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 937-454-1744 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, emergency medical transportation, 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 network retail and non-network retail or mail order 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.aetna.com, Aetna Choice® POS II (Open Access) or call 937-454-1744 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 (waived if using mail order); $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 (waived if using mail order); $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 (waived if using mail order); $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	$100 copayment/visit. Deductible does not apply.	$100 copayment/visit. Deductible does not apply.	None
	Urgent care	$50 copayment/visit. Deductible does not apply.	$50 copayment/visit. Deductible does not apply.	

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 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
	Inpatient services	20% coinsurance	40% coinsurance	
If you are pregnant	Office visits	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	

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 help recovering or have other special health needs	Home health care	20% coinsurance	40% coinsurance	120 visits per calendar year.
	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	Visit limits do not apply to habilitative services.
	Skilled nursing care	20% coinsurance	40% coinsurance	Up to 180 days per calendar year.
	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	40% coinsurance	None
If you, your spouse, or your child(ren) need dental or eye care	Eye exam	$25 copayment/visit. Deductible does not apply.	40% coinsurance	Covered under the medical plan.
	Glasses	Not covered	Not covered	You must pay 100% of this service, even from a network provider.
	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 medically necessary)
- 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

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, health@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 937 454 1744.

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	$0
Coinsurance	$2,150
What isn't covered	
Limits or exclusions	$20
The total Peg would pay is	**$2,580**

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	$710
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Joe would pay is	**$900**

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*	$120
Copayments	$400
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$520**

***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.