BENEFIT • PENSION • ANNUITY
IW TRUST FUNDS
Building Futures Together

1470 Worldwide Place • Vandalia, OH 45377-1156
Phone (937) 454-1744 • Fax (937) 454-5457

October 31, 2022

Dear Non-Medicare Plan Participant,

The non-Medicare Retiree self-pay rates will increase for the upcoming calendar year. The rates you pay for the non-Medicare Retiree plan represent only a portion of the actual cost of the benefit. The cost per adult for the non-Medicare retiree plans are subsidized by **approximately 18%** through active workers' hourly contributions paid into the Benefit Trust.

If you or your spouse are covered by Medicare, you are not eligible for these Plans.

The new monthly self-pay rates for Non-Medicare Retiree Plan A and Plan B effective **January 1, 2023 are as follows:**

Non-Medicare Retiree Plan A: $875 per person per month. The projected cost for this plan is **$1,096.86** per month. You pay less than the cost due to the subsidy.

Non-Medicare Retiree Plan B: $750 per person per month. The projected cost for this plan is **$949.04** per month. Plan B has higher medical and prescription deductibles and coinsurances that are payable by the participant. You pay less than the cost due to the subsidy.

Dependent and/or Adult Children of an eligible retiree will be covered under the same plan as the retiree for **$214 per dependent/adult child** per month**.**

Two plan choices continue to be available for you for the monthly self-payment rates shown above. All members of your family will be required to be in the same plan unless a family member is on the Humana Medicare Advantage plan. Enclosed please find the ***Summary of Benefits and Coverage*** for Plan A and Plan B for the upcoming plan year.

If you are currently covered under Plan A, you have the option to select coverage under Plan B effective January 1, 2023. If you select Plan B, you will NOT be allowed to switch back to Plan A in the future. If you choose to enroll in Plan B, or cancel your retiree health insurance benefits on January 1, 2023, complete the page **on the reverse side of this form and return it to the Trust Office by November 23, 2022.** *If you do not return the form, you will continue to be enrolled in the Plan you are currently in.*

If you cancel your coverage, except to be covered under another *group* policy, you may not purchase coverage from the Benefit Trust in the future.

MEDICARE ELIGIBILITY: Once you or your dependent(s) are eligible for Medicare, coverage under this Plan must end and you may be eligible for coverage under the Plan's insured program through Humana. Due to government guidelines, you must be covered under the Humana program as of your Medicare effective date; Humana cannot retro-activate your coverage. To ensure that you have continuous coverage, **you must notify the Trust Office at least 60 days before your Medicare coverage begins** to request a Retiree Health Insurance Enrollment Form to complete and return with a copy of your Medicare card to the Trust Office at least 60 days before your Medicare effective date. It is **your** responsibility to notify the Trust Office and enroll 60 days prior to the date Medicare coverage begins.

Please contact the Trust Office should you have any questions.

IRON WORKERS DISTRICT COUNCIL OF SOUTHERN OHIO & VICINITY BENEFIT TRUST
RETIREE ENROLLMENT FORM

Only complete this form if you wish to
<u>CHANGE</u> or <u>CANCEL</u>
your Medical Plan Effective 1/1/2023

PARTICIPANT INFORMATION – Please provide all requested information.

Name (Last, First, MI)	Social Security No.
Street Address	Medicare Eligible ☐ Yes ☐ No
City, State Zip Code	Home Telephone No. ( )

DEPENDENT INFORMATION – Please provide all requested information for each eligible dependent (spouse and child) to be covered under the Plan.

Name (Last, First, MI)	Relationship	Social Security No.	Birth Date	Medicare Eligible ☐ Yes ☐ No
Name (Last, First, MI)	Relationship	Social Security No.	Birth Date	Medicare Eligible ☐ Yes ☐ No
Name (Last, First, MI)	Relationship	Social Security No.	Birth Date	Medicare Eligible ☐ Yes ☐ No
Name (Last, First, MI)	Relationship	Social Security No.	Birth Date	Medicare Eligible ☐ Yes ☐ No
Name (Last, First, MI)	Relationship	Social Security No.	Birth Date	Medicare Eligible ☐ Yes ☐ No
Name (Last, First, MI)	Relationship	Social Security No.	Birth Date	Medicare Eligible ☐ Yes ☐ No

MEDICAL PROGRAM ELECTION – Check the appropriate box below, **sign and return this form to the Trust Office by November 23, 2022.** *If you do not return the form, you will continue to be enrolled in the Plan you are currently in.* Remember that you and any non-Medicare eligible dependents will be covered under the same plan.

