Coverage Period: 01/01/2024 – 12/31/2024 Coverage for: Family | Plan Type: PPO

The Summary of Benefits and Coverage (SBC) document will help you choose a health <u>plan</u>. The SBC shows you how you and the <u>plan</u> would share the cost for covered health care services. NOTE: Information about the cost of this <u>plan</u> (called the <u>premium</u>) 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, call 1-866-986-1515. For general definitions of common terms, such as <u>allowed amount</u>, <u>balance billing</u>, <u>coinsurance</u>, <u>copayment</u>, <u>deductible</u>, <u>provider</u>, or other <u>underlined</u> terms, see the Glossary. You can view the Glossary at <u>www.dol.gov/ebsa/healthreform or call 1-866-986-1515</u> to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	\$350 per person/\$1,050 per family.	Generally, you must pay all of the costs from <u>provider</u> up to the <u>deductible</u> amount before this plan begins to pay. If you have other family members on the <u>plan</u> , each family member must meet their own individual <u>deductible</u> until the total amount of <u>deductible</u> expenses paid by all family members meets the overall family <u>deductible</u> .
Are there services covered before you meet your deductible?	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 deductible.	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 deductibles for specific services?	Yes. \$50 for dental benefits 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</u> <u>limit</u> for this <u>plan</u> ?	Medical <u>Preferred Providers</u> : <b>\$12,500</b> per person Medical <u>Non-Preferred Providers</u> : <b>\$25,000</b> per person.	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 out-of-pocket limit?	Premiums, balance-billed charges, health care this plan does not cover, the deductible, hearing aids, skilled nursing facility, supplemental accident benefit, routine physical exams (member only) prescription drugs, and any penalty for failing to preauthorize services.	Even though you pay these expenses, they don't count toward the <u>out-of-pocket</u> <u>limit</u> .
Will you pay less if you use a <u>network provider</u> ?	Yes. See premera.com/sharedadmin or call 1-800-810-BLUE (2583) for a list of network providers. For Teladoc see www.Teladoc.com/Premera or 855-332-4059.	This <u>plan</u> uses a provider <u>network</u> . You will pay less if you use a <u>provider</u> in the plan's <u>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 provider's charge and what your <u>plan</u> pays ( <u>balance billing</u> ). Be aware, your <u>network provider</u> might use an <u>out-of-network provider</u> for some services (such as lab work). Check

Important Questions	Answers	Why This Matters:
		with your <u>provider</u> before you get services. Participants will only be liable for the innetwork cost share for non-network emergency services, non-network providers at in-network facilities, and non-network air ambulance services.
Do you need a <u>referral</u> to see a <u>specialist</u> ?	No.	You can see the specialist you choose without a referral.

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All <u>copayment</u> and <u>coinsurance</u> costs shown in this chart are after your <u>deductible</u> has been met, if a <u>deductible</u> applies.

		What You Will Pay		Limitations, Exceptions, & Other	
Common Medical Event	Services You May Need	Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	Important Information	
	Primary care visit to treat an injury or illness  Specialist visit	\$20 conav/visit		Copay waived for Teladoc visits.  All services must be <u>medically necessary</u> . <u>Preauthorization</u> from ICM required for all outpatient surgeries and procedures,	
If you visit a health care provider's office or clinic	Preventive care/screening/ immunization	\$20 copay/visit  Deductible does not apply.  No charge for lab/ x-ray in conjunction with office visit.  25% coinsurance for all other professional services except routine office visit.	ancillary testing, chemotherapy and radiation. Plan pays 100% for physicals for covered employees and retirees. You may have to pay for services that aren't preventive as defined by the Plan. Acupuncture and spinal manipulation services limited to a combined benefit maximum of \$1,250 per person per calendar year.		
If you have a test	<u>Diagnostic test</u> (x-ray, blood work)	\$20 <u>copay</u> /visit deductible does not apply if done in conjunction with office visit; otherwise 25% <u>coinsurance</u>	50% <u>coinsurance</u>	None	
	Imaging (CT/PET scans, MRIs)	\$20 <u>copay</u> /visit deductible does not apply if done in conjunction with office visit; otherwise 25% <u>coinsurance</u>	50% coinsurance	Preauthorization is required	
If you need drugs to treat your illness or	Generic drugs	\$4 <u>copay</u> /prescription retail;	\$4 copay/prescription retail; \$8 copay/prescription mail	Coverage limited to drugs listed on plan formulary. Covers up to a 30-day supply	

