



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.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 <u>providers</u> up to the medical <u>deductible</u> amount before this <u>plan</u> begins to pay. If you have other family members on the <u>plan</u> , the medical <u>family deductible</u> must be met before the <u>plan</u> begins to pay. The medical <u>deductible</u> does not apply to <u>prescription drugs</u> , routine eye care or routine dental care. |
| Are there services covered before you meet your <u>deductible</u>? | In-network exams, diagnostic testing, imaging, maternity office visits, preventive care, primary care and specialist office visits, outpatient rehabilitation services, outpatient habilitation services, and urgent care billed as freestanding facilities and in-network and out-of-network prescription drugs, home health care, hospice services, and routine dental and eye care 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. Exams, testing, and <u>urgent care</u> billed as a hospital are subject to the <u>deductible</u> . |
| Are there other <u>deductibles</u> for specific services? | No. | You don't have to meet <u>deductibles</u> for specific services. |
| What is the <u>out-of-pocket limit</u> for this <u>plan</u>? | In-network: \$1,500/individual; \$3,000/family. Out-of-network: \$4,000/individual; \$6,250/family. | 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> , the overall family <u>out-of-pocket limit</u> must be met. |
| What is not included in the <u>out-of-pocket limit</u>? | Copayments, <u>deductibles</u> , penalties for failure to obtain precertification, <u>premiums</u> , <u>balance-billing</u> charges and health care this <u>plan</u> doesn't 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 https://harvardpilgrim.org/ironworkers or call 1-800-708-4414 for a list of <u>in-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</u> charge 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. |

| Important Questions | Answers | Why This Matters: |
|--|---------|--|
| 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.

Note: Charges for out-of-network Emergency Services, air ambulance services, and care provided by an out-of-network provider at an in-network facility will be paid as required by the No Surprises Act.

| 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 <u>copay</u> and <u>deductible</u> does not apply. Hospital: 10% <u>coinsurance</u> after <u>deductible</u> . | 40% <u>coinsurance</u> after <u>deductible</u> . | <u>Copay</u> does not count toward the <u>out-of-pocket limit</u> . |
| | <u>Specialist</u> visit | | | |
| | <u>Preventive care</u> / <u>screening</u> / <u>immunization</u> | Office visit or freestanding facility: \$20 <u>copay</u> and <u>deductible</u> does not apply. Hospital: 10% <u>coinsurance</u> after <u>deductible</u> . | 40% <u>coinsurance</u> after <u>deductible</u> . | <u>Copay</u> does not count toward the <u>out-of-pocket limit</u> . Over age 6: limit 1 physical exam/year. Limit 1 gynecological exam/year; no charge for gynecological exam. |
| If you have a test | <u>Diagnostic test</u> (x-ray, blood work) | Office visit or freestanding facility: \$20 <u>copay</u> and <u>deductible</u> does not apply. Hospital: 10% <u>coinsurance</u> after <u>deductible</u> . | 40% <u>coinsurance</u> after <u>deductible</u> . | 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 <u>prescription drug coverage</u> is available at www.express-scripts.com | Generic drugs | Retail: \$15 <u>copay</u> /prescription. Mail order: \$30 <u>copay</u> /prescription. | You pay the full amount and apply for reimbursement of <u>allowed amount</u> . | Retail: 34-day supply. Mail order: 102-day supply. <u>Deductible</u> does not apply. |
| | Preferred brand drugs | Retail: \$30 <u>copay</u> /prescription. Mail order: \$60 <u>copay</u> /prescription. | | <u>Copays</u> do not count toward the <u>out-of-pocket limit</u> . |
| | Non-preferred brand drugs | Retail: \$45 <u>copay</u> /prescription. Mail order: \$90 <u>copay</u> /prescription. | | <u>Deductible</u> does not apply. <u>Copay</u> may be prorated based on number of days' supply. <u>Copay</u> does not count toward the <u>out-of-pocket limit</u> . Available only through Accredo <u>specialty drug</u> pharmacy. |
| | Specialty drugs | Generic: \$30 <u>copay</u> /prescription. Preferred brand: \$60 <u>copay</u> /prescription. Non-preferred brand: \$90 <u>copay</u> /prescription. | Not covered. | |
| If you have outpatient surgery | Facility fee (e.g., ambulatory surgery center) | 10% <u>coinsurance</u> after <u>deductible</u> . | 40% <u>coinsurance</u> after <u>deductible</u> . | None. |
| | Physician/surgeon fees | <u>Deductible</u> applies. Physician: 10% <u>coinsurance</u> . Surgeon: no charge. | 40% <u>coinsurance</u> after <u>deductible</u> . | None. |

