



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, contact the Plan at [www.iwstldc.org](http://www.iwstldc.org) or by calling 1-877-597-8704. 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](http://www.dol.gov/ebsa/healthreform) or call 1-877-597-8704 to request a copy.

| Important Questions  | Answers  | Why This Matters:  |
|--|--|--|
| <b>What is the overall deductible?</b>                             | <u>In-Network</u> : \$400 per person or \$1,200 per family; <u>Out-of-Network</u> : \$700 per person/\$1,400 per family (January 1 – December 31)  | 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> .  |
| <b>Are there services covered before you meet your deductible?</b> | Yes. Absolute Solutions diagnostic imaging, <u>emergency room care</u> , <u>in-network urgent care</u> , <u>in-network</u> office visits, hearing aids, chiropractic services, vision benefits, dental benefits, <u>in-network prescription drugs</u> , and <u>in-network preventive care</u> are covered before you meet your <u>deductible</u> . | This <u>plan</u> covers some items and services even if you have not 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 <a href="https://www.healthcare.gov/coverage/preventive-care-benefits/">https://www.healthcare.gov/coverage/preventive-care-benefits/</a>  |
| <b>Are there other deductibles for specific services?</b>          | Yes. <u>\$25</u> per person or <u>\$75</u> per family for dental benefits. 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.   |
| <b>What is the out-of-pocket limit for this plan?</b>              | Medical: <u>In-Network</u> : \$700 per person or \$2,100 per family; <u>Out-of-Network</u> \$1,400 per person or \$2,800 per family. <u>Prescription Drug</u> : <u>In-Network</u> : \$1,900 per person or \$3,800 per family; <u>Out-of-Network</u> : <u>No limit</u> (January 1 – December 31)  | 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 limits</u> until the overall family <u>out-of-pocket limit</u> has been met.  |
| <b>What is not included in the out-of-pocket limit?</b>            | <u>Premiums</u> , <u>balance-billing</u> charges, dental benefits administered separately by Delta Dental, vision benefits administered separately by VSP, and health care this <u>plan</u> does not cover.  | Even though you pay these expenses, they do not count toward the <u>out-of-pocket limit</u> .  |
| <b>Will you pay less if you use a network provider?</b>            | Yes. See <a href="http://www.anthem.com">www.anthem.com</a> or call 1-800-810-BLUE 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</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. |
| <b>Do you need a referral to see a specialist?</b>                 | 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  |
|--|--|--|--|---|
|  |  | Network Provider<br>(You will pay the least)   | Out-of-Network Provider<br>(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 <u>copay</u> per visit.<br><u>Deductible</u> does not apply.  | 30% <u>coinsurance</u>   | Telemedicine: \$15 <u>copay</u> per visit. <u>In-Network</u> benefit applies if no <u>provider</u> is within 25 miles or if care is needed when you are more than 150 miles from home. Telemedicine: \$15 <u>copay</u> per visit.   |
|  | Specialist visit                                 |  |  | Chiropractic services/spinal manipulations \$5 <u>copay</u> per visit (\$25 <u>copay</u> for retirees); 26-day combined visit limit per calendar year. <u>In-Network</u> benefit applies if no <u>provider</u> is within 25 miles or if care is needed when you are more than 150 miles from home.                  |
|  | Preventive care/screening/immunization           | No charge. <u>Deductible</u> does not apply.   | Not covered  | <u>In-Network</u> benefit applies if no <u>provider</u> is within 25 miles or if care is needed when you are more than 150 miles from home. 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                                     | Diagnostic test (x-ray, blood work)              | No charge up to first \$500, then 10% <u>coinsurance</u>   | No charge up to first \$500, then 30% <u>coinsurance</u>   | No charge for diagnostic imaging (e.g., MRI, CT and PET scan) through Absolute Solutions <u>network</u> and <u>deductible</u> does not apply.<br><br><u>In-Network</u> benefit applies if no <u>provider</u> is within 25 miles or if care is needed when you are more than 150 miles from home.                    |
|  | Imaging (CT/PET scans, MRIs)                     | No charge up to first \$500, then 10% <u>coinsurance</u> unless admitted to hospital or other in-patient facility. Diagnostic imaging services performed by a <u>provider</u> in the Absolute Solutions <u>network</u> is covered at 100%; other <u>in-network</u> imaging is subject to 10% <u>coinsurance</u> after the first \$500. | No charge up to first \$500, then 30% <u>coinsurance</u> unless admitted to hospital or other in-patient facility. |   |

