
 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 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 <u>deductible</u>?	\$500 single/ \$1,000 family for <u>network providers</u> ; \$1,000 single/ \$2,000 family for <u>non-network providers</u>	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> .
Are there services covered before you meet your <u>deductible</u>?	Yes. <u>Network</u> preventive care, <u>network</u> primary care visits, <u>network</u> specialist visits, <u>network</u> prenatal office visits, <u>emergency room care</u> , <u>urgent care</u> visits, <u>network</u> outpatient mental health/behavioral health/substance abuse services office visits, <u>network</u> outpatient rehabilitation services, and <u>network</u> preventive vision exams for children and adults are covered before you meet your <u>deductible</u> .	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 https://www.healthcare.gov/coverage/preventive-care-benefits/ .
Are there other <u>deductibles</u> for specific services?	Yes. \$65 per person for <u>prescription drugs</u> . There are no other specific <u>deductibles</u> .	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.
What is the <u>out-of-pocket limit</u> for this <u>plan</u>?	Medical: <u>Network provider</u> : \$4,000 single/ \$8,000 family; <u>Non-network provider</u> : \$8,000 single/ \$16,000 family <u>Prescription Drugs</u> : <u>In-network</u> : \$4,150 single/ \$8,300 family; <u>Out-of-network</u> : No limit	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 limit</u> until the overall family <u>out-of-pocket limit</u> has been met.
What is not included in the <u>out-of-pocket limit</u>?	<u>Premiums</u> , non- <u>network</u> <u>copayments</u> , penalties for non-compliance, non- <u>network</u> transplant services, <u>balance-billing</u> charges, and health care this <u>plan</u> does not cover.	Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u> .
Will you pay less if you use a <u>network provider</u>?	Yes. See www.anthem.com or call 844-610-1938 for a list of <u>network providers</u> .	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.

Do you need a <u>referral</u> to see a <u>specialist</u> ?	No.	You can see the <u>specialist</u> you choose without a <u>referral</u> .
--	-----	--

 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
		<u>Network Provider</u> (You will pay the least)	<u>Non-Network Provider</u> (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 <u>copayment</u> /visit. <u>Deductible</u> does not apply.	30% <u>coinsurance</u>	None
	<u>Specialist</u> visit	\$30 <u>copayment</u> /visit. <u>Deductible</u> does not apply.	30% <u>coinsurance</u>	None
	<u>Preventive care/screening/immunization</u>	No charge. <u>Deductible</u> does not apply.	30% <u>coinsurance</u>	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)	10% <u>coinsurance</u>	30% <u>coinsurance</u>	None
	Imaging (CT/PET scans, MRIs)	10% <u>coinsurance</u>	30% <u>coinsurance</u>	None
If you need drugs to treat your illness or condition More information about <u>prescription drug coverage</u> is available at www.caremark.com .	Generic drugs	\$65 <u>deductible</u> /person; \$10 <u>copay</u> /prescription (retail); \$20 <u>copay</u> /prescription (mail order). Medical <u>deductible</u> does not apply.	\$65 <u>deductible</u> /person; 50% <u>coinsurance</u> ; Minimum \$55 for retail pharmacies. Mail order not covered. Medical <u>deductible</u> does not apply.	<u>Prescription Drug Benefits</u> are administered by CVS Caremark. For detailed exclusions and <u>plan</u> limitations, refer to the Iron Workers District Council of Southern Ohio & Vicinity Benefit Trust Summary <u>Plan</u> Description located at https://iwtrustfund.com . Limited to a 30-day supply (retail) for non-maintenance medications. Maintenance medications are 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 <u>formulary</u> drugs	\$65 <u>deductible</u> /person; \$40 <u>copay</u> /prescription (retail); \$60 <u>copay</u> /prescription (mail order). Medical <u>deductible</u> does not apply.	\$65 <u>deductible</u> /person; 50% <u>coinsurance</u> ; Minimum \$55 for retail pharmacies. Mail order not covered. Medical <u>deductible</u> does not apply.	<p><u>Specialty drugs</u> are filled through the PrudentRx Copay Program. There is no charge for covered specialty medications that are on the Plan's Exclusive <u>Specialty Drug List</u> and filled at CVS Specialty® Pharmacy. If the <u>specialty drug</u> you take is not included on the Exclusive <u>Specialty Drug List</u>, you will continue to pay the <u>specialty drug copay</u> per prescription. If you do not enroll in PrudentRx, you will pay 30% <u>coinsurance</u> for <u>specialty drugs</u>.</p> <p><u>Prescription Drug out-of-pocket limit</u>: \$4,150/single or \$8,300/family <u>in-network</u>; no limit <u>out-of-network</u>.</p>
	Brand non- <u>formulary/specialty</u> drugs	\$65 <u>deductible</u> /person; \$60 <u>copay</u> /prescription (retail); \$90 <u>copay</u> /prescription (mail order). Medical <u>deductible</u> does not apply.	\$65 <u>deductible</u> /person; 50% <u>coinsurance</u> . Minimum \$55 for retail pharmacies. Mail order not covered. Medical <u>deductible</u> does not apply.	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	10% <u>coinsurance</u>	30% <u>coinsurance</u>	None
	Physician/surgeon fees	10% <u>coinsurance</u>	30% <u>coinsurance</u>	None
If you need immediate medical attention	<u>Emergency room care</u>	\$135 <u>copayment</u> /visit. <u>Deductible</u> does not apply.	\$135 <u>copayment</u> /visit. <u>Deductible</u> does not apply.	<u>Copay</u> waived if admitted to hospital.
	<u>Emergency medical transportation</u>	20% <u>coinsurance</u>	20% <u>coinsurance</u>	None
	<u>Urgent care</u>	\$65 <u>copayment</u> /visit. <u>Deductible</u> does not apply.	\$65 <u>copayment</u> /visit. <u>Deductible</u> does not apply.	
If you have a hospital stay	Facility fee (e.g., hospital room)	10% <u>coinsurance</u>	30% <u>coinsurance</u>	None
	Physician/surgeon fees	10% <u>coinsurance</u>	30% <u>coinsurance</u>	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	\$30 <u>copayment</u> /visit for office visit; <u>deductible</u> does not apply. 10% <u>coinsurance</u> for other outpatient services.	30% <u>coinsurance</u>	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	10% <u>coinsurance</u>	30% <u>coinsurance</u>	
If you are pregnant	Office visits	\$30 <u>copayment</u> for first prenatal visit; after first visit, no charge. <u>Deductible</u> does not apply.	30% <u>coinsurance</u>	<u>Cost sharing</u> does not apply to certain <u>preventive services</u> . Depending on the type of services, a <u>copayment</u> or <u>coinsurance</u> may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e., ultrasound).
	Childbirth/delivery professional services	10% <u>coinsurance</u>	30% <u>coinsurance</u>	
	Childbirth/delivery facility services	10% <u>coinsurance</u>	30% <u>coinsurance</u>	
If you need help recovering or have other special health needs	<u>Home health care</u>	10% <u>coinsurance</u>	30% <u>coinsurance</u>	120 visits per calendar year.
	<u>Rehabilitation services</u>	Outpatient: \$30 <u>copayment/visit</u> ; <u>deductible</u> does not apply. Inpatient: 10% <u>coinsurance</u>	30% <u>coinsurance</u>	Speech therapy only covered for the correction of a speech impairment. Inpatient <u>rehabilitation services</u> are limited to 60 days per person per calendar year combined for <u>in-network</u> and <u>out-of-network</u> services (limit includes day rehab therapy).
	<u>Habilitation services</u>	10% <u>coinsurance</u>	30% <u>coinsurance</u>	
	<u>Skilled nursing care</u>	10% <u>coinsurance</u>	30% <u>coinsurance</u>	Up to 180 days per calendar year.
	<u>Durable medical equipment</u>	20% <u>coinsurance</u>	40% <u>coinsurance</u>	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.
	<u>Hospice services</u>	20% <u>coinsurance</u>	20% <u>coinsurance</u>	None