<sup>\*</sup> For more information about limitations and exceptions, see the <u>plan</u> or policy document at www.ironworkerstrust.com

Common Medical Event	Services You May Need	What You Will Pay Network Provider Out-of-Network Provider		Limitations, Exceptions, & Other	
	osivious rou may noou	(You will pay the least)	(You will pay the most)	Important Information	
condition		\$8 copay/prescription mail		for a retail prescription and 31-90 day	
More information about prescription drug coverage is available at www.envisionrx.com	Preferred brand drugs	\$4 <u>copay</u> /prescription retail; \$8 <u>copay</u> /prescription mail	\$4 <u>copay</u> /prescription retail; \$8 <u>copay</u> /prescription mail	supply for a mail order prescription.  Specialty drugs are limited to a 30-day supply. Preauthorization required for chemotherapy.	
www.cmvisioni.x.com	Non-preferred brand drugs	Not covered	Not covered	chemotherapy.	
	Specialty drugs	\$4 <u>copay</u> /prescription retail; \$8 <u>copay</u> /prescription mail	\$4 <u>copay</u> /prescription retail; \$8 <u>copay</u> /prescription mail		
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center) Physician/surgeon fees	25% <u>coinsurance</u>	50% coinsurance	Preauthorization is required.	
	Emergency room care	25% <u>coinsurance</u>	50% <u>coinsurance.</u>	None	
If you need immediate	Emergency medical transportation	25% <u>coinsurance</u>	50% coinsurance	None	
medical attention	<u>Urgent care</u>	25% <u>coinsurance</u>	50% <u>coinsurance</u>	Network provider physician services billed as office visits with no associated facility charge are subject only to the \$20 copay.	
If you have a hospital	Facility fee (e.g., hospital room)	25% coinsurance	50% coinsurance	Preauthorization is required to avoid a \$250 penalty.	
stay	Physician/surgeon fees	25% <u>coinsurance</u>	50% <u>coinsurance</u>	<u>None</u>	
If you need mental health, behavioral	Outpatient services	25% coinsurance	50% coinsurance	None	
health, or substance abuse services	Inpatient services	25% <u>coinsurance</u>	50% coinsurance	Preauthorization is required to avoid a \$250 penalty.	
If you are pregnant	Office visits	\$20 copay/visit deductible does not apply /_25% coinsurance for all other professional services except routine office visit.	50% coinsurance	Cost-sharing does not apply for preventive services. Depending on the type of services, a copayment or coinsurance may apply.	
	Childbirth/delivery professional services	25% <u>coinsurance</u>	50% <u>coinsurance</u>	No coverage for dependent child, except ACA preventive services.	
	Childbirth/delivery facility	25% <u>coinsurance</u>	50% <u>coinsurance</u>	No coverage for a dependent child or	

 $<sup>^{\</sup>star}$  For more information about limitations and exceptions, see the  $\underline{\text{plan}}$  or policy document at www.ironworkerstrust.com

		What You Will Pay		Limitations Evacations 9 Other
Common Medical Event	Services You May Need	Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information
	services			child of dependent child.
	Home health care	25% <u>coinsurance</u>	50% <u>coinsurance</u>	Maximum of 130 visits per year.
	Rehabilitation services	25% <u>coinsurance</u>	50% <u>coinsurance</u>	Pulmonary rehabilitation is not covered. Maintenance rehabilitation not covered. Preauthorization required after 8 visits. For inpatient services, preauthorization is required.
If you need help recovering or have other special health needs	Habilitation services	Not Covered	Not Covered	Limited neurodevelopmental therapy benefit for children age 6 and younger to a lifetime benefit of \$3,000. No age or dollar limit when for treatment of a mental disorder. For inpatient services, preauthorization is required.
	Skilled nursing care	25% <u>coinsurance</u>	50% coinsurance	Maximum of 120 days. For inpatient services, <u>preauthorization</u> is required.
	Durable medical equipment	25% <u>coinsurance</u>	50% coinsurance	Preauthorization 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.
	Hospice services	25% <u>coinsurance</u>	50% <u>coinsurance</u>	None
If your child needs dental or eye care	Children's eye exam	\$15 <u>copay</u> /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 <u>copay</u> for lenses \$15 <u>copay</u> 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.

