IRONWORKERS LOCAL 11
BENEFIT FUNDS & TRAINING FACILITY
BUILT ON TRUST, FOUNDED ON SERVICE

12 Edison Place, Springfield, NJ 07081 Ph(973) 376-7230 Fax(973) 376-2094 www.ironnj.com

June 1, 2022

Re: Summary of Benefits and Coverage (SBC)

Dear Participant and Family;

Enclosed you will find the Iron Workers Local 11 Welfare Fund's Summary of Benefits and Coverage (SBC). The SBC provides a general description of the health benefits provided by our Fund. SBCs are required by the Affordable Care Act (ACA). Please share the SBC with your family members who are eligible for Fund coverage.

The federal government created the SBC to help people who are shopping for coverage when the health care exchanges opened in 2014. They let you see if different plans cover the same benefits (office visits, chiropractic care and prescription drugs, for example), and how much coverage they offer for those benefits—what the coinsurance and copayments are for different services. For that reason, we were not allowed to change much of the SBC to make it better fit with your benefits.

To best understand the benefits provided by this Fund, we recommend that you visit the Ironworkers Local 11 Benefit Funds and Training Facility website (http://www.ironnj.com/) or the Horizon Blue Cross Blue Shield of New Jersey website (http://www.HorizonBlue.com/) and read the materials that the Fund has created for you—your Summary Plan Description (SPD) and the other benefit materials that you are used to seeing from the Fund.

SBC Examples
The SBC includes three examples—one for having a baby, one for managing type 2 diabetes and one for a simple fracture. The examples show the health care costs for you and the Fund that are involved with getting care for each of these three situations.

As you read these examples, it's very important to keep in mind that the costs shown are national averages; they do not tell you what the actual services might cost where you live. Also, your doctor might choose a different course of treatment than what is used to create the example costs. Or your doctor could be an Out-of-Network Provider—the examples only show costs of In-Network Providers. There are lots of ways that your costs may be different than what is shown in the example even though you are dealing with the same thing—type 2 diabetes, for example.

These examples are included in the SBC to help you compare how different health plans might cover the same condition—***not for predicting your own actual health care expenses.***

SBC Terms
The SBC might use different terms than you are used to seeing when talking about your benefits. And there is something called a "Glossary of Health Coverage and Medical Terms" mentioned in the SBC. The Glossary gives definitions of common health insurance terms. Unfortunately, it is a national glossary and it may explain things differently than we usually do. But the government will not let us change any of the definitions or even add some that might be helpful. You can view the Glossary at www.dol.gov/ebsa/healthreform or call (800) 355-BLUE(2583) to request a copy.

If you read the SBC or the Glossary and anything seems confusing or doesn't quite line up with the way our Fund works, we suggest that you go to the Ironworkers Local 11 Benefit Funds and Training Facility website, the Horizon Blue Cross Blue Shield of New Jersey website, your SPD and the other benefit materials that you get from our Fund.

For More Information
If you have any questions about Fund-provided coverage, please call the Fund Office at (973) 376-7230 or Horizon at (800) 355-BLUE (2583).

If you have general questions about the SBC itself, you may want to contact the Employee Benefits Security Administration of the U.S. Department of Labor at (866) 444-3272 or www.dol.gov/ebsa, or the U.S. Department of Health and Human Services at (877) 267-2323 Ext. 61565 or www.cciio.cms.gov.

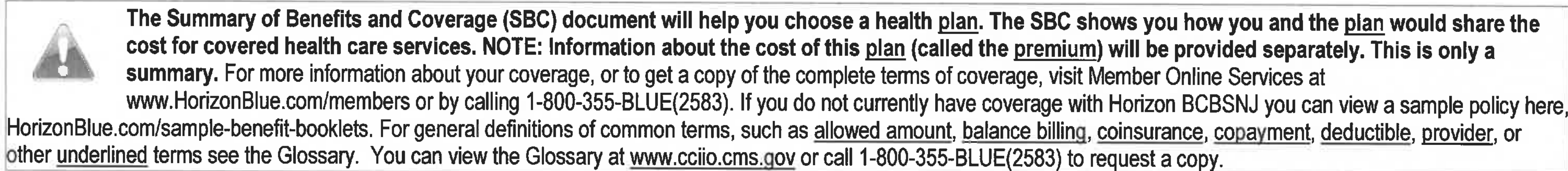
Please keep the SBC with your SPD for easy reference. Receipt of this document does not constitute a determination of your eligibility.

