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.ironworkersdcwny.com** or by calling the Fund Office at **1-800-288-0782** or **1-585-424-3510.**

Important Questions	Answers	Why this Matters:
What is the overall deductible?	In-Network: **$400** per person/**$800** per family; Out-of-Network: **$800** per person/**$1,600** per family. Doesn't apply to prescription drug, dental or optical benefits and in-network preventive care. Balance bills, and excluded services also do not count toward the **deductible**.	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?	No.	You don't have to meet **deductibles** for specific services, but see the chart starting on page 2 for other costs for services this plan covers.
Is there an out–of–pocket limit on my expenses?	Yes. In-Network: **$3,000** (medical)/**$4,150** (prescription drug) per person; **$6,000** (medical)/**$8,300** (prescription drug) per family. Out-of-Network: None	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, balance bills, dental and optical expenses and health care this plan does not cover.	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.

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If you aren't clear about any of the bolded terms used in this form, see the Glossary. You can view the Glossary at **www.dol.gov/ebsa/healthreform** or call **1-800-288-0782** or **1-585-424-3510** to request a copy.

Does this plan use a network of providers?	Yes. See **www.excellusbcbs.com** or call **1-800-499-1275** for a list of In-Network 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 6. See your policy or plan document for additional information about **excluded services**.

- **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 in-network **providers** by charging you lower **deductibles, copayments** and **coinsurance** amounts.

Common Medical Event	Service 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	20% coinsurance	40% coinsurance	-None-
	Specialist visit	20% coinsurance	40% coinsurance	-None-
	Other practitioner office visit	50% coinsurance for chiropractors; 20% coinsurance for all other practitioners	50% coinsurance for chiropractors; 40% coinsurance for all other practitioners	Maximum chiropractic benefit of $550 per person per calendar year. Children not eligbile for chiropractic services unless medically necessary.

Common Medical Event	Service 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	Preventive care/screening/immunization	No Charge	40% coinsurance	Subject to age and frequency limits.
If you have a test	Diagnostic test (x-ray, blood work)	20% coinsurance	40% coinsurance	-None-
	Imaging (CT/PET scans, MRIs)	20% coinsurance	40% coinsurance	Subject to prior authorization.
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.express-scripts.com.	Generic drugs	$10 co-pay retail; $20 co-pay mail order	$10 co-pay retail; mail order not covered	No charge for preventive drugs. Certain drugs subject to prior authorization and/or quantity limitations. If you choose a brand name drug with a generic equivalent, you pay the applicable coinsurance plus the difference in cost between the generic and brand drug. Must use Accredo Pharmacy for specialty drugs. Non-formulary drugs not covered.
	Preferred brand name drugs	20% coinsurance ($20 min/$40 max) retail; 20% coinsurance ($50 min/$100 max) mail order	20% coinsurance ($20 min/$40 max) Mail order not covered	
	Non-preferred brand name drugs	20% coinsurance ($40 min/$80 max) retail; 20% coinsurance ($100 min/$200 max) mail order	20% coinsurance ($40 min/$80 max) Mail order not covered	
	Preferred Specialty Drugs	20% coinsurance ($300 max) mail order	Not Covered	
	Non-preferred Specialty Drugs	20% coinsurance ($400 max) mail order	Not Covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	No charge	30% coinsurance	Subject to prior authorization.
	Physician/surgeon fees	20% coinsurance	40% coinsurance	Subject to prior authorization.

Common Medical Event	Service 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 immediate medical attention	Emergency room services	20% coinsurance; no charge for facility	20% coinsurance; no charge for facility	Non-emergency use of emergency room services not covered.
	Emergency medical transportation	No charge	No charge	Non-emergency use of emergency transportation services not covered.
	Urgent care	20% coinsurance; no charge for facility	20% coinsurance; no charge for facility	-None-
If you have a hospital stay	Facility fee (e.g., hospital room)	$100 copayment	$200 copayment and 30% coinsurance	Subject to prior authorization.
	Physician/surgeon fee	20% coinsurance	40% coinsurance	Subject to prior authorization.
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	20% coinsurance	40% coinsurance	-None-
	Mental/Behavioral health inpatient services	$100 copayment	$200 copayment and 30% coinsurance	Subject to prior authorization.
	Substance use disorder outpatient services	20% coinsurance	40% coinsurance	-None-
	Substance use disorder inpatient services	$100 copayment	$200 copayment and 30% coinsurance	Subject to prior authorization.
If you are pregnant	Prenatal and postnatal care	No Charge	40% coinsurance	-None-
	Delivery and all inpatient services	$100 copayment (facility); 20% coinsurance physician fees	$200 copayment and 30% coinsurance (facility); 40% coinsurance physician fees	Subject to prior authorization for confinements over 48 hours following a normal birth or 96 hours following a cesarean section.

