialist you choose without permission from this plan.
Are there services this plan doesn't cover?	Yes	Some of the services this plan doesn't cover are listed on page 5. See your policy or plan document for additional information about excluded services.

Questions: Call 800-749-2631 or visit us at www.epstpa.com
If you aren't clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary at http://www.dol.gov/ebsa/pdf/SBCUniformGlossary.pdf or call 1-800-749-2631 to request a copy.

OMB Control Numbers 1545-2229, 1210-0147, and 0938-1146

- **Copayments** are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.
- **Coinsurance** is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is $1,000, your **coinsurance** payment of 20% would be $200. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges $1,500 for an overnight stay and the **allowed amount** is $1,000, you may have to pay the $500 difference. (This is called **balance billing**.)
- This plan may encourage you to use PPO **providers** by charging you lower **deductibles**, **copayments** and **coinsurance** amounts.

Common Medical Event	Services You May Need	Your Cost If You Use an In-network Provider	Your Cost If You Use an Out-of-network Provider	Limitations & Exceptions
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$25 copay / visit	50% coinsurance	
	Specialist visit	$25 copay / visit	50% coinsurance	
	Other practitioner office visit	20% coinsurance for chiropractor	50% coinsurance for chiropractor	Chiropractic care limited to 12 visits per month not to exceed 30 visits per year.
	Preventive care/screening/immunization	No Charge	Not Covered	None
If you have a test	Diagnostic test (x-ray, blood work)	20% coinsurance after deductible	50% coinsurance	No charge if billed with office visit.
	Imaging (CT/PET scans, MRIs)	20% coinsurance after deductible	50% coinsurance	No charge if OneCall Medical is utilized.

Common Medical Event	Services You May Need	Your Cost If You Use an In-network Provider	Your Cost If You Use an Out-of-network Provider	Limitations & Exceptions
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.maxcarerx.com	Generic drugs	$10 retail 30-day $25 90-day per prescription	Not Covered	1-30 day supply - $10 90-day supply (retail/mail order) - $25.
	Preferred brand drugs	$50 retail 30-day $125 90-day per prescription after deductible	Not Covered	1-30 day supply - $50 90-day supply (retail/mail order) - $125
	Non-preferred brand drugs	50% co-insurance	Not Covered	Rx Deductible $500 per year, excluding generics.
	Specialty drugs	50% co-insurance	Not Covered	Rx Deductible $500 per year, excluding generics.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance	50% coinsurance + $250 copay per confinement	
	Physician/surgeon fees	20% coinsurance	50% coinsurance	
If you need immediate medical attention	Emergency room services	$100 copay + 20% coinsurance	$100 copay + 20% coinsurance	Benefits reduced by 50% if care not deemed to be life or limb threatening. Copay waived if admitted.
	Emergency medical transportation	20% coinsurance	20% coinsurance	
	Urgent care	$35 copay	50% coinsurance	
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance	50% coinsurance + $250 copay per confinement	Requires pre-certification.
	Physician/surgeon fee	20% coinsurance	50% coinsurance	

Common Medical Event	Services You May Need	Your Cost If You Use an In-network Provider	Your Cost If You Use an Out-of-network Provider	Limitations & Exceptions
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	20% coinsurance	50% coinsurance	26 visits per year
	Mental/Behavioral health inpatient services	20% coinsurance	50% coinsurance + $250 copay per confinement	30 days per year Requires pre-certification.
	Substance use disorder outpatient services	20% coinsurance	50% coinsurance	26 visits per year
	Substance use disorder inpatient services	20% coinsurance	50% coinsurance + $250 copay per confinement	30 days per year Requires pre-certification.
If you are pregnant	Prenatal and postnatal care	20% coinsurance	50% coinsurance	
	Delivery and all inpatient services	20% coinsurance	50% coinsurance + $250 copay per confinement	Requires pre-certification.
If you need help recovering or have other special health needs	Home health care	20% coinsurance	50% coinsurance	60 visit maximum per calendar year
	Rehabilitation services	20% coinsurance	50% coinsurance	
	Habilitation services	20% coinsurance	50% coinsurance	Developmental delays not covered.
	Skilled nursing care	20% coinsurance	50% coinsurance	30-day maximum per calendar year Requires pre-certification.
	Durable medical equipment	20% coinsurance	50% coinsurance	Limited to rental up to purchase price
	Hospice service	No Charge	50% coinsurance	Requires recertification by physician every 30 days
If your child needs dental or eye care	Eye exam	No Charge	Not Covered	Vision screening provided by pediatrician
	Glasses	Not Covered	Not Covered	Not Covered
	Dental check-up	No Charge	Not Covered	Oral health screening provided by pediatrician.

Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy or plan document for other excluded services.)

- Acupuncture
- Bariatric surgery
- Hearing aids (Adult)
- Private-duty nursing
- Cosmetic surgery
- Infertility treatment
- Routine foot care
- Dental care (Adult)
- Long-term care
- Weight loss programs
- Routine eye care (Adult)
- Non-emergency care when traveling outside the U.S

Other Covered Services (This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)

- Chiropractic care

Your Rights to Continue Coverage:

If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a **premium**, which may be significantly higher than the premium you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply.

For more information on your rights to continue coverage, contact the Plan at Daryl Thomason Trucking (580) 584-2877. You may also contact the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565.

Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to **appeal** or file a **grievance**. For questions about your rights, this notice, or assistance, you can contact: Darlene Timbes at Daryl Thomason Trucking (580) 584-2877. You may also contact the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa. You may also contact Equitable Plan Services, Inc. at 800-749-2631.

Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al 800-749-2631.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 800-749-2631.

Chinese (中文): 如果需要中文的帮助，**请拨打这个号码** 800-749-2631.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 800-749-2631.

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

About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.

This is not a cost estimator.

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

Having a baby
(normal delivery)

- **Amount owed to providers:** $7,540
- **Plan pays** $5,140
- **Patient pays** $2,400

Sample care costs:

Hospital charges (mother)	$2,700
Routine obstetric care	$2,100
Hospital charges (baby)	$900
Anesthesia	$900
Laboratory tests	$500
Prescriptions	$200
Radiology	$200
Vaccines, other preventive	$40
Total	**$7,540**

Patient pays:

Deductibles	$1500
Copays	$0
Coinsurance	$750
Limits or exclusions	$150
Total	**$2,400**

Managing type 2 diabetes
(routine maintenance of a well-controlled condition)

- **Amount owed to providers:** $5,400
- **Plan pays** $3,106
- **Patient pays** $2,294

Sample care costs:

Prescriptions	$2,900
Medical Equipment and Supplies	$1,300
Office Visits and Procedures	$700
Education	$300
Laboratory tests	$100
Vaccines, other preventive	$100
Total	**$5,400**

Patient pays:

Deductibles	$1150
Copays	$1065
Coinsurance	$0
Limits or exclusions	$79
Total	**$2,294**

Questions and answers about the Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

- Costs don't include **premiums**.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network **providers**. If the patient had received care from out-of-network **providers**, costs would have been higher.

What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how **deductibles**, **copayments**, and **coinsurance** can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

Does the Coverage Example predict my own care needs?

✘ **No.** Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

Does the Coverage Example predict my future expenses?

✘ **No.** Coverage Examples are **not** cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your **providers** charge, and the reimbursement your health plan allows.

Can I use Coverage Examples to compare plans?

✓ **Yes.** When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

Are there other costs I should consider when comparing plans?

✓ **Yes.** An important cost is the **premium** you pay. Generally, the lower your **premium**, the more you'll pay in out-of-pocket costs, such as **copayments**, **deductibles**, and **coinsurance**. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.