
 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](http://www.iwdcphila.com) or by calling 1-215-537-0900 to request a copy.

Important Questions	Answers	Why This Matters:
<p><b>What is the overall deductible?</b></p>	<p><u>In-Network Medical</u>: \$1,500 person/ \$3,000 family  <u>Out-of-Network Medical</u>: \$2,750 person/ \$5,500 family</p>	<p>Generally, you must pay all of the costs from <u>providers</u> up to the <u>deductible</u> amount before this <u>plan</u> begins to pay. If you have other family members on the <u>plan</u>, each family member must meet their own individual <u>deductible</u> until the total amount of <u>deductible</u> expenses paid by all family members meets the overall family <u>deductible</u>.</p>
<p><b>Are there services covered before you meet your deductible?</b></p>	<p>Yes. <u>Preventive care</u>, <u>prescription drug coverage</u>, and optical and dental care are covered before you meet your <u>deductible</u>.</p>	<p>This <u>plan</u> covers some items and services even if you haven't yet met the <u>deductible</u> amount. But a <u>copayment</u> or <u>coinsurance</u> may apply. For example, this <u>plan</u> covers certain <u>preventive services</u> without <u>cost sharing</u> and before you meet your <u>deductible</u>. See a list of covered <u>preventive services</u> at <a href="https://www.healthcare.gov/coverage/preventive-care-benefits/">https://www.healthcare.gov/coverage/preventive-care-benefits/</a></p>
<p><b>Are there other deductibles for specific services?</b></p>	<p>Yes. \$100 individual for <u>prescription drug coverage</u>. There are no other specific <u>deductibles</u>.</p>	<p>You must pay all of the costs for these services up to the specific <u>deductible</u> amount before this <u>plan</u> begins to pay for these services.</p>
<p><b>What is the out-of-pocket limit for this plan?</b></p>	<p><u>In-Network Medical</u>: \$6,075 person/\$12,075 family  <u>Prescription drug coverage</u>: \$1,825 person/\$3,725 family  <u>Out-of-Network Medical</u>: \$8,000 person/\$16,000 family</p>	<p>The <u>out-of-pocket limit</u> is the most you could pay in a year for covered services. If you have other family members in this <u>plan</u>, they have to meet their own <u>out-of-pocket limits</u> until the overall family <u>out-of-pocket limit</u> has been met.</p>
<p><b>What is not included in the out-of-pocket limit?</b></p>	<p><u>In-Network</u> and <u>Out-of-Network</u>: <u>premiums</u>, <u>balance billing</u>, health care this <u>plan</u> does not cover, penalties for failure to obtain <u>preauthorization</u> for services and optical and dental care; <u>Out-of-Network</u> also does not include: <u>copayments</u> and <u>deductibles</u>.</p>	<p>Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u>.</p>

Important Questions	Answers	Why This Matters:
<p><b>Will you pay less if you use a <u>network provider</u>?</b></p>	<p>Yes. For a list of <u>in-network providers</u>, see <a href="http://www.ibx.com">www.ibx.com</a> or call 1-800-ASK-BLUE (275-2583).</p>	<p>This <u>plan</u> uses a <u>provider network</u>. You will pay less if you use a <u>provider</u> in the <u>plan's network</u>. You will pay the most if you use an <u>out-of-network provider</u>, and you might receive a bill from a <u>provider</u> for the difference between the <u>provider's charge</u> and what your <u>plan</u> pays (<u>balance billing</u>). Be aware your <u>network provider</u> might use an <u>out-of-network provider</u> for some services (such as lab work). Check with your <u>provider</u> before you get services.</p>
<p><b>Do you need a <u>referral</u> to see a <u>specialist</u>?</b></p>	<p>No.</p>	<p>You can see the <u>specialist</u> you choose without a <u>referral</u>.</p>

