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 1-215-537-0900. 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.iwdcphila.com or by calling 1-215-537-0900 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	In-Network: $0 Out-of-Network: $500 person/ $1,000 family	In-Network: See the Common Medical Events chart below for your costs for services this plan covers. Out-of-Network: 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?	In-Network: Not Applicable. Out-of-Network: Yes. Preventive care, prescription drugs, optical and dental care are covered before you meet your deductible.	In-Network: This plan does not have a deductible. Out-of-Network: This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply.
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: $6,075 person/$12,075 family Prescription drugs: $1,825 person/$3,725 family Out-of-Network Medical: $8,000 person/$16,000 family	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.
What is not included in the out-of-pocket limit?	In-Network and Out-of-Network: premiums, balance billing, health care this plan does not cover, penalties for failure to obtain preauthorization for services and optical and dental care; Out-of-Network also does not include: copayments and deductibles.	Even though you pay these expenses, they don't count toward the out-of-pocket limit.

Important Questions	Answers	Why This Matters:
Will you pay less if you use a network provider?	Yes. For a list of in-network providers, see www.ibx.com or call 1-800-ASK-BLUE (275-2583).	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 copay/visit	30% coinsurance	None.
	Specialist visit	$20 copay/visit	30% coinsurance	Chiropractic care 20 visits/year.
	Preventive care/screening/ immunization	No charge	30% coinsurance; deductible does not apply	Age and frequency limits 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)	No charge if performed by HCSC provider, $100 copay/test all other in-network providers	30% coinsurance	Failure to obtain preauthorization for out-of-network outpatient diagnostic arthroscopy and endoscopy will result in 20% reduction in benefits.
	Imaging (CT/PET scans, MRIs)	No charge if performed by HCSC provider, $100 copay/test all other in-network providers	30% coinsurance	Failure to obtain preauthorization for out-of-network outpatient imaging will result in 20% reduction in benefits.

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 drugs to treat your illness or condition **More information about prescription drug coverage is available at** www.iwdcphila.com or by calling EnvisionRx at 800-361-4542.	Generic drugs	Retail (30-day supply): $10 copay/prescription, Retail (90-day supply of maintenance drugs at retail outlet): $30 copay/prescription; Mail Order (90-day supply): $20 copay/prescription	Retail only (30-day supply): $10 copay/prescription plus difference between out-of-network cost and allowed amount	Out-of-network medical deductible does not apply to prescription drug coverage. No charge for ACA-required generic preventive drugs (such as contraceptives) (or brand drug if generic is not medically appropriate). Step Therapy is mandatory for all drugs.
	Preferred brand drugs	Retail (30-day supply): $25 copay/prescription Mail Order (90-day supply): $50 copay/prescription	Retail only (30-day supply): $25 copay/prescription plus difference between out-of-network cost and allowed amount	If a brand name drug is purchased when a generic is available and medically appropriate, you pay the difference in cost, plus applicable copay. ACA contraceptives and preventive prescriptions covered at no charge only if generic is unavailable or medically inappropriate. Step Therapy is mandatory for all drugs.
	Non-preferred brand drugs	Retail (30-day supply): $100 copay/prescription Mail Order (90-day supply): $200 copay/prescription	Retail only (30-day supply): $50 copay/prescription plus difference between out-of-network cost and allowed amount	
	Specialty drugs	Mail order only: 2% of cost of drug subject to regular copay minimum	Not covered	Preauthorization required. $250/max copay per prescription. Step Therapy mandatory for all drugs. Must use mail order pharmacy.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	No charge	30% coinsurance	Preauthorization required for certain out-of-network surgery; Failure to obtain preauthorization for out-of-network surgery will result in 20% reduction in benefits.
	Physician/surgeon fees	No charge	30% coinsurance	

