**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 complete terms of coverage, call 1-866-986-1515. 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.dol.gov/ebsa/healthreform or call 1-866-986-1515 to request a copy.

| Important Questions | Answers | Why This Matters: |
|---|---|---|
| **What is the overall deductible?** | **$250** per person/**$500** per family. | Generally, you must pay all of the costs from provider up to the deductible 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 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 plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost sharing and before you meet your deductible. See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/. |
| **Are there other deductibles for specific services?** | **Yes.** $50 for dental benefits<br>There are no other specific deductibles. | You must pay all of the costs for these services up to the specific deductible amount before this plan begins to pay for these services. |
| **What is the out-of-pocket limit for this plan?** | Medical Preferred Providers: **$4,250** per person / $**8,500** per family.<br>Medical Non-Preferred Providers: **$8,000** per person after the deductible.<br>Formulary Prescription Drugs: **$6,350** per person / **$12,700** per family.<br>Non-Formulary Prescription Drugs: No limit. | 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?** | Premiums, balance-billed charges, health care this plan does not cover, hearing aids, dental, vision, and any penalty for failing to preauthorize services. | 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 premera.com/sharedadmin or call 1-800-810-BLUE (2583) for a list of network providers. For Teladoc see | 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 |

| Important Questions | Answers | Why This Matters: |
|---|---|---|
| | www.Teladoc.com/Premera or 855-332-4059. (Not applicable to Medicare eligible Retirees) For vision see www.vsp.com. | charge and what your plan pays (balance billing). Be aware, your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services. Participants will only be liable for the in-network cost share for non-network emergency services, non-network providers at in-network facilities, and non-network air ambulance services. |
| **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 | $20 copay/visit Deductible does not apply. No charge for lab/ x-ray if within two weeks of office visit. 20% coinsurance for all other professional services except routine office visit. | 40% coinsurance / 20% coinsurance out of area | Copay waived for Teladoc visits. All services must be medically necessary. Preauthorization required for all outpatient surgeries and procedures, ancillary testing, chemotherapy and radiation. Spinal manipulation and Acupuncture limited to combined 24 visits per calendar year. |
| | Specialist visit | | | |
| | Preventive care/screening/ immunization | No Charge Deductible does not apply. | 40% coinsurance / 20% coinsurance out of area | Preventive services are ACA recommendations. Services provided outside these recommendations are subject to applicable copays and coinsurance. You may have to pay for services that aren't preventive. Ask your provider if the services you need are preventive. Then check what your plan will pay for. |
| **If you have a test** | Diagnostic test (x-ray, blood work) | No charge if within two weeks of otherwise 20% coinsurance | 40% coinsurance / 20% coinsurance out of area | None |
| | Imaging (CT/PET scans, MRIs) | No charge if within two weeks of otherwise 20% coinsurance | 40% coinsurance / 20% coinsurance out of area | Preauthorization is required |

* For more information about limitations and exceptions, see the plan or policy document at www.ironworkerstrust.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.navitus.com. | Generic drugs | $4 copay/prescription retail; $8 copay/prescription mail | $4 copay/prescription retail; $8 copay/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. The first fill and all subsequent specialty drug refills are required to be filled at Lumicera Health Services (855)-847-3553. Preauthorization required for chemotherapy. |
| | Preferred brand drugs | $4 copay/prescription retail; $8 copay/prescription mail | $4 copay/prescription retail; $8 copay/prescription mail | |
| | Non-preferred brand drugs | Not covered | Not covered | |
| | Specialty drugs | $4 copay/prescription retail; $4 copay/prescription mail | $4 copay/prescription retail; $4 copay/prescription mail | |
| **If you have outpatient surgery** | Facility fee (e.g., ambulatory surgery center) | 20% coinsurance | 40% coinsurance / 20% coinsurance out of area | Preauthorization is required. |
| | Physician/surgeon fees | | | |
| **If you need immediate medical attention** | Emergency room care | 20% coinsurance | 20% coinsurance. | None |
| | Emergency medical transportation | 20% coinsurance | 40% coinsurance / 20% coinsurance out of area | None |
| | Urgent care | 20% coinsurance | 40% coinsurance / 20% coinsurance out of area | 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 stay** | Facility fee (e.g., hospital room) | 20% coinsurance | 40% coinsurance / 20% coinsurance out of area | Preauthorization is required to avoid a $250 penalty. |
| | Physician/surgeon fees | 20% coinsurance | 40% coinsurance / 20% coinsurance out of area | None |
| **If you need mental health, behavioral health, or substance abuse services** | Outpatient services | 20% coinsurance | 40% coinsurance / 20% coinsurance out of area | None |
| | Inpatient services | 20% coinsurance | 40% coinsurance / 20% coinsurance out of area | Preauthorization is required to avoid a $250 penalty. |
| **If you are pregnant** | Office visits | $20 copay/visit deductible does not apply. | 40% coinsurance / 20% coinsurance out of area | Cost-sharing does not apply for preventive services. Depending on the type of services, a copayment or coinsurance may apply. |
| | Childbirth/delivery professional services | 20% coinsurance | 40% coinsurance / 20% coinsurance out of area | No coverage for dependent child, except ACA preventive services. |

| 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) | |
| | Childbirth/delivery facility services | 20% coinsurance | 40% coinsurance / 20% coinsurance 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** | Home health care | 20% coinsurance | 40% coinsurance / 20% coinsurance out of area | Maximum of 130 visits per year. |
| | Rehabilitation services | 20% coinsurance | 40% coinsurance / 20% coinsurance out of area | Pulmonary rehabilitation is not covered. Maintenance rehabilitation is not covered. Preauthorization required after 8 visits. For inpatient services, preauthorization is required. |
| | Habilitation services | 20% coinsurance | 40% coinsurance / 20% coinsurance out of area | 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 | 20% coinsurance | 40% coinsurance / 20% coinsurance out of area | Maximum of 120 days. For inpatient services, preauthorization is required. |
| | Durable medical equipment | 20% coinsurance | 40% coinsurance / 20% coinsurance out of area | 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 | 20% coinsurance | 40% coinsurance / 20% coinsurance out of area | None |
| **If your child needs dental or eye care** | Children's eye exam | $15 copay/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 copay for lenses<br>$15 copay 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. |

## 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
- Bariatric surgery
- Chiropractic Care (combined with acupuncture)
- 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: Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform and Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, at 1-877-267-2323 x61565 or 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 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 on how 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: 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 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.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 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:**

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

**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)*

| **Total Example Cost** | **$12,700** |
|---|---|

**In this example, Peg would pay:**

| *Cost Sharing* | |
|---|---|
| Deductibles | $250 |
| Copayments | $10 |
| Coinsurance | $2,200 |
| *What isn't covered* | |
| Limits or exclusions | $60 |
| **The total Peg would pay is** | **$2,520** |

## 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)*

| **Total Example Cost** | **$5,600** |
|---|---|

**In this example, Joe would pay:**

| *Cost Sharing* | |
|---|---|
| Deductibles | $250 |
| Copayments | $300 |
| Coinsurance | $200 |
| *What isn't covered* | |
| Limits or exclusions | $20 |
| **The total Joe would pay is** | **$770** |

## 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)*

| **Total Example Cost** | **$2,800** |
|---|---|

**In this example, Mia would pay:**

| *Cost Sharing* | |
|---|---|
| Deductibles | $250 |
| Copayments | $0 |
| Coinsurance | $500 |
| *What isn't covered* | |
| Limits or exclusions | $0 |
| **The total Mia would pay is** | **$750** |

The plan would be responsible for the other costs of these EXAMPLE covered services.