




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 1-866-986-1515. 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.dol.gov/ebsa/healthreform](http://www.dol.gov/ebsa/healthreform) or call 1-866-986-1515 to request a copy.

Important Questions	Answers	Why This Matters:
<p>What is the overall <a href="#">deductible</a>?</p>	<p><b>\$250</b> per person/<b>\$500</b> per family.</p>	<p>Generally, you must pay all of the costs from <a href="#">provider</a> up to the <a href="#">deductible</a> amount before this plan begins to pay. If you have other family members on the <a href="#">plan</a>, each family member must meet their own individual <a href="#">deductible</a> until the total amount of <a href="#">deductible</a> expenses paid by all family members meets the overall family <a href="#">deductible</a>.</p>
<p>Are there services covered before you meet your <a href="#">deductible</a>?</p>	<p><b>Yes.</b> preventive care, routine physical exam for employee, office visit with a network provider, hearing aids, outpatient prescription drugs, supplemental accident benefit services are covered before you meet your <a href="#">deductible</a>.</p>	<p>This <a href="#">plan</a> covers some items and services even if you haven't yet met the <a href="#">deductible</a> amount. But a <a href="#">copayment</a> or <a href="#">coinsurance</a> may apply. For example, this plan covers certain <a href="#">preventive services</a> without cost sharing and before you meet your <a href="#">deductible</a>. See a list of covered <a href="#">preventive services</a> at <a href="https://www.healthcare.gov/coverage/preventive-care-benefits/">https://www.healthcare.gov/coverage/preventive-care-benefits/</a>.</p>
<p>Are there other <a href="#">deductibles</a> for specific services?</p>	<p><b>Yes.</b> \$50 for dental benefits                  There are no other specific <a href="#">deductibles</a>.</p>	<p>You must pay all of the costs for these services up to the specific <a href="#">deductible</a> amount before this <a href="#">plan</a> begins to pay for these services.</p>
<p>What is the <a href="#">out-of-pocket limit</a> for this <a href="#">plan</a>?</p>	<p>Medical <a href="#">Preferred Providers</a>: <b>\$4,250</b> per person / <b>\$8,500</b> per family.                  Medical <a href="#">Non-Preferred Providers</a>: <b>\$8,000</b> per person after the deductible.                  Formulary <a href="#">Prescription Drugs</a>: <b>\$4,950</b> per person / <b>\$9,900</b> per family.                  Non-Formulary <a href="#">Prescription Drugs</a>: No limit.</p>	<p>The <a href="#">out-of-pocket limit</a> is the most you could pay in a year for covered services. If you have other family members in this <a href="#">plan</a>, they have to meet their own <a href="#">out-of-pocket limits</a> until the overall family <a href="#">out-of-pocket limit</a> has been met.</p>
<p>What is not included in the <a href="#">out-of-pocket limit</a>?</p>	<p><a href="#">Premiums</a>, <a href="#">balance-billed</a> charges, health care this <a href="#">plan</a> does not cover, hearing aids, dental, vision, and any penalty for failing to <a href="#">preauthorize</a> services.</p>	<p>Even though you pay these expenses, they don't count toward the <a href="#">out-of-pocket limit</a>.</p>
<p>Will you pay less if you use a <a href="#">network provider</a>?</p>	<p><b>Yes.</b> See <a href="http://premera.com/sharedadmin">premera.com/sharedadmin</a> or call 1-800-810-BLUE (2583) for a list of <a href="#">network providers</a>. For Teladoc see</p>	<p>This <a href="#">plan</a> uses a provider <a href="#">network</a>. You will pay less if you use a <a href="#">provider</a> in the plan's <a href="#">network</a>. You will pay the most if you use an <a href="#">out-of-network provider</a>, and you might receive a bill from a <a href="#">provider</a> for the difference between the provider's</p>