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 immediate medical attention	Emergency room care	$150 copay/visit	$150 copay/visit	Copay waived if admitted to hospital.
	Emergency medical transportation	No charge	No charge	Preauthorization required for non-emergency use of ambulance. Failure to obtain preauthorization will result in a 20% reduction in benefits.
	Urgent care	$50 copay/visit	30% insurance	Copay waived if sent to Emergency Room.
If you have a hospital stay	Facility fee (e.g., hospital room)	$100 copay/day up to a maximum of $500/admission	30% coinsurance	Transplants not covered. Failure to obtain preauthorization for non-emergency out-of-network admission will result in $1,000 penalty. Out-of-network inpatient services limited to 70 days/year.
	Physician/surgeon fees	No charge	30% coinsurance	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Office visits:$20 copay/visit; Other outpatient: No charge	30% coinsurance	None
	Inpatient services	$100 copay/day up to a maximum of $500/admission	30% coinsurance	Failure to obtain preauthorization for non-emergency out-of-network admission will result in $1,000 penalty. Out-of-network inpatient services limited to 70 days/year.
If you are pregnant	Office visits	$20 copay (applies to first visit only), thereafter, no charge	30% coinsurance	Copay only applies to first in-network prenatal visit. In-network cost sharing does not apply to ACA preventive screenings. Maternity care may include tests and services described somewhere else in the SBC (e.g., ultrasound). Prenatal care (other than ACA-required preventive screenings) is not covered for dependent children.
	Childbirth/delivery professional services	No charge	30% coinsurance	Failure to obtain preauthorization for birthing center for stays that exceed 48 hours (for normal delivery) or 96 hours (for C-section) will result in $1,000 penalty. Delivery charges are not covered for dependent children.
	Childbirth/delivery facility services	No charge	30% coinsurance	

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	Failure to obtain preauthorization will result in a 20% reduction in benefits.
	Rehabilitation services	Outpatient: $20 copay/visit; Inpatient: $100 copay/day up to a maximum of $500/admission	30% coinsurance	Plan covers physical, occupational and speech therapy. Cardiac rehabilitation limited to 36 visits/year; pulmonary rehabilitation limited to 12 visits/year. 20% reduction in benefits for failure to obtain preauthorization for out-of-network speech therapy. Out-of-network inpatient services limited to 70 days/year.
	Habilitation services	Not covered	Not covered	You must pay 100% of charges, even in-network.
	Skilled nursing care	No charge	30% coinsurance	Failure to obtain preauthorization for out-of-network care will result in $1,000 penalty for inpatient services. Out-of-network inpatient services limited to 70 days/year.
	Durable medical equipment	No charge	30% coinsurance	Preauthorization required for purchases over $500 and all rentals. 20% reduction in benefits for failure to obtain preauthorization.
	Hospice services	No charge	30% coinsurance	Failure to obtain preauthorization for out-of-network care will result in $1,000 penalty for inpatient services, 20% reduction for outpatient services. Out-of-network inpatient services limited to 70 days/year.
If your child needs dental or eye care	Children's eye exam	No charge	Amounts over $20	None. Optical benefits administered separately by National Vision Administrators, LLC (NVA). Medical plan deductible and out-of-pocket limit do not apply to these services.
	Children's glasses	Amounts over $60/frames and no charge for lenses	Amounts over $100/frames and $40/single vision lenses or $60 bifocal lenses	One pair every 2 years or 1 every year if prescription changes. Optical benefits administered separately from medical plan. Medical plan deductible and out-of-pocket limit do not apply to these services.
	Children's dental check-up	Amounts over plan allowance	Amounts over plan allowance	Dental benefits administered separately by Fidelio Dental Insurance Company. Medical plan deductible and out-of-pocket limit do not apply to these 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
- Habilitation services
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Routine foot care

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

- Chiropractic care (20 visits per calendar year)
- Dental care (Adult) (benefit paid up to Plan allowance/preauthorization required for charges of $250 or more)
- Hearing aids (Up to $750 Personal Choice PPO Plan allowance per ear every 2 years)
- Infertility treatment (limited to drugs purchased through Fund Office & physician fees)
- Private-duty nursing (outpatient only)
- Routine eye care (Adult) (up to $20/exam every 2 years)
- Weight loss programs (as required by the health reform law) (nutrition counseling for weight management only, 6 visits/year)

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 U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 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 Iron Workers District Council (Philadelphia and Vicinity) Health Benefit Plan, 2 International Plaza, Suite 120, Philadelphia, Pennsylvania 19113-1504 or via phone at 1-215-537-0900. 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 Para obtener asistencia en Español, llame al 1-215-537-0900.

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	$0
Specialist copay	$20
Hospital (facility) copay	$100
Other copay	$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	$0
Copayments	$420
Coinsurance	$0
What isn't covered	
Limits or exclusions	$20
The total Peg would pay is	**$440**

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

The plan's overall deductible	$0
Specialist copay	$20
Hospital (facility) copay	$100
Other copay	$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	$0
Copayments	$1,200
Coinsurance	$0
What isn't covered	
Limits or exclusions	$30
The total Joe would pay is	**$1,200**

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

The plan's overall deductible	$0
Specialist copay	$20
Hospital (facility) copay	$100
Other copay	$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	$0
Copayments	$430
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$430**

The **plan** would be responsible for the other costs of these EXAMPLE covered services.
Your Health Reimbursement Account (HRA) may be available for reimbursement for out-of-pocket expenses