☐ Plan B ($750 per adult/$214 per child per month)

☐ Cancel Retiree Health Insurance Coverage for the participant and dependent(s) listed above effective at midnight on December 31, 2022.

AUTHORIZATION – Please read the paragraph below, sign and date.

I agree that my dependents and I will abide by the Plan provisions and understand that the Plan provisions may change. I have read the materials describing the Plan. I certify that the information on this form is correct. I understand that once I elect Plan B, I cannot enroll in Plan A in the future. I understand that if I cancel my coverage, I may not be able to purchase coverage from the Iron Workers District Council of Southern Ohio & Vicinity Benefit Trust in the future.

Participant Signature	**Date**

Return completed forms to:

Iron Workers Trust Funds
1470 Worldwide Place
Vandalia, OH 45377

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Benefit Trust Summary of Material Modifications

Date of Notification: October 2022

To: Benefit Plan Participants

ADDITION OF SURGERYPLUS PROGRAM FOR ACTIVES/DEPENDENTS AND NON-MEDICARE RETIREES/DEPENDENTS - Effective January 1, 2023

Effective January 1, 2023, the Benefit Trust has contracted with Employer Direct Healthcare to utilize its SurgeryPlus program. The SurgeryPlus program only covers certain medical procedures and you will be provided with more detail as to whether you qualify. If your procedure qualifies for the program, and you utilize the SurgeryPlus program, the normal Plan deductible and coinsurance for that covered service will be waived. You may also qualify for certain travel benefits relative to your treatment which will vary depending on the distance from your home to the medical provider. For more information, you may contact SurgeryPlus via email at IWTrustFund@SurgeryPlus.com; or by phone at 855-810-4950.

SurgeryPlus will be sending information about this benefit to your home within the upcoming weeks.

CHANGES TO ACTIVE PARTICIPANT BANK & SELF-PAY RULES - Effective for hours worked on and after January 1, 2023

Reserve Accumulation Account Hour Bank

In order to be eligible to use your **Reserve Accumulation Account Hour Bank** to continue your eligibility for coverage under the Plan, you must have worked a minimum of forty (40) hours in Covered Employment (meaning work for a Contributing Employer in a bargaining unit job) during the three-consecutive month period in which you worked less than the required 270 hours. For example, if you worked 40 or more hours during the 3-month period, but less than 270 hours, you can use your Hour Bank to reach 270. But, if you worked less than 40 hours during such period, you cannot use the bank. The only exceptions to the 40-hour rule is if you are off work during the 3-month period due to a bonafide workers' compensation claim approved through the State; or, if you are in the process of retirement with the Iron Workers District Council of Southern Ohio and Vicinity Pension Trust during such 3-month period and you commence your pension during that period.

Money Bank

Similarly, in order to be eligible to use your **Money Bank** to continue your eligibility for coverage under the Plan, you must have worked a minimum of forty (40) hours in Covered Employment (meaning work for a Contributing Employer in a bargaining unit job) during the three-consecutive month period in which you worked less than the required 270 hours. For example, if you worked 40 or more hours during the 3-month period, but less than 270 hours, you can use your Money Bank to reach 270. But, if you worked less than 40 hours during such period, you cannot use the bank. The only exceptions to the 40-hour rule is if you are off work during the 3-month period due to a bonafide workers' compensation claim approved through the State; or, if you are in the process of

retirement with the Iron Workers District Council of Southern Ohio and Vicinity Pension Trust during such 3-month period and you commence your pension during that period.

Self-Payments

The cost of Self-Payment Continuation Coverage is determined within the sole and exclusive discretion of the Board of Trustees, and is subject to change at any time. At present, the cost is determined as follows:

(1) January 1, 2023 – December 31, 2023, the Self-Payment rate will be 50% of the COBRA rate in effect during that calendar year.
(2) January 1, 2024 – December 31, 2024, the Self-Payment rate will be 75% of the COBRA rate in effect during that calendar year.
(3) On and after January 1, 2025, the Self-Payment rate will be 90% of the COBRA rate in effect during each such calendar year.