Important Questions	Answers	Why This Matters:
	<a href="http://www.Teladoc.com/Premera">www.Teladoc.com/Premera</a> or 855-332-4059. (Not applicable to Medicare eligible Retirees) For vision see <a href="http://www.vsp.com">www.vsp.com</a> .	charge and what your <a href="#">plan</a> pays ( <a href="#">balance billing</a> ). Be aware, your <a href="#">network provider</a> might use an <a href="#">out-of-network provider</a> for some services (such as lab work). Check with your <a href="#">provider</a> before you get services. Participants will only be liable for the in-network cost share for non-network emergency services, non-network providers at in-network facilities, and non-network air ambulance services.
Do you need a <a href="#">referral</a> to see a <a href="#">specialist</a> ?	No.	You can see the <a href="#">specialist</a> 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 <a href="#">provider's office or clinic</a>	Primary care visit to treat an injury or illness	\$20 <a href="#">copay</a> /visit <a href="#">Deductible</a> does not apply.		Copay waived for Teladoc visits. All services must be <a href="#">medically necessary</a> . <a href="#">Preauthorization</a> required for all outpatient surgeries and procedures, ancillary testing, chemotherapy and radiation. Spinal manipulation and Acupuncture limited to combined 24 visits per calendar year.
	<a href="#">Specialist</a> visit	No charge for lab/ x-ray if within two weeks of office visit. 20% <a href="#">coinsurance</a> for all other professional services except routine office visit.	40% <a href="#">coinsurance</a> / 20% <a href="#">coinsurance</a> out of area	
	<a href="#">Preventive care/screening/immunization</a>	No Charge <a href="#">Deductible</a> does not apply.	40% <a href="#">coinsurance</a> / 20% <a href="#">coinsurance</a> out of area	
If you have a test	<a href="#">Diagnostic test</a> (x-ray, blood work)	No charge if within two weeks of otherwise 20% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a> / 20% <a href="#">coinsurance</a> out of area	None
	Imaging (CT/PET scans, MRIs)	No charge if within two weeks of otherwise 20% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a> / 20% <a href="#">coinsurance</a> out of area	<a href="#">Preauthorization</a> is required

\* For more information about limitations and exceptions, see the [plan](#) or policy document at [www.ironworkerstrust.com](http://www.ironworkerstrust.com)

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 drugs to treat your illness or condition</b> More information about <a href="#">prescription drug coverage</a> is available at <a href="http://www.costcohealthsolutions.com/">www.costcohealthsolutions.com/</a>	Generic drugs	\$4 <a href="#">copay</a> /prescription retail; \$8 <a href="#">copay</a> /prescription mail	\$4 <a href="#">copay</a> /prescription retail; \$8 <a href="#">copay</a> /prescription 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. <u>Specialty drugs</u> are limited to a 30-day supply. The first fill and all subsequent specialty drug refills are required to be filled at Costco Health Solutions (CHS). <u>Preauthorization</u> required for chemotherapy.
	Preferred brand drugs	\$4 <a href="#">copay</a> /prescription retail; \$8 <a href="#">copay</a> /prescription mail	\$4 <a href="#">copay</a> /prescription retail; \$8 <a href="#">copay</a> /prescription mail	
	Non-preferred brand drugs	Not covered	Not covered	
	<a href="#">Specialty drugs</a>	\$4 <a href="#">copay</a> /prescription retail; \$4 <a href="#">copay</a> /prescription mail	\$4 <a href="#">copay</a> /prescription retail; \$4 <a href="#">copay</a> /prescription mail	
<b>If you have outpatient surgery</b>	Facility fee (e.g., ambulatory surgery center)	20% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a> / 20% <a href="#">coinsurance</a> out of area	<u>Preauthorization</u> is required.
	Physician/surgeon fees			
<b>If you need immediate medical attention</b>	<a href="#">Emergency room care</a>	20% <a href="#">coinsurance</a>	20% <a href="#">coinsurance</a>	None
	<a href="#">Emergency medical transportation</a>	20% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a> / 20% <a href="#">coinsurance</a> out of area	None
	<a href="#">Urgent care</a>	20% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a> / 20% <a href="#">coinsurance</a> out of area	Network provider physician services billed as office visits with no associated facility charge are subject only to the \$20 copay.
<b>If you have a hospital stay</b>	Facility fee (e.g., hospital room)	20% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a> / 20% <a href="#">coinsurance</a> out of area	<u>Preauthorization</u> is required to avoid a \$250 penalty.
	Physician/surgeon fees	20% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a> / 20% <a href="#">coinsurance</a> out of area	None
<b>If you need mental health, behavioral health, or substance abuse services</b>	Outpatient services	20% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a> / 20% <a href="#">coinsurance</a> out of area	None
	Inpatient services	20% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a> / 20% <a href="#">coinsurance</a> out of area	<u>Preauthorization</u> is required to avoid a \$250 penalty.
<b>If you are pregnant</b>	Office visits	\$20 <a href="#">copay</a> /visit <u>deductible</u> does not apply.	40% <a href="#">coinsurance</a> / 20% <a href="#">coinsurance</a> out of area	<u>Cost-sharing</u> does not apply for <u>preventive services</u> . Depending on the type of services, a <u>copayment</u> or <u>coinsurance</u> may apply.
	Childbirth/delivery professional services	20% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a> / 20% <a href="#">coinsurance</a> out of area	No coverage for dependent child, except ACA preventive services.