| Common Medical Event   | Services You May Need                          | What You Will Pay   |  | Limitations, Exceptions, & Other Important Information  |
|--|--|---|--|---|
|  |  | Network Provider<br>(You will pay the least)  | Out-of-Network Provider<br>(You will pay the most)   |   |
| <b>If you need drugs to treat your illness or condition</b><br>More information about <u>prescription drug coverage</u> is available at <a href="http://www.express-scripts.com">www.express-scripts.com</a> . | Generic drugs                                  | \$10 <u>copay</u> per fill retail,<br>\$25 <u>copay</u> per fill mail order.<br><u>Deductible</u> does not apply. | Full price of the retail prescription minus the discounted retail price minus the <u>copay</u> amount. | Covers up to a 30-day supply (retail); 31-90 day supply (mail order).<br><br>No charge for FDA-approved generic contraceptives (or brand name contraceptives if a generic is medically inappropriate).                                    |
|  | Preferred brand drugs                          | \$25 <u>copay</u> per fill retail,<br>\$60 <u>copay</u> per fill mail order.<br><u>Deductible</u> does not apply. |  | Covers up to a 30-day supply (retail); 31-90 day supply (mail order). Restricted coverage for OxyContin. After the first 30-day fill, refills of over 4 pills per day must be approved by the PBM or the prescription will not be filled. |
|  | Non-preferred brand drugs                      | \$40 <u>copay</u> per fill retail,<br>\$100 <u>copay</u> per fill mail order. <u>Deductible</u> does not apply.   |  |   |
|  | <u>Specialty drugs</u>                         | \$100 <u>copay</u> per fill retail or fill mail order. <u>Deductible</u> does not apply.                          | Not covered  | Must go through pharmacy benefit manager's specialty program to obtain <u>specialty drugs</u> .   |
| <b>If you have outpatient surgery</b>  | Facility fee (e.g., ambulatory surgery center) | 10% <u>coinsurance</u>  | 30% <u>coinsurance</u>   | <u>In-Network</u> benefit applies if no <u>provider</u> is within 25 miles or if care is needed when you are more than 150 miles from home.   |
|  | Physician/surgeon fees                         |   |  |   |
| <b>If you need immediate medical attention</b>   | <u>Emergency room care</u>                     | \$150 <u>copay</u> per visit.<br><u>Deductible</u> does not apply.  | \$150 <u>copay</u> per visit.<br><u>Deductible</u> does not apply.                                     | <u>Copay</u> waived if admitted to hospital.  |
|  | <u>Emergency medical transportation</u>        | 10% <u>coinsurance</u>  | 30% <u>coinsurance</u>   | <u>In-Network</u> benefit applies if no <u>provider</u> is within 25 miles or if care is needed when you are more than 150 miles from home.   |
|  | <u>Urgent care</u>                             | \$25 <u>copay</u> per visit.<br><u>Deductible</u> does not apply.   |  |   |
| <b>If you have a hospital stay</b>   | Facility fee (e.g., hospital room)             | 10% <u>coinsurance</u>  | 30% <u>coinsurance</u>   | Private rooms covered only if <u>medically necessary</u> .<br><u>In-Network</u> benefit applies if no <u>provider</u> is within 25 miles or if care is needed when you are more than 150 miles from home.                                 |
|  | Physician/surgeon fees                         |   |  |   |