Sincerely,

BOARD OF TRUSTEES

This SMM is intended to provide you with an easy-to-understand description of certain changes to the Plan. This SMM, of course, cannot contain a full restatement of the terms and provisions of the Plan. If any conflict should arise between this SMM and the Plan, or if any provision or feature is not discussed in this SMM or is only partially discussed, then the terms of the Plan will govern in all such cases.

The Board of Trustees reserves the right to amend the Plan, or any benefits provided under the Plan, in whole or in part, at any time and for any reason, in accordance with applicable law, the amendment procedures established under the Plan, and the Trust Agreement.

The Board of Trustees (or its duly-authorized designee) has the exclusive right and power, in its sole and absolute discretion, to interpret the terms of the Plan and decide all matters arising under the Plan.

ONLINE SECURITY TIPS

You can reduce the risk of fraud and loss to your retirement account by following these basic rules:

• REGISTER, SET UP AND ROUTINELY MONITOR YOUR ONLINE ACCOUNT

- Maintaining online access to your retirement account allows you to protect and manage your investment.
- Regularly checking your retirement account reduces the risk of fraudulent account access.
- Failing to register for an online account may enable cybercriminals to assume your online identify.

• USE STRONG AND UNIQUE PASSWORDS

- Don't use dictionary words.
- Use letters (both upper and lower case), numbers, and special characters.
- Don't use letters and numbers in sequence (no "abc", "567", etc.).
- Use 14 or more characters.
- Don't write passwords down.
- Consider using a secure password manager to help create and track passwords.
- Change passwords every 120 days, or if there's a security breach.
- Don't share, reuse, or repeat passwords.

• USE MULTI-FACTOR AUTHENTICATION

- Multi-Factor Authentication (also called two-factor authentication) requires a second credential to verify your identity (for example, entering a code sent in real-time by text message or email).

• KEEP PERSONAL CONTACT INFORMATION CURRENT

- Update your contact information when it changes, so you can be reached if there's a problem.
- Select multiple communication options.

• CLOSE OR DELETE UNUSED ACCOUNTS

- The smaller your on-line presence, the more secure your information. Close unused accounts to minimize your vulnerability.
- Sign up for account activity notifications.

• BE WARY OF FREE WI-FI

- Free Wi-Fi networks, such as the public Wi-Fi available at airports, hotels, or coffee shops pose security risks that may give criminals access to your personal information.
- A better option is to use your cellphone or home network.

• BEWARE OF PHISHING ATTACKS

- Phishing attacks aim to trick you into sharing your passwords, account numbers, and sensitive information, and gain access to your accounts. A phishing message may look like it comes from a trusted organization, to lure you to click on a dangerous link or pass along confidential information.

- Common warning signs of phishing attacks include:
  - A text message or email that you didn't expect or that comes from a person or service you don't know or use.
  - Spelling errors or poor grammar.
  - Mismatched links (a seemingly legitimate link sends you to an unexpected address). Often, but not always, you can spot this by hovering your mouse over the link without clicking on it, so that your browser displays the actual destination.
  - Shortened or odd links or addresses.
  - An email request for your account number or personal information (legitimate providers should never send you emails or texts asking for your password, account number, personal information, or answers to security questions).
  - Offers or messages that seem too good to be true, express great urgency, or are aggressive and scary.
  - Strange or mismatched sender addresses.
  - Anything else that makes you feel uneasy.

- **USE ANTIVIRUS SOFTWARE AND KEEP APPS AND SOFTWARE CURRENT**
  - Make sure that you have trustworthy antivirus software installed and updated to protect your computers and mobile devices from viruses and malware. Keep all your software up to date with the latest patches and upgrades. Many vendors offer automatic updates.

