This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at **www.tuftshealthplan.com/carelink/ironworkers** or by calling **Iron Clad at (617) 436-3500**.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	In-Network: **$300/**person, **$600/**family; Out-of-Network: **$300/**person, **$600/**family; one cumulative **deductible**. The **deductible** applies to the medical benefits cited in the chart starting on page 2; for other benefits, see your Plan Document.	You must pay all the costs up to the **deductible** amount before this plan begins to pay for covered services you use. Check your plan document to see when the **deductible** starts over (usually, but not always, January 1st). See the chart starting on page 2 for how much you pay for covered services after you meet the **deductible**.
Are there other deductibles for specific services?	No.	You don't have to meet **deductibles** for specific services, but see the chart starting on page 2 for other costs for services this plan covers.
Is there an out–of–pocket limit on my expenses?	Yes. In-Network: **$1,500/**person, **$3,000/**family; Out-of-Network: **$4,000/**person, **$6,250/**family.	The **out-of-pocket limit** is the most you could pay during a calendar year for your share of the cost of covered services, excluding the **deductible** and any co-pays as noted in the next item. This limit helps you plan for health care expenses.
What is not included in the out–of–pocket limit?	Balance billing, health care this plan does not cover, co-payments, deductibles, services excluded from out-of-pocket expenses, and penalties for failure to obtain pre-authorization for services.	Even though you pay these expenses, they don't count toward the **out-of-pocket limit**.

Important Questions	Answers	Why this Matters:
Is there an overall annual limit on what the plan pays?	No.	The chart starting below describes any limits on what the plan will pay for *specific* covered services, such as office visits.
Does this plan use a network of providers?	Yes. For a list of in-network **providers**, see **www.tuftshealthplan.com/carelink/ironworkers**, or call **(800) 768-4695**.	If you use an in-network doctor or other health care **provider**, this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network **provider** for some services. Plans use the term in-network, **preferred**, or participating for **providers** in their **network**. See the chart starting below for how this plan pays different kinds of **providers**.
Do I need a referral to see a specialist?	No.	You can see the **specialist** you choose without permission from this plan.
Are there services this plan doesn't cover?	Yes.	Some of the services this plan doesn't cover are listed on page 6. See your policy or plan document for additional information about **excluded services**.

- **Copayments** are fixed dollar amounts (for example, $20) you pay for covered health care, usually when you receive the service.
- **Coinsurance** is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is $1,000, your **coinsurance** payment of 10% would be $100. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount.** If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges $1,500 for an overnight stay and the **allowed amount** is $1,000, you may have to pay the $500 difference. (This is called **balance billing**.) You may also have to pay the usual 40% **coinsurance** and **deductible**.
- This Plan may encourage you to use in-network **providers** by charging you lower **deductibles**, **copayments** and **coinsurance** amounts.
- This Plan covers only those services that are medically necessary.

Common Medical Event	Service You May Need	Your Cost if You Use an In-Network Provider	Your Cost if You Use an Out-of-Network Provider	Limitations & Exceptions
If you visit a health care provider's office or clinic that is billing as a stand-alone provider, and not as a hospital	Primary care visit to treat an injury or illness	$20 co-pay	40% co-insurance	No deductible for in-network visit for stand-alone billing. If billed as a hospital, subject to deductible and co-insurance
	Specialist visit	$20 co-pay	40% co-insurance	
	Other practitioner office visit	20% co-insurance (chiropractor)	20% co-insurance (chiropractor)	Chiropractor limited to 26 visits per coverage period
	Preventive care/ screening/immunization	$20 co-pay	40% co-insurance	No deductible for in-network visit for stand-alone billing. If billed as a hospital, subject to deductible and co-insurance