| Common Medical Event  | Services You May Need                     | What You Will Pay  |  | Limitations, Exceptions, & Other Important Information   |
|---|---|--|--|--|
|   |   | Network Provider<br>(You will pay the least)   | Out-of-Network Provider<br>(You will pay the most) |  |
| If you need mental health, behavioral health, or substance abuse services | Outpatient services                       | \$25 <u>copay</u> per office visit and related services; <u>deductible</u> does not apply. 10% <u>coinsurance</u> for other outpatient services      | 30% <u>coinsurance</u>                             | <u>In-Network</u> benefit applies if no <u>provider</u> is within 25 miles or if care is needed when you are more than 150 miles from home.  |
|   | Inpatient services                        | 10% <u>coinsurance</u>   |  |  |
| If you are pregnant   | Office visits                             | \$25 <u>copay</u> , 1st visit only (if billed separately from the delivery fee) for confirmation of the pregnancy. <u>Deductible</u> does not apply. | 30% <u>coinsurance</u>                             | <u>In-Network</u> benefit applies if no <u>provider</u> is within 25 miles or if care is needed when you are more than 150 miles from home. Prenatal care (other than ACA-required preventive screenings) is not covered for dependent children. <u>Cost sharing</u> does not apply for preventive services. |
|   | Childbirth/delivery professional services | 10% <u>coinsurance</u>   | 30% <u>coinsurance</u>                             | Private rooms covered only if <u>medically necessary</u> . <u>In-Network</u> benefit applies if no <u>provider</u> within 25 miles or you are more than 150 miles from home. Delivery expenses are not covered for dependent children.   |
|   | Childbirth/delivery facility services     |  |  |  |
| If you need help recovering or have other special health needs            | Home health care                          | 10% <u>coinsurance</u>   | 30% <u>coinsurance</u>                             | <u>In-Network</u> benefit applies if no <u>provider</u> within 25 miles, or if you are more than 150 miles from home.  |
|   | Rehabilitation services                   | 10% <u>coinsurance</u>   | 30% <u>coinsurance</u>                             | Limited to 60 combined visits per person per calendar year for physical, occupational and speech therapy. <u>In-Network</u> benefit applies if no <u>provider</u> within 25 miles or if care is needed when you are more than 150 miles from home.   |
|   | Habilitation services (speech therapy)    | 10% <u>coinsurance</u>   | 30% <u>coinsurance</u>                             | Coverage for speech therapy only. <u>In-Network</u> benefit applies if no <u>provider</u> is within 25 miles or if care is needed when you are more than 150 miles from home.  |
|   | Skilled nursing care                      | 10% <u>coinsurance</u>   | 30% <u>coinsurance</u>                             | Custodial care not covered. Limited to 45 days per calendar year. Limited to semi-private room. <u>In-Network</u> benefit applies if no <u>provider</u> is within 25 miles or if care is needed when you are more than 150 miles from home.  |
|   | Durable medical equipment                 | 10% <u>coinsurance</u>   | 30% <u>coinsurance</u>                             | Rental cost up to the purchase price. <u>In-Network</u> benefit applies if no <u>provider</u> is within 25 miles or if care is needed when you are more than 150 miles from home.  |
|   | Hospice services                          | 10% <u>coinsurance</u>   | 30% <u>coinsurance</u>                             | <u>In-Network</u> benefit applies if no <u>provider</u> is within 25 miles or if care is needed when you are more than 150 miles from home.  |

| Common Medical Event                   | Services You May Need      | What You Will Pay   |   | Limitations, Exceptions, & Other Important Information  |
|--|----------------------------|---|---|---|
|  |                            | Network Provider<br>(You will pay the least)  | Out-of-Network Provider<br>(You will pay the most)  |   |
| If your child needs dental or eye care | Children's eye exam        | \$10 <u>copayment</u> per exam. <u>Deductible</u> does not apply.   | Reimbursement up to \$42. <u>Deductible</u> does not apply.   | Coverage limited to one exam per year. Administered separately by VSP. Your <u>cost sharing</u> does not count toward the <u>out-of-pocket limit</u> .  |
|  | Children's glasses         | No charge for most lenses. Frames are covered up to \$150 allowance, plus 20% off the amount over your allowance. <u>Deductible</u> does not apply. | Frames reimbursed up to \$45. Reimbursement up to \$80 for certain lenses. Other lenses not covered. <u>Deductible</u> does not apply.                | Lenses are covered once per calendar year. Frames are covered once per two calendar years. Certain lenses are not covered. Administered separately by VSP. Your <u>cost sharing</u> does not count toward the <u>out-of-pocket limit</u> .  |
|  | Children's dental check-up | No charge after \$25 dental <u>deductible</u> .   | No charge after \$25 dental <u>deductible</u> if <u>in-network provider</u> is more than 25 miles from your home. Otherwise, 30% <u>coinsurance</u> . | <u>Deductible</u> : \$25 per person and \$75 per family. \$2,000 annual maximum per person and \$2,000 lifetime maximum per person for orthodontia. Only for Locals 46, 103, 392, 396 and 782. This benefit is separately insured and administered by Delta Dental. Your <u>cost sharing</u> does not count toward the <u>out-of-pocket limit</u> . |

