



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 Plan Booklet/Summary Plan Description and Summary Material Modifications, visit [www.ironworkerstrust.com](http://www.ironworkerstrust.com) or call 1-866-986-1515, option 1. 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](http://www.healthcare.gov/sbc-glossary) or call 1-866-986-1515 to request a copy.

Important Questions	Answers	Why This Matters:
<p>What is the overall <a href="#">deductible</a>?</p>	<p>\$250 per person/\$500 per family.</p>	<p>Generally, you must pay all of the costs from providers up to the <a href="#">deductible</a> amount before this <a href="#">plan</a> begins to pay. If you have other family members on the <a href="#">plan</a>, each family member must meet their own individual <a href="#">deductible</a> until the total amount of <a href="#">deductible</a> expenses paid by all family members meets the overall family <a href="#">deductible</a>.</p>
<p>Are there services covered before you meet your <a href="#">deductible</a>?</p>	<p>Yes. preventive care, routine physical exam for employee, office visit with a network provider, hearing aids, outpatient prescription drugs, supplemental accident benefit services are covered before you meet your <a href="#">deductible</a>.</p>	<p>This <a href="#">plan</a> covers some items and services even if you haven't yet met the <a href="#">deductible</a> amount. But a <a href="#">copayment</a> or <a href="#">coinsurance</a> may apply. For example, this <a href="#">plan</a> covers certain <a href="#">preventive services</a> without cost sharing and before you meet your <a href="#">deductible</a>. See a list of covered <a href="#">preventive services</a> at <a href="https://www.healthcare.gov/coverage/preventive-care-benefits/">https://www.healthcare.gov/coverage/preventive-care-benefits/</a>.</p>
<p>Are there other <a href="#">deductibles</a> for specific services?</p>	<p>Yes. \$50 for dental benefits (Active Employees and Dependents of Active Employees only)          There are no other specific <a href="#">deductibles</a>.</p>	<p>You must pay all of the costs for these services up to the specific <a href="#">deductible</a> amount before this <a href="#">plan</a> begins to pay for these services.</p>
<p>What is the <a href="#">out-of-pocket limit</a> for this <a href="#">plan</a>?</p>	<p>Medical <a href="#">Preferred Providers</a>: \$4,250 per person / \$8,500 per family.          Medical <a href="#">Non-Preferred Providers</a>: \$8,000 per person after the deductible.          Formulary <a href="#">Prescription Drugs</a>: \$3,650 per person / \$7,300 per family.          Non-Formulary <a href="#">Prescription Drugs</a>: No limit.</p>	<p>The <a href="#">out-of-pocket limit</a> is the most you could pay in a year for covered services. If you have other family members in this <a href="#">plan</a>, they have to meet their own <a href="#">out-of-pocket limits</a> until the overall family <a href="#">out-of-pocket limit</a> has been met.</p>
<p>What is not included in the <a href="#">out-of-pocket limit</a>?</p>	<p><a href="#">Premiums</a>, <a href="#">balance-billed</a> charges, health care this <a href="#">plan</a> does not cover, hearing aids, dental, vision, and any penalty for failing to <a href="#">preauthorize</a> services.</p>	<p>Even though you pay these expenses, they don't count toward the <a href="#">out-of-pocket limit</a>.</p>

Will you pay less if you use a <a href="#">network provider</a> ?	Yes. See <a href="#">premera.com</a> or call 1-800-810-BLUE (2583) for a list of <a href="#">network providers</a> . For Teladoc see <a href="#">www.Teladoc.com/Premera</a> or 855-332-4059. (Not applicable to Medicare eligible Retirees)	This <a href="#">plan</a> uses a provider <a href="#">network</a> . You will pay less if you use a <a href="#">provider</a> in the plan's <a href="#">network</a> . You will pay the most if you use an <a href="#">out-of-network provider</a> , and you might receive a bill from a <a href="#">provider</a> for the difference between the provider's charge and what your <a href="#">plan</a> pays ( <a href="#">balance billing</a> ). Be aware, your <a href="#">network provider</a> might use an <a href="#">out-of-network provider</a> for some services (such as lab work). Check with your <a href="#">provider</a> before you get services.
Do you need a <a href="#">referral</a> to see a <a href="#">specialist</a> ?	No.	You can see the <a href="#">specialist</a> you choose without a <a href="#">referral</a> .