Common Medical Event	Service 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 help recovering or have other special health needs	Home health care	No charge	30% coinsurance	Subject to prior authorization. Limited to 40 visits per person per year, combined in and out-of-network.
	Rehabilitation services	$100 copayment for inpatient rehabilitation; 20% coinsurance for outpatient services	$200 copayment and 30% coinsurance for inpatient rehabilitation; 40% coinsurance for outpatient services	Subject to prior authorization. Limited to 60 inpatient days per year, combined in and out-of-network.
	Habilitation services	20% coinsurance	40% coinsurance	Subject to prior authorization.
	Skilled nursing care	$100 copayment	$200 copayment and 30% coinsurance	Subject to prior authorization. Limited to 60 days per person per year, combined in and out-of-network.
	Durable medical equipment	20% coinsurance	40% coinsurance	Subject to prior authorization.
	Hospice service	No charge	30% coinsurance	Limited to 180 days per person per year, combined in and out-of-network.
If your child needs dental or eye care	Eye exam	Amounts over $200 for both exam and glasses or contacts.	Amounts over $200 for both exam and glasses or contacts.	Limited to one exam every 24 months. Maximum allowance does not apply to eye exam benefit for dependents under age 19.
	Glasses	Amounts over $200 for both exam and glasses or contacts.	Amounts over $200 for both exam and glasses or contacts.	Limited to one pair of eye glasses or supply of contact lenses every 24 months. Sunglasses and non-prescription lenses excluded.
	Dental check-up	20% coinsurance	20% coinsurance	Oral exams limited to once every six months.

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	● Infertility treatment	● Non-emergency care when traveling outside the U.S. or Canada, except for BlueCard Worldwide
● Bariatric surgery	● Long-term care	
● Cosmetic surgery		● Weight loss programs

Other Covered Services (This isn't a complete list. Check your policy or plan document for other covered services and your costs for those services.)		
● Chiropractic care ($550 calendar year maximum. Dependent children not eligible unless medically necessary.)	● Hearing aids ($500 maximum per ear every three years.)	● Routine eye care (Adult) (Maximum reimbursement of $200 every two years for exam and glasses or contact lenses.)
	● Habilitation Services	
● Dental care (Adult) ($1,500 calendar year maximum for participants age 19 and older. $2,050 lifetime orthodontia maximum for all participants.)	● Private-duty nursing (40 home care visits per person per calendar year. Must be for skilled care)	● Routine foot care (Foot orthotics are subject to a $1,000 annual maximum.)

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 1-800-288-0782 or 1-585-424-3510. You may also contact your state insurance department, 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 or www.cciio.cms.gov.

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 the Fund Office at 1-800-288-0782 or 1-585-424-3510 or Excellus at 1-800-499-1275. You may also contact the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform for more information regarding your rights.

Does this Coverage Provide Minimum Essential Coverage?

The Affordable Care Act requires most people to have health care coverage that qualifies as "minimum essential coverage." **This plan or policy does provide minimum essential coverage.**

Does this Coverage Meet the Minimum Value Standard?

The Affordable Care Act establishes a minimum value standard of benefits of a health plan. The minimum value standard is 60% (actuarial value). **This health coverage does meet the minimum value standard for the benefits it provides.**

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** $6,420
- **Patient pays** $1,120

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	$400
Co-pays	$220
Coinsurance	$470
Limits or exclusions	$30
Total	**$1,120**

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

- **Amount owed to providers:** $5,400
- **Plan pays** $4,120
- **Patient pays** $1,280

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	$400
Co-pays	$400
Coinsurance	$400
Limits or exclusions	$80
Total	**$1,280**

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.

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