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 617-265-3757 or 800-637-3736. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms see the Glossary. You can view the Glossary at www.www.dol.gov/ebsa/healthreform.com or call 617-265-3757 or 800-637-3736 to request a copy.

Important Questions	Answers	Why This Matters:
What is the medical deductible?	In-network and out-of-network medical (combined): **$300**/individual; **$600**/family.	Generally, you must pay all of the costs from medical providers up to the medical deductible amount before this plan begins to pay. If you have other family members on the plan, the medical family deductible must be met before the plan begins to pay. The medical deductible does not apply to prescription drugs, routine eye care or routine dental care.
Are there services covered before you meet your deductible?	In-network exams, testing and outpatient mental health and substance abuse treatment billed as freestanding facilities and in-network and out-of-network home health care and hospice 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. Exams, testing and outpatient mental health and substance abuse treatment billed as a hospital are subject to the deductible.
Are there other deductibles for specific services?	No.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	In-network: **$1,500**/individual; **$3,000**/family. Out-of-network: **$4,000**/individual; **$6,250**/family.	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, the overall family out-of-pocket limit must be met.
What is not included in the out-of-pocket limit?	Copayments, deductibles, penalties for failure to obtain precertification, premiums, balance-billing charges and health care this plan doesn't 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.tuftshealthplan.com/carelink/ironworkers or call 800-768-4695 for a list of in-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
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	Office visit or freestanding facility: $20 copay and deductible does not apply. Hospital: 10% coinsurance after deductible.	40% coinsurance after deductible.	Copay does not count toward the out-of-pocket limit.
	Specialist visit			
	Preventive care/screening/ immunization	Office visit or freestanding facility: $20 copay and deductible does not apply. Hospital: 10% coinsurance after deductible.	40% coinsurance after deductible.	Copay does not count toward the out-of-pocket limit. Over age 6: limit 1 physical exam/year. Limit 1 gynecological exam/year; no charge for gynecological exam.
If you have a test	Diagnostic test (x-ray, blood work)	Office visit or freestanding facility: $20 copay and deductible does not apply. Hospital: 10% coinsurance after deductible.	40% coinsurance after deductible.	None.
	Imaging (CT/PET scans, MRIs)			

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.express-scripts.com	Generic drugs	Retail: $15 copay/prescription. Mail order: $30 copay/prescription.	You pay the full amount and apply for reimbursement of allowed amount.	Retail: 34-day supply. Mail order: 102-day supply. Copay does not count toward the out-of-pocket limit.
	Preferred brand drugs	Retail: $30 copay/prescription. Mail order: $60 copay/prescription.		
	Non-preferred brand drugs	Retail: $45 copay/prescription. Mail order: $90 copay/prescription.		
	Specialty drugs	Generic: $30 copay/prescription. Preferred brand: $60 copay/prescription. Non-preferred brand: $90 copay/prescription.	Not covered.	Copay may be prorated based on number of days' supply. Copay does not count toward the out-of-pocket limit. Available only through Accredo specialty drug pharmacy.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	10% coinsurance after deductible.	40% coinsurance after deductible.	None.
	Physician/surgeon fees	Physician: 10% coinsurance. Surgeon: no charge. Deductible applies.	40% coinsurance after deductible.	None.
If you need immediate medical attention	Emergency room care	10% coinsurance after deductible.	40% coinsurance after deductible.	Call 800-768-4695 within 48 hours of emergency admission.
	Emergency medical transportation	10% coinsurance after deductible.	40% coinsurance after deductible.	Local ambulance service only. Nonemergency service covered only if medically necessary.
	Urgent care	Freestanding facility: $20 copay/visit. Hospital: 10% coinsurance. Deductible applies.	40% coinsurance after deductible.	Copay does not count toward the out-of-pocket limit.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you have a hospital stay	Facility fee (e.g., hospital room)	10% coinsurance after deductible.	40% coinsurance after deductible.	Limited to semi-private room rate. Precertification required to avoid 10% penalty up to $500 maximum/first occurrence. Subsequent failures to precertify subject to 20% penalty up to $1,000 maximum. Call 800-768-4695 within 48 hours of emergency admission.
	Physician/surgeon fees	Physician: 10% coinsurance. Surgeon: no charge. Deductible applies.	40% coinsurance after deductible.	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Office visit: $5 copay/visit and deductible does not apply. Other outpatient: 10% coinsurance after deductible.	40% coinsurance after deductible.	Copay does not count toward the out-of-pocket limit. For assistance consult Modern Assistance Programs at 617-774-0331.
	Inpatient services	10% coinsurance after deductible.	40% coinsurance after deductible.	Limited to semi-private room rate. Precertification required to avoid 10% penalty up to $500 maximum/first occurrence. Subsequent failures to precertify subject to 20% penalty up to $1,000 maximum. Call Modern Assistance Programs at 617-774-0331.
If you are pregnant	Office visits	$20 copay/visit. Deductible does not apply.	40% coinsurance after deductible.	Copay does not count toward the out-of-pocket limit. Depending on the type of services, coinsurance and deductible may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound).
	Childbirth/delivery professional services	Physician: 10% coinsurance. Surgeon: no charge. Deductible applies.	40% coinsurance after deductible.	Limited to semi-private room rate.
	Childbirth/delivery facility services	10% coinsurance after deductible.	40% coinsurance after deductible.	