- **KNOW HOW TO REPORT IDENTITY THEFT AND CYBERSECURITY INCIDENTS**
  - The FBI and the Department of Homeland Security have set up valuable sites for reporting cybersecurity incidents:
    - **https://www.fbi.gov/file-repository/cyber-incident-reporting-united-message-final.pdf/view**
    - **https://www.cisa.gov/reporting-cyber-incidents**

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 1-937-454-1744 or visit https://iwtrustfund.com. 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 https://www.healthcare.gov/sbc-glossary/ or call 844-610-1938 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	**$400** single/**$1,000** family for network providers; **$700** single/**$1,800** family for non-network providers	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?	Yes. Network preventive care, network primary care visits, network specialist visits, network prenatal office visits, emergency room care, urgent care visits, network outpatient mental health/behavioral health/substance abuse services office visits, network preventive vision exams for children and adults, and network outpatient rehabilitation services are covered before you meet your deductible.	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost sharing and before you meet your deductible. See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/.
Are there other deductibles for specific services?	Yes. **$50** per person for prescription drugs. 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.
What is the out-of-pocket limit for this plan?	Medical: Network provider: **$3,250** single/ **$6,500** family; Non-network provider: **$6,000** single/**$12,000** family Prescription drugs: Network: **$4,900** single/ **$9,800** family; Out-of-network: **unlimited**	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 limit until the overall family out-of-pocket limit has been met.
What is not included in the out-of-pocket limit?	Premiums, penalties for non-compliance, non-network transplant services, balance-billing charges, and health care this plan does not cover.	Even though you pay these expenses, they don't count toward the out-of-pocket limit.
Will you pay less if you use a network provider?	Yes. See www.anthem.com or call 844-610-1938 for a list of network providers.	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)	Non-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	$25 copayment/visit. Deductible does not apply.	40% coinsurance	None
	Specialist visit	$25 copayment/visit. Deductible does not apply.	40% coinsurance	None
	Preventive care/screening/ immunization	No charge. Deductible does not apply.	40% coinsurance	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)	20% coinsurance	40% coinsurance	None
	Imaging (CT/PET scans, MRIs)	20% coinsurance	40% coinsurance	None
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.caremark.com .	Generic drugs	$50 deductible/person; $10 copay/prescription (retail); $20 copay/prescription (mail order). Medical deductible does not apply.	$50 deductible/person; 50% coinsurance; minimum $40 for retail pharmacies. Mail order not covered. Medical deductible does not apply.	Prescription Drug Benefits are administered by CVS Caremark. For detailed exclusions and plan limitations, refer to the Iron Workers District Council of Southern Ohio & Vicinity Benefit Trust Summary Plan Description located at https://iwtrustfund.com. Limited to a 30-day supply (retail) for non-maintenance medications. Maintenance medications limited to two 30-day supplies (retail). After that, you will need to move to a 90-day supply (retail and mail order). No charge for FDA-approved generic preventive drugs (such as contraceptives) (or brand name drugs if a generic is medically inappropriate).

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Non-Network Provider (You will pay the most)	
	Brand formulary drugs	$50 deductible/person; $25 copay/prescription (retail); $50 copay/prescription (mail order). Medical deductible does not apply.	$50 deductible/person; 50% coinsurance; minimum $40 for retail pharmacies. Mail order not covered. Medical deductible does not apply.	Specialty drugs are filled through the PrudentRx Copay Program. There is no charge for covered specialty medications that are on the Plan's Exclusive Specialty Drug List and filled at CVS Specialty® Pharmacy. If the specialty drug you take is not included on the Exclusive Specialty Drug List, you will continue to pay the specialty drug copay per prescription. If you do not enroll in PrudentRx, you will pay 30% coinsurance for specialty drugs. Prescription drug out-of-pocket limit: Network provider: **$4,900**/single or **$9,800**/family; Out-of-network provider: **no limit**.
	Brand non-formulary/Specialty drugs	$50 deductible/person; $40 copay/prescription (retail); $80 copay/prescription (mail order). Medical deductible does not apply.	$50 deductible/person; 50% coinsurance; minimum $40 for retail pharmacies. Mail order not covered. Medical deductible does not apply.	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance	40% coinsurance	None
	Physician/surgeon fees	20% coinsurance	40% coinsurance	None
If you need immediate medical attention	Emergency room care	$100 copayment/visit. Deductible does not apply.	$100 copayment/visit. Deductible does not apply.	Copay waived if admitted to hospital.
	Emergency medical transportation	20% coinsurance	20% coinsurance	None
	Urgent care	$50 copayment/visit. Deductible does not apply.	$50 copayment/visit. Deductible does not apply.	
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance	40% coinsurance	None
	Physician/surgeon fees	20% coinsurance	40% coinsurance	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$25 copayment/visit for office visit; deductible does not apply. 20% coinsurance for other outpatient services.	40% coinsurance	None