Common Medical Event	Service You May Need	Your Cost if You Use an In-Network Provider	Your Cost if You Use an Out-of-Network Provider	Limitations & Exceptions
If you have a test at a free-standing facility	Diagnostic test (x-ray, blood work)	No charge	40% co-insurance per test	No deductible for in-network visit for stand-alone billing. If billed as a hospital, subject to deductible and 10% co-insurance per test
	Imaging (CT/PET scans, MRIs)	No charge	40% co-insurance per test	
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.tuftshealthplan.com/carelink/ironworkers	Generic drugs	$15 co-pay retail, $30 co-pay mail order	You pay the full amount and apply for reimbursement through Express Scripts	Covers up to a 34-day supply (retail); 102-day supply (mail order). Some prescriptions may be subject to quantity/duration restrictions, step therapy, and/or prior authorization programs. For any questions call Express Scripts at (800) 818-6602 (members) or (800) 922-1557 (pharmacists)
	Preferred brand drugs	$30 co-pay retail, $60 co-pay mail order		
	Non-preferred brand drugs	$45 co-pay retail, $90 co-pay mail order		
	Specialty drugs	Co-pay based on the days supply dispensed to a maximum of $30 generic, $60 preferred brand, $90 non-preferred brand	No coverage	Only covered through Accredo and subject to managed care; you must contact them at (877) 440-9221 (members) or (800) 987-4904 (physicians)
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	10% co-insurance	40% co-insurance	-- None --
	Physician/surgeon fees	10% co-insurance	40% co-insurance	No co-insurance on in-network surgeon's fees
If you need immediate medical attention	Emergency room services (at nearest general hospital)	10% co-insurance	40% co-insurance	Must contact CareAllies within 48 hours of emergency admission
	Emergency medical transportation	10% co-insurance	40% co-insurance	Coverage limited to local ambulance service. Non-emergency transport covered only when medically necessary
	Urgent care	10% co-insurance	40% co-insurance	No co-insurance on in-network physician's fees at free-standing facilities

Common Medical Event	Service You May Need	Your Cost if You Use an In-Network Provider	Your Cost if You Use an Out-of-Network Provider	Limitations & Exceptions
If you have a hospital stay	Facility fee (e.g., hospital room)	10% co-insurance	40% co-insurance	Pre-certify all admissions or benefits reduced by 10% up to $500, and for subsequent events, by 20% up to $1,000
	Physician/surgeon fee	10% co-insurance	40% co-insurance	No co-insurance on in-network surgeon's fees
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	$5 copay	40% co-insurance	Consult with Modern Assistance Programs (MAP) at (617) 774-0331
	Mental/Behavioral health inpatient services	10% co-insurance	40% co-insurance	Pre-certify admissions with MAP or benefits reduced by 10% up to $500, and for subsequent events, by 20% up to $1,000
	Substance use disorder outpatient services	$5 copay	40% co-insurance	Consult with Modern Assistance Programs (MAP) at (617) 774-0331
	Substance use disorder inpatient services	10% co-insurance	40% co-insurance	Pre-certify admissions with MAP or benefits reduced by 10% up to $500, and for subsequent events, by 20% up to $1,000
If you are pregnant	Prenatal and postnatal care in an office or clinic billing as a stand-alone provider, and not as a hospital	$20 co-pay	40% co-insurance	-- None --
	Delivery and all inpatient services	10% co-insurance	40% co-insurance	Pre-certify all admissions or benefits reduced by 10% up to $500, and for subsequent events, by 20% up to $1,000; no co-insurance on in-network surgeon's fees

Common Medical Event	Service You May Need	Your Cost if You Use an In-Network Provider	Your Cost if You Use an Out-of-Network Provider	Limitations & Exceptions
If you need help recovering or have other special health needs	Home health care	No charge	No charge	Prior authorization required; coverage limited to 90 visits/year; no deductible in or out-of-network
	Rehabilitation services including cardiac, speech, physical, and occupational	10% co-insurance inpatient, $20 co-pay outpatient	40% co-insurance inpatient or outpatient	Prior authorization required inpatient or outpatient
	Habilitation services (outpatient)	$20 co-pay	40% co-insurance	Prior authorization required
	Skilled nursing care (facility)	10% co-insurance	40% co-insurance	Must be admitted within 14 days of covered hospital stay of at least 3 days duration; prior authorization required; maximum of 100 days total per benefit year
	Durable medical equipment	No charge	40% co-insurance	Rental cost not to exceed purchase price; requires prior authorization if greater than $1,000
	Hospice service	No charge	No charge	Prior authorization required; no deductible in or out-of-network
If your child needs dental or eye care	Eye exam	No charge	$30 allowance/12 months	Coverage limited to one exam every 12 months
	Glasses	No charge	$60 allowance for lenses and frames	Coverage limited to one pair every 24 months; dependents less than age 19 eligible every 12 months
	Dental check-up	May be no charge	May be no charge	Two exams per year paid at 100% of reasonable and customary charges. Get information on the Cigna dental network at www.cignadentalsa.com

Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy or plan document for other excluded services.)

- Long-term care (custodial)
- Non-emergency care when traveling outside the U.S.
- Routine foot care
- Weight loss programs

Other Covered Services (This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)

- Acupuncture (Subject to pre-approval)
- Bariatric surgery (Subject to pre-certification)
- Chiropractic care (Subject to Plan limits)
- Cosmetic surgery (Covered if due to accidental injury while insured)
- Dental care (Adult) (Subject to Plan limits)
- Hearing aids (Up to $1,500 per ear every 3 years)
- Infertility treatment (Subject to Plan limits)
- Routine eye care (Adult) (Subject to Plan limits)

Your Rights to Continue Coverage:

If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a **premium**, which may be significantly higher than the premium you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply.

For more information on your rights to continue coverage, contact the Fund Office at (617) 265-3757. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cciio.cms.gov.

Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to **appeal.** For questions about your rights, this notice, or assistance, you can contact Iron Clad Insurance at (617) 436-3500. You may also contact the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform.

Does this Coverage Provide Minimum Essential Coverage?

The Affordable Care Act requires most people to have health care coverage that qualifies as "minimum essential coverage." **This plan does provide minimum essential coverage.**

Does this Coverage Meet the Minimum Value Standard?

The Affordable Care Act establishes a minimum value standard of benefits of a health plan. The minimum value standard is 60% (actuarial value). **This health coverage does meet the minimum value standard for the benefits it provides.**

To see examples of how this plan might cover costs for a sample medical situation, see the next page.

About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.

This is not a cost estimator.

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

Having a baby
(normal delivery)

- **Amount owed to providers:** $7,540
- **Plan pays** $6,500
- **Patient pays** $1,040

Sample care costs:

Hospital charges (mother)	$2,700
Routine obstetric care	$2,100
Hospital charges (baby)	$900
Anesthesia	$900
Laboratory tests	$500
Prescriptions	$200
Radiology	$200
Vaccines, other preventive	$40
Total	**$7,540**

Patient pays:

Deductibles	$300
Copays	$0
Coinsurance	$740
Limits or exclusions	$0
Total	**$1,040**

Managing type 2 diabetes
(routine maintenance of a well-controlled condition)

- **Amount owed to providers:** $5,400
- **Plan pays** $4,110
- **Patient pays** $1,290

Sample care costs:

Prescriptions	$2,900
Medical Equipment and Supplies	$1,300
Office Visits and Procedures	$700
Education	$300
Laboratory tests	$100
Vaccines, other preventive	$100
Total	**$5,400**

Patient pays:

Deductibles	$300
Copays	$840
Coinsurance	$110
Limits or exclusions	$40
Total	**$1,290**

Questions and answers about the Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network **providers**. If the patient had received care from out-of-network **providers**, costs would have been higher.

What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how **deductibles**, **copayments**, and **coinsurance** can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

Does the Coverage Example predict my own care needs?

✘ **No.** Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

Does the Coverage Example predict my future expenses?

✘ **No.** Coverage Examples are **not** cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your **providers** charge, and the reimbursement your health plan allows.

Can I use Coverage Examples to compare plans?

✓ **Yes.** When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

Are there other costs I should consider when comparing plans?

✓ **Yes.** You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.

Questions: Call **Iron Clad at (617) 436-3500** or visit us at **www.tuftshealthplan.com/carelink/ironworkers**.
If you aren't clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary at **www.dol.gov/ebsa/healthreform** or call **Iron Clad at (617) 436-3500** to request a copy.