| 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 immediate medical attention | <u>Emergency room care</u> | 10% <u>coinsurance</u> after <u>deductible</u> . | 10% <u>coinsurance</u> after <u>deductible</u> . | Call 800-768-4695 within 48 hours of emergency admission to avoid 10% penalty up to \$500 maximum/first occurrence. |
| | <u>Emergency medical transportation</u> | 10% <u>coinsurance</u> after <u>deductible</u> . | 40% <u>coinsurance</u> after <u>deductible</u> , except 10% <u>coinsurance</u> after <u>deductible</u> for air ambulance. | Local ambulance service only. Nonemergency service covered only if <u>medically necessary</u> . |
| | <u>Urgent care</u> | Freestanding facility: \$20 <u>copay</u> /visit and <u>deductible</u> does not apply. Hospital: 10% <u>coinsurance</u> after <u>deductible</u> . | 40% <u>coinsurance</u> after <u>deductible</u> . | <u>Copay</u> does not count toward the <u>out-of-pocket limit</u> . |
| If you have a hospital stay | Facility fee (e.g., hospital room) | 10% <u>coinsurance</u> after <u>deductible</u> . | 40% <u>coinsurance</u> after <u>deductible</u> . | Limited to semi-private room rate. Precertification required to avoid 10% penalty up to \$500 maximum/first occurrence. |
| | Physician/surgeon fees | <u>Deductible</u> applies. Physician: 10% <u>coinsurance</u> . Surgeon: no charge. | 40% <u>coinsurance</u> after <u>deductible</u> . | Subsequent failures to precertify subject to 20% penalty up to \$1,000 maximum. Call 1-800-708-4414 within 48 hours of emergency admission to avoid 10% penalty up to \$500 maximum/first occurrence. Subsequent failures subject to 20% penalty up to \$1,000 maximum. |
| If you need mental health, behavioral | Outpatient services | Office visit: \$5 <u>copay</u> /visit and <u>deductible</u> does not apply. Other outpatient services: 10% <u>coinsurance</u> after <u>deductible</u> . | 40% <u>coinsurance</u> after <u>deductible</u> . | <u>Copay</u> does not count toward the <u>out-of-pocket limit</u> . For assistance consult Modern Assistance Programs at 617-774-0331. |

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| health, or substance abuse services | Inpatient services | 10% <u>coinsurance</u> after <u>deductible</u> . | 40% <u>coinsurance</u> after <u>deductible</u> . | 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. |
|-------------------------------------|--------------------|--|--|--|

| 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 are pregnant | Office visits | \$20 <u>copay</u> /visit. <u>Deductible</u> does not apply. | 40% <u>coinsurance</u> after <u>deductible</u> . | <u>Copay</u> does not count toward the <u>out-of-pocket limit</u> . Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound). |
| | Childbirth/delivery professional services | <u>Deductible</u> applies. Physician: 10% <u>coinsurance</u> . Surgeon: no charge. | 40% <u>coinsurance</u> after <u>deductible</u> . | Limited to semi-private room rate. |
| | Childbirth/delivery facility services | 10% <u>coinsurance</u> after <u>deductible</u> . | 40% <u>coinsurance</u> after <u>deductible</u> . | |
| If you need help recovering or have other special health needs | <u>Home health care</u> | No charge. <u>Deductible</u> does not apply. | No charge up to <u>allowed amount</u> . <u>Deductible</u> does not apply. | Limit 90 visits/year. Precertify with Harvard Pilgrim at 1-800-708-4414. |
| | <u>Rehabilitation services</u> | Outpatient: \$20 <u>copay</u> /visit and <u>deductible</u> does not apply. Inpatient: 10% <u>coinsurance</u> after <u>deductible</u> . | 40% <u>coinsurance</u> after <u>deductible</u> . | <u>Copay</u> does not count toward the <u>out-of-pocket limit</u> . Precertify with Harvard Pilgrim at 1-800-708-4414. |
| | <u>Habilitation services</u> | Outpatient: \$20 <u>copay</u> /visit and <u>deductible</u> does not apply. Inpatient: 10% <u>coinsurance</u> after <u>deductible</u> . | 40% <u>coinsurance</u> after <u>deductible</u> . | <u>Copay</u> does not count toward the <u>out-of-pocket limit</u> . Precertify with Harvard Pilgrim at 1-800-708-4414. |

