**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: |
|---|---|---|
| **What is the overall deductible?** | **$250** person/**$500** family. Does not apply to preventive care, hearing aids, outpatient prescription drugs, supplemental accident benefits, and any penalty for failing to preauthorize services. | 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?** | **Yes,** $50 for dental benefits (Active Employees and Dependents of Active Employees only). 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. |
| **Is there an out–of–pocket limit on my expenses?** | **Yes.** For preferred medical providers **$4,250** person/**$8,500** family. For non-preferred medical providers **$8,000** per person after the deductible. For formulary prescription drugs **$2,600** person/**$5,200** family. No limit on non-formulary prescription drugs. | 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-billed charges, health care this plan doesn't cover, hearing aids, any penalty for failing to preauthorize services, dental, and vision. Non-preferred provider out-of-pocket is assessed after the deductible. | 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. |

| | | |
|---|---|---|
| **Does this plan use a network of providers?** | **Yes.** For a list of **preferred providers**, see www.premera.com or 1-800-810-BLUE (2583). (Not applicable to Medicare eligible Retirees). | 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 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 5. 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 provider's office or clinic** | Primary care visit to treat an injury or illness | $20/visit. No charge for lab/x-ray in conjunction with office visit. 20% coinsurance for all other professional services except routine office visit. | 40% coinsurance, 20% out of area | All services must be medically necessary. Preauthorization required for all outpatient surgeries and procedures, ancillary testing, chemotherapy and radiation. Medicare retirees do not have co-pays. |
| | Specialist visit | | | |
| | Other practitioner office visit | | | |

| 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 |
|---|---|---|---|---|
| | Preventive care/screening/immunization | No charge. | 40% coinsurance, 20% out of area | Preventive services are ACA recommendations. Services provided outside these recommendations are subject to applicable copays and coinsurance. |
| **If you have a test** | Diagnostic test (x-ray, blood work) | No charge if during office visit; otherwise 20% coinsurance | 40% coinsurance, 20% out of area | ---none--- |
| | Imaging (CT/PET scans, MRIs) | No charge if during office visit; otherwise 20% coinsurance | 40% coinsurance, 20% out of area | Preauthorization required. |
| **If you need drugs to treat your illness or condition**<br><br>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 at retail and 31-90 day supply at mail order. Specialty drugs are limited to a 30-day supply. Preauthorization required for chemotherapy. |
| | 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 | |
| **If you have outpatient surgery** | Facility fee (e.g., ambulatory surgery center) | 20% coinsurance | 40% coinsurance, 20% out of area | Preauthorization required. |
| | Physician/surgeon fees | 20% coinsurance | 40% coinsurance, 20% out of area | Preauthorization required. |
| **If you need immediate medical attention** | Emergency room services | 20% coinsurance | 20% coinsurance | ---none--- |
| | Emergency medical transportation | 20% coinsurance | 40% coinsurance, 20% out of area | ---none--- |
| | Urgent care | 20% coinsurance | 40% coinsurance, 20% out of area | ---none--- |
| **If you have a hospital stay** | Facility fee (e.g., hospital room) | 20% coinsurance | 40% coinsurance, 20% out of area | Preauthorization required to avoid a $250 penalty. |
| | Physician/surgeon fee | 20% coinsurance | 40% coinsurance, 20% out of area | ---none--- |

| 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 | 20% coinsurance | 40% coinsurance, 20% out of area | ---none--- |
| | Mental/Behavioral health inpatient services | 20% coinsurance | 40% coinsurance, 20% out of area | Preauthorization required to avoid a $250 penalty. |
| | Substance use disorder outpatient services | 20% coinsurance | 40% coinsurance, 20% out of area | ---none--- |
| | Substance use disorder inpatient services | 20% coinsurance | 40% coinsurance, 20% out of area | Preauthorization required to avoid a $250 penalty. |
| **If you are pregnant** | Prenatal and postnatal care | 20% coinsurance | 40% coinsurance, 20% out of area | Postnatal care benefits are not covered for a dependent child or child of dependent child. |
| | Delivery and all inpatient services | 20% coinsurance | 40% coinsurance, 20% 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% out of area | Maximum of 130 visits per year. |
| | Rehabilitation services | 20% coinsurance | 40% coinsurance, 20% out of area | Pulmonary rehabilitation is not covered. Maintenance rehabilitation not covered. |
| | Habilitation services | 20% coinsurance | 40% coinsurance, 20% out of area | Includes physical, occupational and speech therapies to improve a mental health condition. |
| | Skilled nursing care | 20% coinsurance | 40% coinsurance, 20% out of area | Maximum of 120 days. |
| | Durable medical equipment | 20% coinsurance | 40% coinsurance, 20% out of area | Preauthorization required for costs over $500. Foot orthotics and supportive devices are only for active employees and are limited to $200 lifetime maximum. |
| | Hospice service | 20% coinsurance | 40% coinsurance, 20% out of area | ---none--- |
| **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 provider benefit limited to $45 per exam. |

| 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 |
|---|---|---|---|---|
| | Glasses | $15/frames<br>$15/lenses | 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. |
| | 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 $2,000. 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 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 (except to correct function disorder)
- 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
- 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.)**

- Acupuncture
- Bariatric surgery
- Chiropractic care
- Dental Care (adult)
- Hearing Aids
- Non-emergency care when traveling outside the United States (care must be medically necessary and considered standard care in the U.S.)
- Habilitation services (limitations apply)
- 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 (oprima 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** $5,730
- **Patient pays** $1,810

**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 | $250 |
| Copays | $10 |
| Coinsurance | $1,400 |
| Limits or exclusions | $150 |
| **Total** | **$1,810** |

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

- **Amount owed to providers:** $5,400
- **Plan pays** $4,470 **Patient pays** $930

**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 | $250 |
| Copays | $160 |
| Coinsurance | $440 |
| Limits or exclusions | $80 |
| **Total** | **$930** |

**Questions:** Call **206-441-7226 or 1-866-986-1515 (Select Option 1)** or visit us at www.ironworkerstrust.com for more information, including a copy of your plan's summary plan description. If you aren't clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary at www.cciio.cms.gov or call **206-441-7226 or 1-866-986-1515 (Select Option 1)** to request a copy.

# 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.

**Questions:** Call **206-441-7226 or 1-866-986-1515 (Select Option 1)** or visit us at www.ironworkerstrust.com for more information, including a copy of your plan's summary plan description. If you aren't clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary at www.cciio.cms.gov or call **206-441-7226 or 1-866-986-1515 (Select Option 1)** to request a copy. Revised 2016-10-11