## Excluded Services & Other Covered Services:

| <b>Services Your Plan Generally Does NOT Cover (Check your policy or <u>plan</u> document for more information and a list of any other excluded services.)</b> |  |  |
|--|--|--|
| • Acupuncture  | • Long-term care (except for <u>skilled nursing care</u> )   | Weight loss programs (unless required under ACA)   |
| <b>Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your <u>plan</u> document.)</b>                     |  |  |
| • Bariatric Surgery (if certain criteria are met)  | • Hearing aids (after a \$250 <u>copay in-network</u> , up to \$2,600 per hearing aid every two years for <u>medically necessary</u> hearing aids prescribed by an audiologist or other physician specializing in ear, nose, and throat). Provided through TruHearing. | • Non-emergency care when traveling outside the U.S.<br>• Private-duty nursing<br>• Routine eye care (Adult and Child) (administered separately by VSP)<br>• Routine foot care |

**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 U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-EBSA (3272) or [www.dol.gov/ebsa/healthreform](http://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](http://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 the Plan at [www.iwstldc.org](http://www.iwstldc.org) or by calling 1-877-597-8704. 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](http://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</u> <u>overall deductible</u> | \$400 |
| ■ <u>Specialist copayment</u>                 | \$25  |
| ■ <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*)

|                           |                 |
|---------------------------|-----------------|
| <b>Total Example Cost</b> | <b>\$12,700</b> |
|---------------------------|-----------------|

In this example, Peg would pay:

| Cost Sharing                      |              |
|-----------------------------------|--------------|
| <u>Deductibles</u>                | \$400        |
| <u>Copayments</u>                 | \$10         |
| <u>Coinsurance</u>                | \$300        |
| What isn't covered                |              |
| Limits or exclusions              | \$60         |
| <b>The total Peg would pay is</b> | <b>\$770</b> |

### Managing Joe's type 2 Diabetes

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

|   |       |
|---|-------|
| ■ The <u>plan's</u> <u>overall deductible</u> | \$400 |
| ■ <u>Specialist copayment</u>                 | \$25  |
| ■ <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*)

|                           |                |
|---------------------------|----------------|
| <b>Total Example Cost</b> | <b>\$5,600</b> |
|---------------------------|----------------|

In this example, Joe would pay:

| Cost Sharing       |         |
|--------------------|---------|
| <u>Deductibles</u> | \$120   |
| <u>Copayments</u>  | \$1,070 |
| <u>Coinsurance</u> | \$0     |

What isn't covered

|                                   |                |
|-----------------------------------|----------------|
| Limits or exclusions              | \$70           |
| <b>The total Joe would pay is</b> | <b>\$1,260</b> |

### Mia's Simple Fracture

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

|   |       |
|---|-------|
| ■ The <u>plan's</u> <u>overall deductible</u> | \$400 |
| ■ <u>Specialist copayment</u>                 | \$25  |
| ■ <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*)

|                           |                |
|---------------------------|----------------|
| <b>Total Example Cost</b> | <b>\$2,800</b> |
|---------------------------|----------------|

In this example, Mia would pay:

| Cost Sharing       |       |
|--------------------|-------|
| <u>Deductibles</u> | \$400 |
| <u>Copayments</u>  | \$240 |
| <u>Coinsurance</u> | \$70  |

What isn't covered

|                                   |              |
|-----------------------------------|--------------|
| Limits or exclusions              | \$0          |
| <b>The total Mia would pay is</b> | <b>\$710</b> |