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| | <u>Skilled nursing care</u> | 10% <u>coinsurance</u> after <u>deductible</u> . | 40% <u>coinsurance</u> after <u>deductible</u> . | Limit 100 days/calendar year. Covered only if admitted within 14 days of a hospital stay of at least 3 days. Precertify with Harvard Pilgrim at 1-800-708-4414. |
| | <u>Durable medical equipment</u> | No charge after <u>deductible</u> . | 40% <u>coinsurance</u> after <u>deductible</u> . | Precertification required for <u>DME</u> greater than \$1,000. Rental cost not to exceed purchase price. |
| | <u>Hospice services</u> | No charge. <u>Deductible</u> does not apply. | No charge up to <u>allowed amount</u> . <u>Deductible</u> does not apply. | Precertify with Harvard Pilgrim at 1-800-708-4414. |

| 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 your child needs dental or eye care | Children's eye exam | No charge. | No charge up to \$30 <u>allowed amount</u> . | <u>Deductible</u> does not apply. Limit 1 exam/12 months. Separately administered by Davis Vision. |
| | Children's glasses | No charge. | No charge up to \$30 <u>allowed amount</u> for frames and \$30 <u>allowed amount</u> for lenses. | <u>Deductible</u> does not apply. Limit 1 pair/12 months (individuals 18 and under). Separately administered by Davis Vision. |
| | Children's dental check-up | No charge up to <u>allowed amount</u> . | No charge up to <u>allowed amount</u> . | <u>Deductible</u> does not apply. Limit: 2 exams/ calendar year. |

Note: Charges for out-of-network Emergency Services, air ambulance services, and care provided by an out-of-network provider at an in-network facility will be paid as required by the No Surprises Act.

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/calender year, \$600/calender year preventive services; \$2,500/calender 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 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: 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

[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](#).

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 <u>plan's overall deductible</u> | \$300 |
| ■ <u>Specialist copayment</u> | \$20 |
| ■ <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:

| <u>Cost Sharing</u> | |
|-----------------------------------|----------------|
| <u>Deductibles</u> | \$300 |
| <u>Copayments</u> | \$120 |
| <u>Coinsurance</u> | \$1,120 |
| <i>What isn't covered</i> | |
| Limits or exclusions | \$20 |
| The total Peg would pay is | \$1,560 |

Managing Joe's Type 2 Diabetes

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

| | |
|--|-------|
| ■ The <u>plan's overall deductible</u> | \$300 |
| ■ <u>Specialist copayment</u> | \$20 |
| ■ <u>Hospital (facility) coinsurance</u> | 10% |
| ■ <u>Other copayment</u> | \$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 **\$5,600**

In this example, Joe would pay:

| <u>Cost Sharing</u> | |
|-----------------------------------|----------------|
| <u>Deductibles</u> | \$140 |
| <u>Copayments</u> | \$1,130 |
| <u>Coinsurance</u> | \$0 |
| <i>What isn't covered</i> | |
| Limits or exclusions | \$20 |
| The total Joe would pay is | \$1,290 |

Mia's Simple Fracture

(in-network emergency room visit and follow up care)

| | |
|--|-------|
| ■ The <u>plan's overall deductible</u> | \$300 |
| ■ <u>Specialist copayment</u> | \$20 |
| ■ <u>Hospital (facility) coinsurance</u> | 10% |
| ■ <u>Other cost sharing</u> | \$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 **\$2,800**

In this example, Mia would pay:

| <u>Cost Sharing</u> | |
|-----------------------------------|--------------|
| <u>Deductibles</u> | \$300 |
| <u>Copayments</u> | \$170 |
| <u>Coinsurance</u> | \$170 |
| <i>What isn't covered</i> | |
| Limits or exclusions | \$0 |
| The total Mia would pay is | \$640 |

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