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Non-Network Provider (You will pay the most)	
	Inpatient services	20% coinsurance	40% coinsurance	
If you are pregnant	Office visits	$25 copayment/visit for first prenatal visit; after first visit, no charge. Deductible does not apply.	40% coinsurance	Cost sharing does not apply to certain preventive services. Depending on the type of services, coinsurance may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e., ultrasound).
	Childbirth/delivery professional services	20% coinsurance	40% coinsurance	
	Childbirth/ delivery facility services	20% coinsurance	40% coinsurance	
	Home health care	20% coinsurance	40% coinsurance	30 visits per calendar year for non-network providers.
If you need help recovering or have other special health needs	Rehabilitation services	Outpatient: $25 copayment/visit; deductible does not apply. Inpatient: 20% coinsurance	40% coinsurance	Speech therapy only covered for the correction of a speech impairment. Inpatient rehabilitation services are limited to 60 days per calendar year combined for both network and non-network services (limit includes day rehabilitation therapy).
	Habilitation services	20% coinsurance	40% coinsurance	Up to 180 days per calendar year.
	Skilled nursing care	20% coinsurance	40% coinsurance	
	Durable medical equipment	20% coinsurance	40% coinsurance	Covered up to the Maximum Allowable Amount for the standard item that is a Covered Service. Rental costs must not be more than the purchase price.
	Hospice services	20% coinsurance	20% coinsurance	None

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Non-Network Provider (You will pay the most)	
If your child needs dental or eye care	Children's eye exam	$25 copayment/visit. Deductible does not apply.	40% coinsurance	Covered under the medical plan.
	Children's glasses	Not covered	Not covered	You must pay 100% of this service, even from a network provider.
	Children's dental check-up	Not covered	Not covered	You must pay 100% of this service, even from a network provider.

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
- Cosmetic surgery (except for reconstructive surgery to correct a physical functional impairment caused by disease, trauma, congenital anomalies, or previous therapeutic process; or following mastectomy)
- Dental care (Adult and Child)
- Hearing aids
- Infertility treatment
- Long-term care
- Routine eye care (Adult and Child) (except eye exams)
- Routine foot care (unless you have been diagnosed with diabetes)
- Weight loss programs (except as required by the health reform law)

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

- Bariatric surgery (covered up to $10,000 per person per lifetime, if medically necessary)
- Chiropractic care (Up to 12 Spinal Manipulations per calendar year)
- Private-duty nursing (only covered in the home)
- Non-emergency and emergency care when traveling outside the U.S. or Canada (see www.bcbsglobalcore.com)

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 Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (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: Penny Brown, Fund Administrator, 1470 Worldwide Place, Vandalia, OH 45377-1156, 1-937-454-1744, penny@iwtrustfund.com. 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. Additionally, a consumer assistance program can help you file your appeal. Contact: U.S. Department of Labor Employee Benefits Security Administration, 200 Constitution Ave., NW Washington, DC 20210, Toll-Free: 866-487-2365, http://www.dol.gov/ebsa/consumer_info_health.html.

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 844-610-1938.

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 network provider pre-natal care and a hospital delivery)

The plan's overall deductible	$400
Specialist copayment	$25
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)*

Total Example Cost	**$12,700**

In this example, Peg would pay:

Cost Sharing	
Deductibles*	$410
Copayments	$30
Coinsurance	$2,150
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$2,650**

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

The plan's overall deductible	$400
Specialist copayment	$25
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)*

Total Example Cost	**$5,600**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$190
Copayments	$700
Coinsurance	$0
What isn't covered	
Limits or exclusions	$720
The total Joe would pay is	**$1,610**

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

The plan's overall deductible	$400
Specialist copayment	$25
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)*

Total Example Cost	**$2,800**

In this example, Mia would pay:

Cost Sharing	
Deductibles*	$410
Copayments	$300
Coinsurance	$130
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$840**

***NOTE: This plan has other deductibles for specific services included in this coverage example. See "Are there other deductibles for specific services?" row above**
The plan would be responsible for the other costs of these EXAMPLE covered services.