 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	15% <u>coinsurance</u>	40% <u>coinsurance</u>	None.
	<u>Specialist</u> visit	15% <u>coinsurance</u>	40% <u>coinsurance</u>	Chiropractic care 20 visits/year.
	<u>Preventive care/screening/immunization</u>	No charge; <u>deductible</u> does not apply	40% <u>coinsurance</u> ; <u>deductible</u> does not apply	Age and frequency limits apply. You may have to pay for services that aren't preventive. Ask your <u>provider</u> if the services needed are preventive. Then check what your <u>plan</u> will pay for.
If you have a test	<u>Diagnostic test</u> (x-ray, blood work)	No charge if performed by HCSC <u>Provider</u> ; \$100 <u>copay</u> /test for all other <u>in-network providers</u>	40% <u>coinsurance</u>	Failure to obtain <u>preauthorization</u> for <u>out-of-network</u> outpatient diagnostic arthroscopy and endoscopy will result in 20% reduction in benefits.
	Imaging (CT/PET scans, MRIs)	No charge if performed by HCSC <u>Provider</u> ; \$100 <u>copay</u> /test for all other <u>in-network providers</u>	40% <u>coinsurance</u>	Failure to obtain <u>preauthorization</u> for <u>out-of-network</u> 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)	
<b>If you need drugs to treat your illness or condition</b> <b>More information about <u>prescription drug coverage</u> is available at <a href="http://www.iwdcphila.com">www.iwdcphila.com</a> or by calling EnvisionRx at 800-361-4542.</b>	Generic drugs	Retail (30-day supply or 90-day supply of maintenance drugs at retail outlet): 15% <u>coinsurance</u> Mail Order (90-day supply): 15% <u>coinsurance</u>	Retail only (30-day supply): 15% <u>coinsurance</u> plus difference between <u>out-of-network</u> cost and <u>allowed amount</u>	<p>Medical <u>deductible</u> does not apply to <u>prescription drug coverage</u>; separate \$100 individual <u>prescription drug deductible</u> applies.</p> <p>No charge for ACA-required generic preventive drugs (such as contraceptives) (or brand drug if generic is not medically appropriate).</p> <p>Step Therapy is mandatory for all drugs.</p>
	Preferred brand drugs	Retail (30-day supply): 15% <u>coinsurance</u> Mail Order (90-day supply): 15% <u>coinsurance</u>	Retail only (30-day supply): 15% <u>coinsurance</u> plus difference between <u>out-of-network</u> cost and <u>allowed amount</u>	<p>If a brand name drug is purchased when a generic is available and medically appropriate, you pay the difference in cost, plus applicable <u>copay</u>.</p> <p>ACA contraceptives and preventive prescriptions covered at no charge only if generic is unavailable or medically inappropriate.</p> <p>Step Therapy is mandatory for all drugs.</p>
	Non-preferred brand drugs	Retail (30-day supply): 15% <u>coinsurance</u> Mail Order (90-day supply): 15% <u>coinsurance</u>	Retail only (30-day supply): 15% <u>coinsurance</u> plus difference between <u>out-of-network</u> cost and <u>allowed amount</u>	<p>Step Therapy is mandatory for all drugs.</p>
	<u>Specialty drugs</u>	Mail order only: 15% <u>coinsurance</u>	Not covered	<p><u>Preauthorization</u> required. \$250/max <u>copay</u> per prescription. Step Therapy mandatory for all drugs. Must use mail order pharmacy.</p>
<b>If you have outpatient surgery</b>	Facility fee (e.g., ambulatory surgery center)	15% <u>coinsurance</u>	40% <u>coinsurance</u>	<p><u>Preauthorization</u> required for certain <u>out-of-network</u> surgery; Failure to obtain <u>preauthorization</u> for <u>out-of-network</u> surgery will result in 20% reduction in benefits.</p>
	Physician/surgeon fees	15% <u>coinsurance</u>	40% <u>coinsurance</u>	

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	<u>Emergency room care</u>	\$150 <u>copay</u> /visit	\$150 <u>copay</u> /visit	<u>Copay</u> waived if admitted to hospital.
	<u>Emergency medical transportation</u>	No charge	No charge	<u>Preauthorization</u> required for non-emergency use of ambulance. Failure to obtain <u>preauthorization</u> will result in a 20% reduction in benefits.
	<u>Urgent care</u>	\$50 <u>copay</u> /visit	40% <u>coinsurance</u>	<u>Copay</u> waived if sent to Emergency Room.
If you have a hospital stay	Facility fee (e.g., hospital room)	\$500 <u>copay</u> /day up to a maximum of 10 days or \$5,000/admission	40% <u>coinsurance</u>	Transplants not covered. Failure to obtain <u>preauthorization</u> for non-emergency <u>out-of-network</u> admission will result in \$1,000 penalty. <u>Out-of-network</u> inpatient services limited to 70 days/year.
	Physician/surgeon fees	15% <u>coinsurance</u>	40% <u>coinsurance</u>	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Office visits and other outpatient: 15% <u>coinsurance</u>	40% <u>coinsurance</u>	None.
	Inpatient services	\$500 <u>copay</u> /day up to a maximum of 10 days or \$5,000/admission	40% <u>coinsurance</u>	Failure to obtain <u>preauthorization</u> for non-emergency <u>out-of-network</u> admission will result in \$1,000 penalty. <u>Out-of-network</u> inpatient services limited to 70 days/year.
If you are pregnant	Office visits	15% <u>coinsurance</u> for first visit, no charge thereafter	40% <u>coinsurance</u>	<u>In-network</u> cost sharing only applies to first <u>in-network</u> prenatal visit. <u>In-network</u> cost sharing does not apply to ACA preventive <u>screenings</u> . Maternity care may include tests and services described somewhere else in the SBC (e.g., ultrasound). Prenatal care (other than ACA-required preventive <u>screenings</u> ) is not covered for dependent children.
	Childbirth/delivery professional services	15% <u>coinsurance</u>	40% <u>coinsurance</u>	Failure to obtain <u>preauthorization</u> for birthing center stays that exceed 48 hours (for normal delivery) or 96 hours (for C-section) will result in \$1,000 penalty. <u>Out-of-network</u> inpatient services limited to 70 days/year.
	Childbirth/delivery facility services	15% <u>coinsurance</u>	40% <u>coinsurance</u>	

