
 **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 the Fund Office at 1-800-288-0782 or 1-585-424-3510. 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.ironworkersdcwny.com](http://www.ironworkersdcwny.com) or call the Fund Office at 1-800-288-0782 or 1-585-424-3510 to request a copy.

Important Questions	Answers	Why This Matters:
<b>What is the overall deductible?</b>	<u>In-Network</u> : \$400 person/ \$800 family <u>Out-of-Network</u> : \$800 person/ \$1,600 family	Generally, you must pay all of the costs from <u>providers</u> up to the <u>deductible</u> amount before this <u>plan</u> 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> .
<b>Are there services covered before you meet your deductible?</b>	Yes. <u>Preventive care</u> and <u>prescription drugs</u> are covered before you meet your <u>deductible</u> .	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. For example, this <u>plan</u> covers certain <u>preventive services</u> without <u>cost sharing</u> and before you meet your <u>deductible</u> . See a list of covered <u>preventive services</u> at <a href="https://www.healthcare.gov/coverage/preventive-care-benefits/">https://www.healthcare.gov/coverage/preventive-care-benefits/</a>
<b>Are there other deductibles for specific services?</b>	No.	You don't have to meet <u>deductibles</u> for specific services.
<b>What is the out-of-pocket limit for this plan?</b>	<u>In-Network</u> Medical: \$3,000 person/ \$6,000 family <u>In-Network</u> Prescription Drugs: \$4,150 person/\$8,300 family <u>Out-of-Network</u> : No limit.	<u>In-Network</u> : 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. <u>Out-of-Network</u> : This <u>plan</u> does not have an <u>out-of-pocket limit</u> on your expenses.
<b>What is not included in the out-of-pocket limit?</b>	<u>In-Network</u> : <u>Premiums</u> , <u>balance billing</u> , dental and optical expenses, and health care this <u>plan</u> does not cover. <u>Out-of-Network</u> : Not Applicable	<u>In-Network</u> : Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u> . <u>Out-of-Network</u> : This <u>plan</u> does not have an <u>out-of-pocket limit</u> on your expenses.
<b>Will you pay less if you use a network provider?</b>	Yes. See <a href="http://www.excellusbcbs.com">www.excellusbcbs.com</a> or call 1-800-499-1275 for a list of <u>In-Network</u> providers.	This <u>plan</u> uses a <u>provider network</u> . You will pay less if you use a <u>provider</u> in the <u>plan's 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 <u>provider's</u> 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 with your <u>provider</u> before you get services.
<b>Do you need a referral to see a specialist?</b>	No.	You can see the <u>specialist</u> you choose without a <u>referral</u> .

 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 <u>provider's office</u> or clinic	Primary care visit to treat an injury or illness	20% <u>coinsurance</u>	40% <u>coinsurance</u>	None
	<u>Specialist</u> visit	20% <u>coinsurance</u> Chiropractor: 50% <u>coinsurance</u>	40% <u>coinsurance</u> Chiropractor: 50% <u>coinsurance</u>	Maximum chiropractic benefit of \$550 per person per calendar year.
	<u>Preventive care/screening/immunization</u>	No charge; <u>deductible</u> does not apply	40% <u>coinsurance</u> ; <u>deductible</u> does not apply	You may have to pay for services that aren't preventive. Ask your <u>provider</u> if the services needed are preventive. Then check what your <u>plan</u> will pay for.
If you have a test	<u>Diagnostic test</u> (x-ray, blood work)	20% <u>coinsurance</u>	40% <u>coinsurance</u>	None
	Imaging (CT/PET scans, MRIs)	20% <u>coinsurance</u>	40% <u>coinsurance</u>	Subject to prior authorization. If preauthorization is not obtained, it may cause additional costs to you.
If you need drugs to treat your illness or condition More information about <b>prescription drug coverage</b> is available at <a href="http://www.expressscripts.com">www.expressscripts.com</a> .	Generic drugs	Retail: \$10 <u>copay</u> /script; Mail order: \$20 <u>copay</u> /script	Retail: \$10 <u>copay</u> /script; Mail order: \$20 <u>copay</u> /script	<u>Deductible</u> does not apply.
	Preferred brand drugs	Retail: 20% <u>coinsurance</u> (\$20 min/\$40 max); Mail order: 20% <u>coinsurance</u> (\$50 min/\$100 max)	Retail only: 20% <u>coinsurance</u> (\$20 min/\$40 max)	No charge for ACA preventive drugs. Certain drugs subject to prior authorization and/or quantity limitations. If preauthorization is not obtained, it may cause additional costs to you.
	Non-preferred brand drugs	Retail: 20% <u>coinsurance</u> (\$40 min/\$80 max); Mail order: 20% <u>coinsurance</u> (\$100 min/\$200 max)	Retail only: 20% <u>coinsurance</u> (\$40 min/\$80 max)	If you choose a brand name drug with a generic equivalent, you pay the applicable <u>coinsurance</u> plus the difference in cost between the generic and brand drug. Non-formulary drugs are not covered.
	<u>Specialty drugs</u>	Preferred: 20% <u>coinsurance</u> (\$300 max) mail order only; Non-Preferred: 20% <u>coinsurance</u> (\$400 max) mail order only	Not covered	Must use Accredo Pharmacy for specialty drugs. Please contact Fund office for more information regarding the Patient Assurance Program (PAP).