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 1-937-454-1744 or visit https://iwtrustfund.com. 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 https://www.healthcare.gov/sbc-glossary or call 844-610-1938 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	**$1,000** single/**$2,000** family for network providers; **$2,000** single/**$4,000** family for non-network providers	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?	Yes. Network preventive care, network primary care visit, network specialist visits, network prenatal office visits, network outpatient mental health/behavioral health/substance abuse services office visits, network preventive vision exams for children and adults, and network outpatient rehabilitation services are covered before you meet your deductible.	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost sharing and before you meet your deductible. See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/.
Are there other deductibles for specific services?	Yes. **$200** per person for prescription drugs. 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.
What is the out-of-pocket limit for this plan?	Medical: Network provider: **$5,250** single/ **$10,500** family; Non-network provider: **$10,500** single/**$21,000** family Prescription drug: Network: **$2,900** single/ **$5,800** family; Out-of-network: **unlimited**	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?	Premiums, penalties for non-compliance, non-network transplant services, balance-billing charges, and health care this plan does not cover.	Even though you pay these expenses, they don't count toward the out-of-pocket limit.
Will you pay less if you use a network provider?	Yes. See www.anthem.com or call 844-610-1938 for a list of network providers.	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)	Non-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	$30 copayment/visit. Deductible does not apply.	50% coinsurance	None
	Specialist visit	$30 copayment/visit. Deductible does not apply.	50% coinsurance	None
	Preventive care/screening/ immunization	No charge. Deductible does not apply.	50% coinsurance	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)	30% coinsurance	50% coinsurance	None
	Imaging (CT/PET scans, MRIs)	30% coinsurance	50% coinsurance	None
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.caremark.com.	Generic drugs	$200 deductible/person; $10 copay/prescription (retail); $20 copay/prescription (mail order). Medical deductible does not apply.	$200 deductible/person; 50% coinsurance; Minimum $50 for retail pharmacies. Medical deductible does not apply.	Prescription Drug Benefits are administered by CVS Caremark. For detailed exclusions and plan limitations refer to the Iron Workers District Council of Southern Ohio & Vicinity Benefit Trust Summary Plan Description located at https://iwtrustfund.com. Limited to a 30-day supply for non-maintenance medications (retail). Maintenance medications are limited to two 30-day supplies (retail). After that, you will need to move to a 90-day supply (retail or mail order). No charge for FDA-approved generic preventive drugs (such as contraceptives) (or brand name contraceptives if a generic is medically inappropriate).

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Non-Network Provider (You will pay the most)	
	Brand formulary drugs	$200 deductible/person; $30 copay/prescription (retail); $70 copay/prescription (mail order). Medical deductible does not apply.	$200 deductible/person; 50% coinsurance; Minimum $50 for retail pharmacies; Mail order not covered. Medical deductible does not apply.	Specialty drugs are filled through the PrudentRx Copay Program. There is no charge for covered specialty medications that are on the Plan's Exclusive Specialty Drug List and filled at CVS Specialty® Pharmacy. If the specialty drug you take is not included on the Exclusive Specialty Drug List, you will continue to pay the specialty drug copay per prescription. If you do not enroll in PrudentRx, you will pay 30% coinsurance for specialty drugs. Prescription drug out-of-pocket limit: Network provider: **$2,900**/single **$5,800**/family; Out-of-network provider: **unlimited.**
	Brand non-formulary/Specialty drugs	$200 deductible/person; 50% coinsurance with $50 minimum/$100 maximum (retail); $125 copay/prescription (mail order). Medical deductible does not apply.	$200 deductible/person; 50% coinsurance; Minimum $50 for retail pharmacies; Mail order not covered. Medical deductible does not apply.	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	30% coinsurance	50% coinsurance	None
	Physician/surgeon fees	30% coinsurance	50% coinsurance	None
If you need immediate medical attention	Emergency room care	30% coinsurance	30% coinsurance	None
	Emergency medical transportation			
	Urgent care			
If you have a hospital stay	Facility fee (e.g., hospital room)	30% coinsurance	50% coinsurance	None
	Physician/surgeon fees			