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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)	
	Childbirth/delivery facility services	20% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a> / 20% <a href="#">coinsurance</a> out of area	No coverage for a dependent child or child of dependent child.
<b>If you need help recovering or have other special health needs</b>	<a href="#">Home health care</a>	20% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a> / 20% <a href="#">coinsurance</a> out of area	Maximum of 130 visits per year.
	<a href="#">Rehabilitation services</a>	20% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a> / 20% <a href="#">coinsurance</a> out of area	Pulmonary rehabilitation is not covered. Maintenance rehabilitation is not covered. Preauthorization required after 8 visits. For inpatient services, <a href="#">preauthorization</a> is required.
	<a href="#">Habilitation services</a>	20% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a> / 20% <a href="#">coinsurance</a> out of area	Limited neurodevelopmental therapy benefit for children age 6 and younger to a lifetime benefit of \$3,000. No age or dollar limit when for treatment of a mental disorder.. For inpatient services, <a href="#">preauthorization</a> is required.
	<a href="#">Skilled nursing care</a>	20% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a> / 20% <a href="#">coinsurance</a> out of area	Maximum of 120 days. For inpatient services, <a href="#">preauthorization</a> is required.
	<a href="#">Durable medical equipment</a>	20% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a> / 20% <a href="#">coinsurance</a> out of area	<a href="#">Preauthorization</a> is required for costs over \$500. Foot orthotics and supportive devices are only for active employees and are limited to \$200 every 5-year period.
	<a href="#">Hospice services</a>	20% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a> / 20% <a href="#">coinsurance</a> out of area	None
<b>If your child needs dental or eye care</b>	Children's eye exam	\$15 <a href="#">copay</a> /visit	All costs exceeding \$45	Benefit limited to once every 18 months. Non-preferred provider benefit limited to \$45 per exam.
	Children's glasses	\$15 <a href="#">copay</a> for lenses \$15 <a href="#">copay</a> frames	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.
	Children's 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 \$2,500.

## 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](#).)

- 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
- Expenses resulting from work related conditions
- 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

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

- Acupuncture
- Bariatric surgery
- Chiropractic Care (combined with acupuncture)
- Dental Care (Adult)
- Hearing Aids
- Non-emergency care when traveling outside the US (care must be medically necessary and considered standard care in the US.
- Private duty nursing
- Routine eye care (adult)

**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: 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) and Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, at 1-877-267-2323 x61565 or [www.cciio.cms.gov](http://www.cciio.cms.gov). 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: 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). You may also contact the Trust Administration Office at 1-866-986-1515.

### 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 1-866-986-1515.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-866-986-1515.

*To see examples of how this [plan](#) might cover costs for a sample medical situation, see the next section.*

### About these Coverage Examples:

\* For more information about limitations and exceptions, see the [plan](#) or policy document at [www.ironworkerstrust.com](http://www.ironworkerstrust.com)



**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](#) \$250
- [Specialist copayment](#) \$20
- Hospital (facility) [coinsurance](#) 20%
- 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>	
<a href="#">Deductibles</a>	\$250
<a href="#">Copayments</a>	\$10
<a href="#">Coinsurance</a>	\$2,200
<i>What isn't covered</i>	
Limits or exclusions	\$60
<b>The total Peg would pay is</b>	<b>\$2,520</b>

### Managing Joe's Type 2 Diabetes

(a year of routine in-network care of a well-controlled condition)

- The [plan's](#) overall [deductible](#) \$250
- [Specialist copayment](#) \$20
- Hospital (facility) [coinsurance](#) 20%
- 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>	
<a href="#">Deductibles</a>	\$250
<a href="#">Copayments</a>	\$300
<a href="#">Coinsurance</a>	\$200
<i>What isn't covered</i>	
Limits or exclusions	\$20
<b>The total Joe would pay is</b>	<b>\$770</b>

### Mia's Simple Fracture

(in-network emergency room visit and follow up care)

- The [plan's](#) overall [deductible](#) \$250
- [Specialist copayment](#) \$20
- Hospital (facility) [coinsurance](#) 20%
- 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>	
<a href="#">Deductibles</a>	\$250
<a href="#">Copayments</a>	\$0
<a href="#">Coinsurance</a>	\$500
<i>What isn't covered</i>	
Limits or exclusions	\$0
<b>The total Mia would pay is</b>	<b>\$750</b>

The [plan](#) would be responsible for the other costs of these EXAMPLE covered services.