The **plan** would be responsible for the other costs of these EXAMPLE covered 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)	
<b>If you have outpatient surgery</b>	Facility fee (e.g., ambulatory surgery center)	No charge	30% <u>coinsurance</u>	Subject to prior authorization. If preauthorization is not obtained, it may cause additional costs to you.
	Physician/surgeon fees	20% <u>coinsurance</u>	40% <u>coinsurance</u>	Subject to prior authorization. If preauthorization is not obtained, it may cause additional costs to you.
<b>If you need immediate medical attention</b>	<u>Emergency room care</u>	20% <u>coinsurance</u> ; no charge for facility	20% <u>coinsurance</u> ; no charge for facility	No coverage if you use emergency room for condition that is not an <u>emergency medical condition</u>
	<u>Emergency medical transportation</u>	No charge	No charge	Non-emergency use of emergency transportation services not covered.
	<u>Urgent care</u>	20% <u>coinsurance</u> ; no charge for facility	20% <u>coinsurance</u> ; no charge for facility	None
<b>If you have a hospital stay</b>	Facility fee (e.g., hospital room)	\$100 <u>copayment</u> /stay	\$200 <u>copayment</u> /stay and 30% <u>coinsurance</u>	Subject to prior authorization. If preauthorization is not obtained, it may cause additional costs to you.
	Physician/surgeon fees	20% <u>coinsurance</u>	40% <u>coinsurance</u>	Subject to prior authorization. If preauthorization is not obtained, it may cause additional costs to you.
<b>If you need mental health, behavioral health, or substance abuse services</b>	Outpatient services	20% <u>coinsurance</u>	40% <u>coinsurance</u>	None
	Inpatient services	\$100 <u>copayment</u> /stay	\$200 <u>copayment</u> /stay and 30% <u>coinsurance</u>	Subject to prior authorization. If preauthorization is not obtained, it may cause additional costs to you.
<b>If you are pregnant</b>	Office visits	No charge	40% <u>coinsurance</u>	Maternity care may include tests and services described somewhere else in the SBC (e.g., ultrasound).
	Childbirth/delivery professional services	20% <u>coinsurance</u> (physician fees)	40% <u>coinsurance</u> (physician fees)	Subject to prior authorization for confinements over 48 hours following a normal birth or 96 hours following a cesarean section. If preauthorization is not obtained, it may cause additional costs to you.
	Childbirth/delivery facility services	\$100 <u>copayment</u> /stay (facility)	\$200 <u>copayment</u> /stay and 30% <u>coinsurance</u> (facility)	Subject to prior authorization for confinements over 48 hours following a normal birth or 96 hours following a cesarean section. If preauthorization is not obtained, it may cause additional costs to you.

