

 **This is only a summary.** If you want more detail about your coverage and costs, you can get the complete terms in the plan’s summary plan description at www.ironworkerstrust.com or by calling 206-441-7226 or 1-866-986-1515 (Select Option 1).

Important Questions	Answers	Why this Matters:
<p>What is the overall <u>deductible</u>?</p>	<p>\$350 person/\$1,050 family. The following services are not subject to the deductible and do not apply toward the deductible: Routine physical exams (member only), PPO office visits, hearing aids, outpatient prescription drugs, supplemental accident benefits, routine colonoscopy and sigmoidoscopy screenings, and any penalty for failing to preauthorize services.</p>	<p>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.</p>
<p>Are there other <u>deductibles</u> for specific services?</p>	<p>Yes, \$50 for dental benefits (Active Employees and Dependents of Active Employees only). There are no other specific deductibles.</p>	<p>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.</p>
<p>Is there an <u>out-of-pocket limit</u> on my expenses?</p>	<p>Yes. For participating providers-\$12,500 per person; for non-participating providers-\$25,000 per person.</p>	<p>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.</p>
<p>What is not included in the <u>out-of-pocket limit</u>?</p>	<p>Premiums, balance-billed charges, health care this plan doesn’t cover, the deductible, skilled nursing facility, supplemental accident benefit, common accident benefit, hearing aids, routine physical exams (member only), prescription drugs, and any penalty for failing to preauthorize services.</p>	<p>Even though you pay these expenses, they don’t count toward the out-of-pocket limit.</p>
<p>Is there an overall annual limit on what the plan pays?</p>	<p>No.</p>	<p>The chart starting on page 2 describes any limits on what the plan will pay for specific covered services, such as office visits.</p>

Does this plan use a <u>network of providers</u> ?	Yes. For a list of PPO or preferred providers , see www.premera.com or 1-800-810-BLUE (2583).	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 <u>specialist</u> ?	No.	You can see the specialist you choose without permission from the plan.
Are there services this plan doesn't cover?	Yes.	Some of the services this plan doesn't cover are listed on pages 61-64. 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 **preferred providers** by charging you lower **deductibles**, **copayments** and **coinsurance** amounts.

Common Medical Event	Services You May Need	Your Cost If You Use a Preferred Provider	Your Cost If You Use a Non-Preferred Provider	Limitations & Exceptions
If you visit a health care <u>provider's office or clinic</u>	Primary care visit to treat an injury or illness	\$20/visit.	50% coinsurance	All services must be medically necessary. Preauthorization from ICM required for all outpatient surgeries and procedures, ancillary testing and chemotherapy and radiation. Plan pays 100% for physicals for covered employees and retirees. Medicare retirees do not have co-pays.
	Specialist visit	No charge for lab/x-ray in conjunction with office visit.		
	Other practitioner office visit	25% coinsurance for all other professional services except routine office visit.		
	Preventive care/screening/immunization			
If you have a test	Diagnostic test (x-ray, blood work)	\$20/visit if done in conjunction with office visit; otherwise 25% coinsurance	50% coinsurance	---none---

NW Ironworkers Shop Health and Security Fund: Shop Employees

Coverage Period: 7/1/16 – 6/30/17

Summary of Benefits and Coverage: What this Plan Covers & What it Costs

Coverage for: **Family** | Plan Type: **PPO - Indemnity**

Common Medical Event	Services You May Need	Your Cost If You Use a Preferred Provider	Your Cost If You Use a Non-Preferred Provider	Limitations & Exceptions
	Imaging (CT/PET scans, MRIs)	\$20/visit if done in conjunction with office visit; otherwise 25% coinsurance	50% coinsurance	Preauthorization required.
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.envisionrx.com	Generic drugs	\$4 retail/\$8 mail	\$4 retail/\$8 mail	Coverage limited to drugs listed on plan formulary. Covers up to a 30-day supply for a retail prescription and 31-90 day supply for a mail order prescription.
	Preferred brand drugs	\$4 retail/\$8 mail	\$4 retail/\$8 mail	
	Non-preferred brand drugs	Not covered	Not covered	
	Specialty drugs	\$4 retail/\$8 mail	\$4 retail/\$8 mail	Specialty drugs are limited to a 30 day supply Preauthorization required for chemotherapy.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	25% coinsurance	50% coinsurance	Preauthorization required.
	Physician/surgeon fees	25% coinsurance	50% coinsurance	Preauthorization required.
If you need immediate medical attention	Emergency room services	25% coinsurance	50% coinsurance	---none---
	Emergency medical transportation	25% coinsurance	50% coinsurance	---none---
	Urgent care	25% coinsurance	50% coinsurance	---none---
If you have a hospital stay	Facility fee (e.g., hospital room)	25% coinsurance	50% coinsurance	Preauthorization required to avoid a \$250 penalty.
	Physician/surgeon fee	25% coinsurance	50% coinsurance	---none---