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Non-Network Provider (You will pay the most)	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$30 copayment/visit for office visit; deductible does not apply. 30% coinsurance for other outpatient services.	50% coinsurance	None
	Inpatient services	30% coinsurance	50% coinsurance	
If you are pregnant	Office visits	$30 copayment for first prenatal visit; after first visit, no charge. Deductible does not apply.	50% coinsurance	Cost sharing does not apply to certain preventive services. Depending on the type of services, a copayment or coinsurance may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e., ultrasound).
	Childbirth/delivery professional services	30% coinsurance	50% coinsurance	
	Childbirth/delivery facility services	30% coinsurance	50% coinsurance	
If you need help recovering or have other special health needs	Home health care	30% coinsurance	50% coinsurance	30 visits per calendar year for non-network providers.
	Rehabilitation services	Outpatient: $30 copayment/visit; deductible does not apply. Inpatient: 30% coinsurance.	50% coinsurance	Speech therapy only covered for the correction of a speech impairment. Inpatient rehabilitation services limited to 60 days per person per calendar year combined for in-network and out-of-network services (limit includes day rehabilitation therapy).
	Habilitation services	30% coinsurance	50% coinsurance	
	Skilled nursing care	30% coinsurance	50% coinsurance	Up to 180 days per benefit period.
	Durable medical equipment	30% coinsurance	50% coinsurance	Covered up to the Maximum Allowable Amount for the standard item that is a Covered Service. Rental costs must not be more than the purchase price.
	Hospice services	30% coinsurance	30% coinsurance	None

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Non-Network Provider (You will pay the most)	
If your child needs dental or eye care	Children's eye exam	$30 copayment/visit. Deductible does not apply.	50% coinsurance	Covered under the medical plan.
	Children's glasses	Not covered	Not covered	You must pay 100% of this service, even from a network provider.
	Children's dental check-up	Not covered	Not covered	You must pay 100% of this service, even from a network provider.

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
- Cosmetic surgery (except for reconstructive surgery to correct a physical functional impairment caused by disease, trauma, congenital anomalies, or previous therapeutic process; or following mastectomy)
- Dental care (Adult and Child)
- Hearing aids
- Infertility treatment
- Long-term care
- Routine eye care (Adult and Child) (except eye exams)
- Routine foot care (unless you have been diagnosed with diabetes)
- Weight loss programs (except as required by the health reform law)

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

- Bariatric surgery (covered up to $10,000 per person per lifetime, if medically necessary)
- Chiropractic care (Up to 12 Spinal Manipulations per calendar year)
- Private-duty nursing (only covered in the home)
- Non-emergency and emergency care when traveling outside the U.S. or Canada (see www.bcbsglobalcore.com)

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 Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (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: Penny Brown, Fund Administrator, 1470 Worldwide Place, Vandalia, OH 45377-1156, 1-937-454-1744, penny@iwtrustfund.com. 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. Additionally, a consumer assistance program can help you file your appeal. Contact: U.S. Department of Labor Employee Benefits Security Administration, 200 Constitution Ave., NW Washington, DC 20210, Toll-Free: 866-487-2365, http://www.dol.gov/ebsa/consumer_info_health.html.

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 844-610-1938.

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 network provider pre-natal care and a hospital delivery)

The plan's overall deductible	**$1,000**
Specialist copayment	**$30**
Hospital (facility) coinsurance	**30%**
Other coinsurance	**30%**

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*	$1,010
Copayments	$30
Coinsurance	$3,040
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$4,140**

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

The plan's overall deductible	**$1,000**
Specialist copayment	**$30**
Hospital (facility) coinsurance	**30%**
Other coinsurance	**30%**

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	$340
Copayments	$810
Coinsurance	$0
What isn't covered	
Limits or exclusions	$720
The total Joe would pay is	**$1,870**

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

The plan's overall deductible	**$1,000**
Specialist copayment	**$30**
Hospital (facility) coinsurance	**30%**
Other coinsurance	**30%**

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*	$1,010
Copayments	$240
Coinsurance	$310
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,560**

***NOTE: This plan has other deductibles for specific services included in this coverage example. See "Are there other deductibles for specific services?" row above**
The plan would be responsible for the other costs of these EXAMPLE covered services.