 $<sup>^{\</sup>star}$  For more information about limitations and exceptions, see the  $\underline{\text{plan}}$  or policy document at www.ironworkerstrust.com

#### **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
- Expenses resulting from work related conditions

- 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

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

- Acupuncture (combined with spinal manipulation)
- Bariatric surgery
- Chiropractic Care (combined with acupuncture)
- Dental Care (Adult)

- Hearing Aids
- Non-emergency care when traveling outside the US (care must be <u>medically necessary</u> 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: Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or <a href="www.dol.gov/ebsa/healthreform">www.dol.gov/ebsa/healthreform</a> and Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, at 1-877-267-2323 x61565 or <a href="www.cciio.cms.gov">www.cciio.cms.gov</a>. Other coverage options may be available to you, too, including buying individual insurance coverage through the <a href="Health Insurance">Health Insurance</a> <a href="Marketplace">Marketplace</a>. For more information about the <a href="Marketplace">Marketplace</a>, visit <a href="www.HealthCare.gov">www.HealthCare.gov</a> or call 1-800-318- 2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your <u>plan</u> for a denial of a <u>claim</u>. This complaint is called a <u>grievance</u> or <u>appeal</u>. For more information about your rights, look at the explanation of benefits you will receive for that medical <u>claim</u>. Your <u>plan</u> documents also provide complete information on how to submit a <u>claim</u>, <u>appeal</u>, or a <u>grievance</u> for any reason to your <u>plan</u>. For more information about your rights, this notice, or assistance, contact: Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform. You may also contact the Trust Administration Office at 1-866-986-1515.

### 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 <u>plan</u> doesn't meet the <u>Minimum Value Standards</u>, you may be eligible for a <u>premium tax credit</u> to help you pay for a <u>plan</u> through the <u>Marketplace</u>.

### Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al 1-866-986-1515.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-866-986-1515.

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

<sup>\*</sup> For more information about limitations and exceptions, see the plan or policy document at www.ironworkerstrust.com

### **About these Coverage Examples:**



This is not a cost estimator. Treatments shown are just examples of how this <u>plan</u> might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your <u>providers</u> charge, and many other factors. Focus on the <u>cost-sharing</u> amounts (<u>deductibles</u>, <u>copayments</u> and <u>coinsurance</u>) and <u>excluded services</u> under the <u>plan</u>. Use this information to compare the portion of costs you might pay under different health <u>plans</u>. 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 <u>plan's</u> overall <u>deductible</u>	\$350
■ Specialist coinsurance	25%
■ Hospital (facility) <u>coinsurance</u>	25%
Other coinsurance	25%

### 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		
<u>Deductibles</u>	\$350	
<u>Copayments</u>	\$10	
<u>Coinsurance</u>	\$2,700	
What isn't covered		
Limits or exclusions	\$60	
The total Peg would pay is	\$3,120	

## Managing Joe's Type 2 Diabetes

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

■ The plan's overall deductible	\$350
■ Specialist coinsurance	25%
Hospital (facility) coinsurance	25%
Other <u>coinsurance</u>	25%

#### This EXAMPLE event includes services like:

<u>Primary care physician</u> 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		
<u>Deductibles</u>	\$350	
Copayments	\$200	
Coinsurance	\$400	
What isn't covered		
Limits or exclusions	\$20	
The total Joe would pay is	\$970	

## Mia's Simple Fracture

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

■ The <u>plan's</u> overall <u>deductible</u>	\$350
■ Specialist coinsurance	25%
■ Hospital (facility) coinsurance	25%
Other <u>coinsurance</u>	25%

#### This EXAMPLE event includes services like:

Emergency room care (including medical supplies)

Diagnostic test (x-ray)

<u>Durable medical equipment</u> (crutches)

Rehabilitation services (physical therapy)

Total Example Cost	\$2,800
In this example, Mia would pay:	
Cost Sharing	
<u>Deductibles</u>	\$350
Copayments	\$0
Coinsurance	\$600
What isn't covered	
Limits or exclusions	\$0
The total Mia would pay is	\$950