 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)	Non-Preferred (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 <a href="#">copay</a> /visit <a href="#">Deductible</a> does not apply.	40% <a href="#">coinsurance</a> / 20% <a href="#">coinsurance</a> out of area	Copay waived for Teladoc visits. All services must be <u>medically necessary</u> . <u>Preauthorization</u> required for all outpatient surgeries and procedures, ancillary testing, chemotherapy and radiation. Medicare retirees do not have <a href="#">copays</a> .
	<a href="#">Specialist</a> visit	No charge for lab/ x-ray in conjunction with office visit. 20% <a href="#">coinsurance</a> for all other professional services except routine office visit.		
	<a href="#">Preventive care/screening/immunization</a>	No Charge <a href="#">Deductible</a> does not apply.	40% <a href="#">coinsurance</a> / 20% <a href="#">coinsurance</a> out of area	Preventive services are ACA recommendations. Services provided outside these recommendations are subject to applicable <a href="#">copays</a> and <a href="#">coinsurance</a> . You may have to pay for services that aren't <a href="#">preventive</a> . Ask your <a href="#">provider</a> if the services you need are preventive. Then check what your <a href="#">plan</a> will pay for.
If you have a test	<a href="#">Diagnostic test</a> (x-ray, blood work)	No charge if during office visit, otherwise 20% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a> / 20% <a href="#">coinsurance</a> out of area	None
	Imaging (CT/PET scans, MRIs)	No charge if during office visit, otherwise 20% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a> / 20% <a href="#">coinsurance</a> out of area	<u>Preauthorization</u> is required

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Preferred Provider (You will pay the least)	Non-Preferred (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.envisionrx.com">www.envisionrx.com</a>	Generic drugs	\$4 <a href="#">copay</a> /prescription retail; \$8 <a href="#">copay</a> /prescription mail	\$4 <a href="#">copay</a> /prescription retail; \$8 <a href="#">copay</a> /prescription mail	Coverage limited to drugs listed on plan formulary. Covers up to a 30-day supply at retail and 31-90 day supply at mail order. Specialty drugs are limited to a 30-day supply. <a href="#">Preauthorization</a> required for chemotherapy
	Preferred brand drugs	\$4 <a href="#">copay</a> /prescription retail; \$8 <a href="#">copay</a> /prescription mail	\$4 <a href="#">copay</a> /prescription retail; \$8 <a href="#">copay</a> /prescription mail	
	Non-preferred brand drugs	Not covered	Not covered	
	<a href="#">Specialty drugs</a>	\$4 <a href="#">copay</a> /prescription retail; \$8 <a href="#">copay</a> /prescription mail	\$4 <a href="#">copay</a> /prescription retail; \$8 <a href="#">copay</a> /prescription mail	
<b>If you have outpatient surgery</b>	Facility fee (e.g., ambulatory surgery center)	20% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a> / 20% <a href="#">coinsurance</a> out of area	<a href="#">Preauthorization</a> is required.
	Physician/surgeon fees	20% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a> / 20% <a href="#">coinsurance</a> out of area	<a href="#">Preauthorization</a> is required.
<b>If you need immediate medical attention</b>	<a href="#">Emergency room care</a>	20% <a href="#">coinsurance</a>	20% <a href="#">coinsurance</a> .	None
	<a href="#">Emergency medical transportation</a>	20% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a> / 20% <a href="#">coinsurance</a> out of area	None
	<a href="#">Urgent care</a>	20% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a> / 20% <a href="#">coinsurance</a> out of area	None
<b>If you have a hospital stay</b>	Facility fee (e.g., hospital room)	20% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a> / 20% <a href="#">coinsurance</a> out of area	<a href="#">Preauthorization</a> is required to avoid a \$250 penalty.
	Physician/surgeon fees	20% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a> / 20% <a href="#">coinsurance</a> out of area	<a href="#">None</a>
<b>If you need mental health, behavioral health, or substance abuse services</b>	Outpatient services	20% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a> / 20% <a href="#">coinsurance</a> out of area	None
	Inpatient services	20% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a> / 20% <a href="#">coinsurance</a> out of area	<a href="#">Preauthorization</a> is required to avoid a \$250 penalty.
<b>If you are pregnant</b>	Office visits	\$20 <a href="#">copay</a> /visit <a href="#">deductible</a> does not apply.	40% <a href="#">coinsurance</a> / 20% <a href="#">coinsurance</a> out of area	<a href="#">Cost-sharing</a> does not apply for <a href="#">preventive services</a> . Depending on the type of services, a <a href="#">copayment</a> or <a href="#">coinsurance</a> may apply.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Preferred Provider (You will pay the least)	Non-Preferred (You will pay the most)	
	Childbirth/delivery professional services	20% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a> / 20% <a href="#">coinsurance</a> out of area	No coverage for dependent child, except ACA preventive services.
	Childbirth/delivery facility services	20% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a> / 20% <a href="#">coinsurance</a> out of area	No coverage for a dependent child or child of dependent child.
If you need help recovering or have other special health needs	<a href="#">Home health care</a>	20% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a> / 20% <a href="#">coinsurance</a> out of area	Maximum of 130 visits per year.
	<a href="#">Rehabilitation services</a>	20% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a> / 20% <a href="#">coinsurance</a> out of area	Pulmonary rehabilitation is not covered. Maintenance rehabilitation not covered. Preauthorization required after 8 visits.
	<a href="#">Habilitation services</a>	20% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a> / 20% <a href="#">coinsurance</a> out of area	Includes physical, occupational and speech therapies to improve a mental health condition. Limited to children age 6 and younger and a lifetime maximum of \$3,000 unless for treatment of a mental disorder.
	<a href="#">Skilled nursing care</a>	20% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a> / 20% <a href="#">coinsurance</a> out of area	Maximum of 120 days.
	<a href="#">Durable medical equipment</a>	20% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a> / 20% <a href="#">coinsurance</a> out of area	<u>Preauthorization</u> is required for costs over \$500. Foot orthotics and supportive devices are only for active employees and are limited to \$200 every 5-year period.
	<a href="#">Hospice services</a>	20% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a> / 20% <a href="#">coinsurance</a> out of area	None
If your child needs dental or eye care	Children's eye exam	\$15 <a href="#">copay</a> /visit	All costs exceeding \$45	Benefit limited to once every 18 months. Non-preferred provider benefit limited to \$45 per exam.
	Children's glasses	\$15 <a href="#">copay</a> for lenses \$15 <a href="#">copay</a> frames	All costs exceeding \$45/lenses and \$47/frames	Benefit limited to once every 18 months. Non-preferred provider benefit limited to \$45 for lenses and \$47 for frames.
	Children's dental check-up	Diagnostic/preventive no charge	Diagnostic/preventive no charge	Benefit applicable to children up to age 18. All others subject to annual maximum of \$2,500. Not applicable for Retirees and/or their eligible dependents.