NW Ironworkers Shop Health and Security Fund: Shop Employees

Coverage Period: 7/1/16 – 6/30/17

Summary of Benefits and Coverage: What this Plan Covers & What it Costs

Coverage for: **Family** | Plan Type: **PPO - Indemnity**

Common Medical Event	Services You May Need	Your Cost If You Use a Preferred Provider	Your Cost If You Use a Non-Preferred Provider	Limitations & Exceptions
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	25% coinsurance	50% coinsurance	---none---
	Mental/Behavioral health inpatient services	25% coinsurance	50% coinsurance	Preauthorization required to avoid a \$250 penalty.
	Substance use disorder outpatient services	25% coinsurance	50% coinsurance	---none---
	Substance use disorder inpatient services	25% coinsurance	50% coinsurance	Preauthorization required to avoid a \$250 penalty.
If you are pregnant	Prenatal and postnatal care	25% coinsurance	50% coinsurance	No coverage for a dependent child or child of dependent child.
	Delivery and all inpatient services	25% coinsurance	50% coinsurance	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	25% coinsurance	50% coinsurance	Maximum of 130 visits per year.
	Rehabilitation services	25% coinsurance	50% coinsurance	Pulmonary rehabilitation is not covered. Maintenance rehabilitation not covered.
	Habilitation services	Not covered	Not covered	Limited neurodevelopmental therapy benefit for children age 6 and younger.
	Skilled nursing care	25% coinsurance	50% coinsurance	Maximum of 120 days.
	Durable medical equipment	25% coinsurance	50% coinsurance	Preauthorization required for costs over \$500. Foot orthotics and supportive devices for active employee's only and limited \$200 lifetime maximum.
	Hospice service	25% coinsurance	50% coinsurance	Lifetime maximum of \$10,000.
If your child needs dental or eye care	Eye exam	\$15/visit	All costs exceeding \$45.	Benefit limited to once every 18 months. Non-preferred provided benefit limited to \$45 per exam.
	Glasses	\$15/frames \$15/lenses	All costs exceeding \$45/lenses and \$47/frames	Benefit limited to once every 18 months. Non-preferred provided benefit limited to \$45 for lenses and \$47 for frames.

Common Medical Event	Services You May Need	Your Cost If You Use a Preferred Provider	Your Cost If You Use a Non-Preferred Provider	Limitations & Exceptions
	Dental check-up	Diagnostic/preventive 100% after deductible.	\$50 deductible, then 10% coinsurance for basic restorative and 15% for other restorative services	Benefit applicable to children up to age 18. All others subject to annual maximum of \$2,000. 30% coinsurance for prosthodontics services and 50% coinsurance for orthodontic services up to lifetime maximum of \$2,000. Not applicable for Retirees and/or their eligible dependents

Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover (This isn't a complete list. Check your plan's summary plan description for other <u>excluded services</u> .)		
<ul style="list-style-type: none"> • 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 (except to correct function disorder) • Infertility treatment 	<ul style="list-style-type: none"> • Injury or Illness for which a third-party may be responsible. • Long term care • Penile implants • Pregnancy for a Dependent Child • Pulmonary Rehabilitation 	<ul style="list-style-type: none"> • Routine foot care • Weight loss programs • Work related injury or illness • See the Plan Booklet and Summary Plan Description for other exclusions that may apply.
Other Covered Services (This isn't a complete list. Check your plan's summary plan description for other covered services and your costs for these services.)		
<ul style="list-style-type: none"> • Acupuncture • Bariatric surgery • Chiropractic care • Dental Care (adult) 	<ul style="list-style-type: none"> • Habilitation services (limitations apply) • Hearing Aids • Non-emergency care when traveling outside the United States (care must be medically necessary and considered standard of care in the U.S.) 	<ul style="list-style-type: none"> • Private duty nursing • Routine eye care (adult)

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 206-441-7226 or 1-866-986-1515 (Select Option 1). 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 1-877267-2323 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: www.ironworkerstrust.com or by calling 206-441-7226 or 1-866-986-1515 (Select Option 1). 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 additional information.

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.**

Language Access Services:

Para obtener asistencia en Español, llame al **206-441-7226** or **1-866-986-1515** (oprime el numero 1).

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 \$5,290
- Patient pays \$2,250

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	\$350
Copays	\$10
Coinsurance	\$1,740
Limits or exclusions	\$150
Total	\$2,250

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

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

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	\$350
Copays	\$360
Coinsurance	\$330
Limits or exclusions	\$80
Total	\$1,120

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.