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need help recovering or have other special health needs	Home health care	No charge. Deductible does not apply.	No charge up to allowed amount. Deductible does not apply.	Limit 90 visits/year. Precertify with CareAllies at 800-768-4695.
	Rehabilitation services	Outpatient: $20 copay/visit. Inpatient: 10% coinsurance. Deductible applies.	40% coinsurance after deductible.	Copay does not count toward the out-of-pocket limit. Precertify with CareAllies at 800-768-4695.
	Habilitation services	Outpatient: $20 copay/visit. Inpatient: 10% coinsurance. Deductible applies.	40% coinsurance after deductible.	Copay does not count toward the out-of-pocket limit. Precertify with CareAllies at 800-768-4695.
	Skilled nursing care	10% coinsurance after deductible.	40% coinsurance after deductible.	Limit 100 days/calendar year. Covered only if admitted within 14 days of a hospital stay of at least 3 days. Precertify with CareAllies at 800-768-4695.
	Durable medical equipment	No charge after deductible.	40% coinsurance after deductible.	Precertification required for DME greater than $1,000. Rental cost not to exceed purchase price.
	Hospice services	No charge. Deductible does not apply.	No charge up to allowed amount. Deductible does not apply.	Precertify with CareAllies at 800-768-4695.
If your child needs dental or eye care	Children's eye exam	No charge.	No charge up to $30 allowed amount.	Limit 1 exam/12 months. Separately administered by Davis Vision.
	Children's glasses	No charge.	No charge up to $30 allowed amount for frames and $30 allowed amount for lenses.	Limit 1 pair/12 months (individuals 18 and under). Separately administered by Davis Vision.
	Children's dental check-up	No charge up to allowed amount.	No charge up to allowed amount.	Limit: 2 exams/ calendar year.

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.)

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

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

- Acupuncture (precertification required)
- Bariatric surgery (precertification required)
- Chiropractic care (limit 26 visits/year)
- Cosmetic surgery (only if due to accidental bodily injury, congenital deformity or disease, previous therapeutic process, or mastectomy)
- Dental care (Adult) (limit: 2 exams/calendar year, $600/calendar year preventive services; $2,500/calendar year major services)
- Hearing aids ($2,500/ear every 3 years)
- Infertility treatment (limit 3 treatment cycles)
- Private-duty nursing
- Routine eye care (Adult) (limit 1 exam/12 months; 1 pair glasses/24 months)

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 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 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 to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact: the Fund Office at 617-265-3757 or 800-637-3736. You may also contact the Department of Labor's Employee Benefits Security Administration at 866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform.

Does this plan provide Minimum Essential Coverage? Yes

If you don't have Minimum Essential Coverage for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

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.

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

About these Coverage Examples:

This is not a cost estimator. Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby
(9 months of in-network pre-natal care and a hospital delivery)

The plan's overall deductible	$300
Specialist copayment	$20
Hospital (facility) coinsurance	10%
Other coinsurance	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	**$12,800**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$300
Copayments	$140
Coinsurance	$1,130
What isn't covered	
Limits or exclusions	$10
The total Peg would pay is	**$1,580**

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

The plan's overall deductible	$300
Specialist copayment	$20
Hospital (facility) coinsurance	10%
Other copayment	$15

This EXAMPLE event includes services like:
Primary care physician office visits (*including disease education*)
Diagnostic tests (*blood work*)
Prescription drugs
Durable medical equipment (*glucose meter*)

Total Example Cost	**$7,400**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$190
Copayments	$1,510
Coinsurance	$0
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$1,720**

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

The plan's overall deductible	$300
Specialist copayment	$20
Hospital (facility) coinsurance	10%
Other cost sharing	$0

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	**$1,900**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$300
Copayments	$140
Coinsurance	$110
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$550**

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