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 help recovering or have other special health needs</b>	<u>Home health care</u>	No charge	40% <u>coinsurance</u>	Failure to obtain <u>preauthorization</u> will result in a 20% reduction in benefits.
	<u>Rehabilitation services</u>	15% <u>coinsurance</u>	40% <u>coinsurance</u>	<u>Plan</u> 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 <u>preauthorization</u> for <u>out-of-network</u> speech therapy. <u>Out-of-network</u> inpatient services limited to 70 days/year.
	<u>Habilitation services</u>	Not covered	Not covered	You must pay 100% of charges, even <u>in-network</u> .
	<u>Skilled nursing care</u>	No charge	40% <u>coinsurance</u>	Failure to obtain <u>preauthorization</u> for <u>out-of-network</u> care will result in \$1,000 penalty for inpatient services. <u>Out-of-network</u> inpatient services limited to 70 days/year.
	<u>Durable medical equipment</u>	No charge	40% <u>coinsurance</u>	<u>Preauthorization</u> required for purchases over \$500 and all rentals. 20% reduction in benefits for failure to obtain <u>preauthorization</u> .
	<u>Hospice services</u>	No charge	40% <u>coinsurance</u>	Failure to obtain <u>preauthorization</u> for <u>out-of-network</u> care will result in \$1,000 penalty for inpatient services, 20% reduction for outpatient services. <u>Out-of-network</u> inpatient services limited to 70 days/year.
<b>If your child needs dental or eye care</b>	Children's eye exam	No charge	Amounts over \$20	Optical benefits administered separately by National Vision Administrators, LLC (NVA). Medical <u>plan deductible</u> and <u>out-of-pocket limit</u> 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 <u>plan</u> . Medical <u>plan deductible</u> and <u>out-of-pocket limit</u> do not apply to these services.
	Children's dental check-up	Amounts over <u>plan</u> allowance	Amounts over <u>plan</u> allowance	Dental benefits administered separately by Fidelio Dental Insurance Company. Medical <u>plan deductible</u> and <u>out-of-pocket limit</u> 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](http://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](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: 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](http://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** \$1,500 0
- **Specialist coinsurance** 15%
- **Hospital (facility) copay** \$500
- **Other coinsurance** 15%

**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:**

<i>Cost Sharing</i>	
Deductibles*	\$1,560
Copayments	\$360
Coinsurance	\$1,280
<i>What isn't covered</i>	
Limits or exclusions	\$20
<b>The total Peg would pay is</b>	<b>\$3,220</b>

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

- **The plan's overall deductible** \$1,500
- **Specialist coinsurance** 15%
- **Hospital (facility) copay** \$500
- **Other coinsurance** 15%

**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:**

<i>Cost Sharing</i>	
Deductibles*	\$1,240
Copayments	\$0
Coinsurance	\$620
<i>What isn't covered</i>	
Limits or exclusions	\$0
<b>The total Joe would pay is</b>	<b>\$1,860</b>

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

- **The plan's overall deductible** \$1,500
- **Specialist coinsurance** 15%
- **Hospital (facility) copay** \$500
- **Other coinsurance** 15%

**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:**

<i>Cost Sharing</i>	
Deductibles*	\$1,510
Copayments	\$110
Coinsurance	\$110
<i>What isn't covered</i>	
Limits or exclusions	\$0
<b>The total Mia would pay is</b>	<b>\$1,730</b>

\*NOTE: This plan has other deductibles for specific services included in this coverage example. See "Are there other deductibles for specific services?" row above. Your Health Reimbursement Account (HRA) may be available for reimbursement for out-of-pocket expenses.

The plan would be responsible for the other costs of these EXAMPLE covered services.