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 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:
What is the overall deductible?	In-Network: $400 person/ $800 family Out-of-Network: $800 person/ $1,600 family	Generally, you must pay all of the costs from providers 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 and prescription drugs 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?	No.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	In-Network Medical: $3,000 person/ $6,000 family In-Network Prescription Drugs: $4,150 person/$8,300 family Out-of-Network: No limit.	In-Network: 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. Out-of-Network: This plan does not have an out-of-pocket limit on your expenses.
What is not included in the out-of-pocket limit?	In-Network: Premiums, balance billing, dental and optical expenses, and health care this plan does not cover. Out-of-Network: Not Applicable	In-Network: Even though you pay these expenses, they don't count toward the out-of-pocket limit. Out-of-Network: This plan does not have an out-of-pocket limit on your expenses.
Will you pay less if you use a network provider?	Yes. See **www.excellusbcbs.com** or call **1-800-499-1275** for a list of In-Network providers.	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 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.
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% coinsurance	40% coinsurance	None
	Specialist visit	20% coinsurance Chiropractor: 50% coinsurance	40% coinsurance Chiropractor: 50% coinsurance	Maximum chiropractic benefit of $550 per person per calendar year.
	Preventive care/screening/ immunization	No charge; deductible does not apply	40% coinsurance; deductible does not apply	You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for.
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 preauthorization is not obtained, it may cause additional costs to you.
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.expressscripts.com.	Generic drugs	Retail: $10 copay/script; Mail order: $20 copay/script	Retail: $10 copay/script; Mail order: $20 copay/script	Deductible does not apply. 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. 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. Non-formulary drugs are not covered. Must use Accredo Pharmacy for specialty drugs. Please contact Fund office for more information regarding the Patient Assurance Program (PAP).
	Preferred brand drugs	Retail: 20% coinsurance ($20 min/$40 max); Mail order: 20% coinsurance ($50 min/$100 max)	Retail only: 20% coinsurance ($20 min/$40 max)	
	Non-preferred brand drugs	Retail: 20% coinsurance ($40 min/$80 max); Mail order: 20% coinsurance ($100 min/$200 max)	Retail only: 20% coinsurance ($40 min/$80 max)	
	Specialty drugs	Preferred: 20% coinsurance ($300 max) mail order only; Non-Preferred: 20% coinsurance ($400 max) mail order only	Not covered	

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 have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	No charge	30% coinsurance	Subject to prior authorization. If preauthorization is not obtained, it may cause additional costs to you.
	Physician/surgeon fees	20% coinsurance	40% coinsurance	Subject to prior authorization. If preauthorization is not obtained, it may cause additional costs to you.
If you need immediate medical attention	Emergency room care	20% coinsurance; no charge for facility	20% coinsurance; no charge for facility	No coverage if you use emergency room for condition that is not an emergency medical condition
	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/stay	$200 copayment/stay and 30% coinsurance	Subject to prior authorization If preauthorization is not obtained, it may cause additional costs to you.
	Physician/surgeon fees	20% coinsurance	40% coinsurance	Subject to prior authorization. If preauthorization is not obtained, it may cause additional costs to you.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	20% coinsurance	40% coinsurance	None
	Inpatient services	$100 copayment/stay	$200 copayment/stay and 30% coinsurance	Subject to prior authorization. If preauthorization is not obtained, it may cause additional costs to you.
If you are pregnant	Office visits	No charge	40% coinsurance	Maternity care may include tests and services described somewhere else in the SBC (e.g., ultrasound).
	Childbirth/delivery professional services	20% coinsurance (physician fees)	40% coinsurance (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 copayment/stay (facility)	$200 copayment/stay and 30% coinsurance (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)	
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. If preauthorization is not obtained, it may cause additional costs to you.
	Rehabilitation services	$100 copayment/stay for inpatient rehabilitation; 20% coinsurance for outpatient services	$200 copayment/stay 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 If preauthorization is not obtained, it may cause additional costs to you.
	Habilitation services	20% coinsurance	40% coinsurance	Subject to prior authorization. . If preauthorization is not obtained, it may cause additional costs to you.
	Skilled nursing care	$100 copayment/stay	$200 copayment/stay and 30% coinsurance	Subject to prior authorization. Limited to 60 days per person per year, combined in- and out-of-network If preauthorization is not obtained, it may cause additional costs to you.
	Durable medical equipment	20% coinsurance	40% coinsurance	Subject to prior authorization. If preauthorization is not obtained, it may cause additional costs to you.
	Hospice services	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	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 cost sharing does not count toward the out-of-pocket limit.
	Children's glasses	Amounts over $200 for glasses or contacts.	Amounts over $200 for glasses or contacts.	
	Children's dental check-up	20% coinsurance	20% coinsurance	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 cost sharing does not count toward the out-of-pocket limit.

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 calendar year maximum. Dependent children not eligible unless medically necessary.)
- 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. 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: 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.

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, kwiijigo 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)*

Total Example Cost	**$12,700**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$400
Copayments	$150
Coinsurance	$810
What isn't covered	
Limits or exclusions	$20
The total Peg would pay is	**$1,380**

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)*

Total Example Cost	**$5,600**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$400
Copayments	$130
Coinsurance	$1,050
What isn't covered	
Limits or exclusions	$250
The total Joe would pay is	**$1,830**

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)*

Total Example Cost	**$2,800**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$400
Copayments	$10
Coinsurance	$370
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$780**