## 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](#).)

- Benefits when Medicare is or could be primary (this exclusion applies if you are eligible to enroll in Medicare, but fail to do so)
- Cosmetic Surgery
- Infertility treatment
- Injury or Illness for which a third-party may be responsible
- Long-term care
- Penile Implants
- Pregnancy for a Dependent Child
- Pulmonary Rehabilitation
- Routine foot care
- Weight loss programs
- Work related injury or illness
- See the Plan Booklet and Summary Plan Description for other exclusions that may apply.

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

- Acupuncture
- Bariatric surgery
- Chiropractic Care
- Dental Care (Adult)
- Hearing Aids
- Non-emergency care when traveling outside the US (care must be medically necessary and considered standard care in the US.
- Private duty nursing
- Routine eye care (adult)

**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 U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or [www.dol.gov/ebsa/healthreform](http://www.dol.gov/ebsa/healthreform) and Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, at 1-877-267-2323 x 61565 or [www.cciio.cms.gov](http://www.cciio.cms.gov). 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 [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: U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-EBSA (3272) or [www.dol.gov/ebsa/healthreform](http://www.dol.gov/ebsa/healthreform) or contact the Administration Office at 1-866-986-1515.

### 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 1-866-986-1515.

-----*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 [plan's](#) overall [deductible](#) \$250
- [Specialist copayment](#) \$20
- Hospital (facility) [coinsurance](#) 20%
- Other [coinsurance](#) 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>\$12,800</b>
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In this example, Peg would pay:

<i>Cost Sharing</i>	
Deductibles	\$250
Copayments	\$60
Coinsurance	\$2,500
<i>What isn't covered</i>	
Limits or exclusions	\$60
<b>The total Peg would pay is</b>	<b>\$2,870</b>

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

- The [plan's](#) overall [deductible](#) \$250
- [Specialist copayment](#) \$20
- Hospital (facility) [coinsurance](#) 20%
- Other [coinsurance](#) 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>\$7,400</b>
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In this example, Joe would pay:

<i>Cost Sharing</i>	
Deductibles	\$250
Copayments	\$400
Coinsurance	\$400
<i>What isn't covered</i>	
Limits or exclusions	\$60
<b>The total Joe would pay is</b>	<b>\$1,110</b>

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

- The [plan's](#) overall [deductible](#) \$250
- [Specialist copayment](#) \$20
- Hospital (facility) [coinsurance](#) 20%
- Other [coinsurance](#) 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>\$1,900</b>
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In this example, Mia would pay:

<i>Cost Sharing</i>	
Deductibles	\$250
Copayments	\$60
Coinsurance	\$300
<i>What isn't covered</i>	
Limits or exclusions	\$0
<b>The total Mia would pay is</b>	<b>\$610</b>