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)	
<b>If you need help recovering or have other special health needs</b>	<u>Home health care</u>	No charge	30% <u>coinsurance</u>	Subject to prior authorization. Limited to 40 visits per person per year, combined <u>in-</u> and <u>out-of-network</u> . If preauthorization is not obtained, it may cause additional costs to you.
	<u>Rehabilitation services</u>	\$100 <u>copayment</u> /stay for inpatient rehabilitation; 20% <u>coinsurance</u> for outpatient services	\$200 <u>copayment</u> /stay and 30% <u>coinsurance</u> for inpatient rehabilitation; 40% <u>coinsurance</u> for outpatient services	Subject to prior authorization. Limited to 60 inpatient days per year, combined <u>in-</u> and <u>out-of-network</u> If preauthorization is not obtained, it may cause additional costs to you.
	<u>Habilitation services</u>	20% <u>coinsurance</u>	40% <u>coinsurance</u>	Subject to prior authorization. . If preauthorization is not obtained, it may cause additional costs to you.
	<u>Skilled nursing care</u>	\$100 <u>copayment</u> /stay	\$200 <u>copayment</u> /stay and 30% <u>coinsurance</u>	Subject to prior authorization. Limited to 60 days per person per year, combined <u>in-</u> and <u>out-of-network</u> If preauthorization is not obtained, it may cause additional costs to you.
	<u>Durable medical equipment</u>	20% <u>coinsurance</u>	40% <u>coinsurance</u>	Subject to prior authorization. If preauthorization is not obtained, it may cause additional costs to you.
	<u>Hospice services</u>	No charge	30% <u>coinsurance</u>	Limited to 180 days per person per year, combined <u>in-</u> and <u>out-of-network</u> .
<b>If your child needs dental or eye care</b>	Children's eye exam	No charge	No charge	You have the option to opt out of, or opt into, optical plan once per year. Limited to one exam and pair of eye glasses or supply of contact lenses every 24 months. Maximum allowance does not apply to eye exam benefit for dependents under age 19. Sunglasses and non-prescription lenses excluded. Your <u>cost sharing</u> does not count toward the <u>out-of-pocket limit</u> .
	Children's glasses	Amounts over \$200 for glasses or contacts.	Amounts over \$200 for glasses or contacts.	
	Children's dental check-up	20% <u>coinsurance</u>	20% <u>coinsurance</u>	You have the option to opt out of, or opt into, dental plan once per year. Oral exams limited to once every six months. Your <u>cost sharing</u> does not count toward the <u>out-of-pocket limit</u> .

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

## 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.)

- Acupuncture
- Bariatric surgery
- Cosmetic surgery
- Infertility treatment
- Long-term care
- Gene therapy and related services
- Non-emergency care when traveling outside the U.S. or Canada, except for BlueCard Worldwide
- Weight loss programs (except as required by the health reform law)

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

- Chiropractic care (\$550 per person calendar year maximum.)
- Dental care (Adult) (\$1,500 calendar year maximum for individuals age 19 and older. \$2,050 lifetime orthodontia maximum for all participants.)
- Hearing aids (\$1,000 maximum every three years.)
- Private-duty nursing (40 home care visits per person per calendar year. Must be for skilled care.)
- Routine eye care (Adult) (Maximum reimbursement of \$200 every two years for exam and glasses or contact lenses.)
- Routine foot care (Foot orthotics are subject to a \$1,000 annual maximum.)

**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: The Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or [www.dol.gov/ebsa/healthreform](http://www.dol.gov/ebsa/healthreform). 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 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: 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](http://www.dol.gov/ebsa/healthreform).

### 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 1-800-288-0782 or 1-585-424-3510.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-288-0782 or 1-585-424-3510.

Chinese (中文): 如果需要中文的帮助, 请拨打这个号码 1-800-288-0782 or 1-585-424-3510.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijigo holne' 1-800-288-0782 or 1-585-424-3510.

————— *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 \$400
- Specialist coinsurance 20%
- Hospital (facility) copay \$100
- 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>\$12,700</b>
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In this example, Peg would pay:

<i>Cost Sharing</i>	
<u>Deductibles</u>	\$400
<u>Copayments</u>	\$150
<u>Coinsurance</u>	\$810
<i>What isn't covered</i>	
Limits or exclusions	\$20
<b>The total Peg would pay is</b>	<b>\$1,380</b>

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

- The plan's overall deductible \$400
- Specialist coinsurance 20%
- Hospital (facility) copay \$100
- 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>\$5,600</b>
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In this example, Joe would pay:

<i>Cost Sharing</i>	
<u>Deductibles</u>	\$400
<u>Copayments</u>	\$130
<u>Coinsurance</u>	\$1,050
<i>What isn't covered</i>	
Limits or exclusions	\$250
<b>The total Joe would pay is</b>	<b>\$1,830</b>

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

- The plan's overall deductible \$400
- Specialist coinsurance 20%
- Hospital (facility) copay \$100
- 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>\$2,800</b>
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In this example, Mia would pay:

<i>Cost Sharing</i>	
<u>Deductibles</u>	\$400
<u>Copayments</u>	\$10
<u>Coinsurance</u>	\$370
<i>What isn't covered</i>	
Limits or exclusions	\$0
<b>The total Mia would pay is</b>	<b>\$780</b>