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		<u>Network Provider</u> (You will pay the least)	<u>Non-Network Provider</u> (You will pay the most)	
If your child needs dental or eye care	Children's eye exam	\$30 <u>copayment</u> /visit. <u>Deductible</u> does not apply.	30% <u>coinsurance</u>	Covered under the medical <u>plan</u> .
	Children's glasses	Not covered	Not covered	Not covered by the medical <u>plan</u> . You must pay 100% of this service, even from a <u>network provider</u> . The VSP vision <u>plan</u> is available through the Fund if you meet the eligibility requirements and your child(ren) are covered under the <u>plan</u> ; you are eligible for the VSP vision <u>plan</u> if you do not have to supplement or self-pay for your benefits; the vision <u>plan</u> includes coverage for glasses/contacts and eye exams, subject to any limits.
	Children's dental check-up	Not covered	Not covered	Not covered by the medical <u>plan</u> . You must pay 100% of this service, even from a <u>network provider</u> . A dental <u>plan</u> administered by Delta Dental is available through the Fund if you meet the eligibility requirements and your child(ren) are covered under the <u>plan</u> ; you are eligible for the dental <u>plan</u> if you do not have to supplement or self-pay for your benefits.

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 & Child) (A dental plan administered by Delta Dental is available through the Fund if you meet the eligibility requirements; you are eligible for the dental plan if you do not have to supplement or self-pay for your benefits)
- Hearing aids
- Infertility treatment
- Long-term care
- Routine eye care (Adult & Child) (The VSP vision plan is available through the Fund if you meet the eligibility requirements; you are eligible for the vision plan if you do not have to supplement or self-pay for your benefits; the vision plan includes coverage for glasses/contacts and eye exams, subject to any limits)
- 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, @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 <u>plan's</u> overall <u>deductible</u>	\$500
■ <u>Specialist copayment</u>	\$30
■ <u>Hospital (facility) coinsurance</u>	10%
■ <u>Other coinsurance</u>	10%

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>	
<u>Deductibles*</u>	\$510
<u>Copayments</u>	\$30
<u>Coinsurance</u>	\$1,060
<i>What isn't covered</i>	
Limits or exclusions	\$60
The total Peg would pay is	\$1,660

Managing Joe's Type 2 Diabetes

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

■ The <u>plan's</u> overall <u>deductible</u>	\$500
■ <u>Specialist copayment</u>	\$30
■ <u>Hospital (facility) coinsurance</u>	10%
■ <u>Other coinsurance</u>	10%

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>	
<u>Deductibles</u>	\$210
<u>Copayments</u>	\$940
<u>Coinsurance</u>	\$0
<i>What isn't covered</i>	
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 <u>plan's</u> overall <u>deductible</u>	\$500
■ <u>Specialist copayment</u>	\$30
■ <u>Hospital (facility) coinsurance</u>	10%
■ <u>Other coinsurance</u>	10%

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>	
<u>Deductibles</u>	\$510
<u>Copayments</u>	\$380
<u>Coinsurance</u>	\$100
<i>What isn't covered</i>	
Limits or exclusions	\$0
The total Mia would pay is	\$990

***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.