ERISA Information

Plan Sponsor:	Board of Trustees of the Iron Workers Local 11 Welfare Fund
Sponsor's EIN #:	226041517
Plan Number:	501

Sincerely,

The Board of Trustees



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, visit Member Online Services at www.HorizonBlue.com/members or by calling 1-800-355-BLUE(2583). If you do not currently have coverage with Horizon BCBSNJ you can view a sample policy here, HorizonBlue.com/sample-benefit-booklets. 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.cciio.cms.gov or call 1-800-355-BLUE(2583) to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	**In-network basic expenses:** None **Out-of-network basic expenses:** $500 individual / $1,000 family	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?	No.	You must meet your deductible first for all out-of-network basic expenses and all in-network and out-of-network Supplemental Services and Supplies.
Are there other deductibles for specific services?	Yes. In-network Supplemental Services and Supplies, **$500** individual / **$1,000** family and Out-of-network Supplemental Services and Supplies, **$500 individual/ $1,000 family**	This Supplemental Services out-of-network deductible is combined with the out-of-network basic expenses deductible. You must pay all 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?	For in-network basic expenses **$500** per individual per year.	The in-network **out-of-pocket limit** is the most you could pay in a year for covered services that don't require a copayment. If you have other family members in this **plan**, they have to meet their own **out-of-pocket limits.**
What is not included in the out-of-pocket limit?	Copayments, 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. For a list of in-network **providers**, see **www.HorizonBlue.com** or call **1-800-355-BLUE (2583).**	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 don't need a referral to see a specialist.	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)	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	$25.00 copayment per visit.	30% coinsurance, after deductible.	none
	Specialist visit	$30.00 copayment per visit.	30% coinsurance, after deductible.	
	Preventive care/screening/ immunization	No charge.	30% coinsurance, after deductible.	One per calendar year. You may have to pay for services that are not 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)	10% coinsurance	30% coinsurance, after deductible.	Laboratory Corporation of America (LabCorp) and Quest Diagnostics are the only participating Labs in this Network in New Jersey.
	Imaging (CT/PET scans, MRIs)	10% coinsurance	30% coinsurance, after deductible.	Pre-authorization required by prescribing physician by contacting eviCore at 866-496-6200.
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.[insert].com	Generic drugs	Retail: 10% coinsurance ($5 minimum copayment) Mail Order: 10% coinsurance ($10 minimum copayment)	Not Covered	30-day supply retail and specialty & 90-day supply mail order. For brand name prescriptions, when a generic drug is available, you pay the cost difference between brand and generic price, in addition to the required copayment. The maximum copayment/prescription is $75 retail and $150/prescription mail order. Pre-certification required for certain drugs. Mail Order and Specialty prescriptions must be obtained via the Benecard Central Fill facility 1-888-907-0070. More information about **prescription drug coverage** is available at www.benecard.com
	Preferred brand drugs	Retail: 10% coinsurance ($15 minimum copayment) Mail Order: 10% coinsurance ($30 minimum copayment)	Not Covered	
	Non-preferred brand drugs	Retail: 10% coinsurance ($30 minimum copayment) Mail Order: 10%	Not Covered	

Common Medical Event	Services You May Need	What You Will Pay: Network Provider (You will pay the least)	What You Will Pay: Out-of-Network Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information
		coinsurance ($60 minimum copayment)		
	Specialty drugs	10% coinsurance ($50 min. copayment and $100 max.)	Not Covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	10% coinsurance	30% coinsurance, after deductible.	___none___
	Physician/surgeon fees	10% coinsurance	30% coinsurance, after deductible.	___none___
If you need immediate medical attention	Emergency room care	$100.00 copayment per visit for Outpatient Hospital.	$100.00 copayment per visit for Outpatient Hospital.	Copay waived if admitted within 24 hours. Applies only to emergency room medical emergency and accidental injury.
	Emergency medical transportation	20% coinsurance, after Supplemental Services and Supplies deductible.	30% coinsurance, after Supplemental Services and Supplies deductible.	The out-of-network Supplemental Services deductible is combined with the Basic Services individual/family out-of-network deductible.
	Urgent care	$25.00 copayment per visit for Office. $30.00 Copayment per visit for Specialist. _	30% coinsurance, after deductible.	___none___
If you have a hospital stay	Facility fee (e.g., hospital room)	10% coinsurance	30% coinsurance, after deductible.	Requires pre-approval; 50% penalty applies for non-compliance. In-network & Out-of-network inpatient separation period is limited to 90 days.
	Physician/surgeon fees	10% coinsurance	30% coinsurance, after deductible.	___none___
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$25 copayment per office visit.	30% coinsurance, after deductible.	___none___
	Inpatient services	10% coinsurance	30% coinsurance, after deductible.	Requires pre-approval; 50% penalty applies for non-compliance. In-network & Out-of-network inpatient separation period is limited to 90 days.
If you are pregnant	Office visits	$30.00 copayment for	30% coinsurance, after deductible.	Cost sharing does not apply for preventive services. Maternity care may

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
		initial visit		include tests and services described elsewhere in the SBC (i.e. Ultrasound.)
	Childbirth/delivery professional services	10% coinsurance	30% coinsurance, after deductible.	none
	Childbirth/delivery facility services	10% coinsurance	30% coinsurance, after deductible.	In-network & Out-of-network inpatient separation period is limited to 90 days.
If you need help recovering or have other special health needs	Home health care	10% coinsurance	30% coinsurance, after deductible.	Requires pre-approval; 50% penalty applies for non-compliance. In-network & Out-of-network inpatient separation period is limited to 90 days. Payable up to 90 visits a year.
	Rehabilitation services	10% coinsurance	30% coinsurance, after deductible.	Requires pre-approval; 50% penalty applies for non-compliance. In-network & Out-of-network inpatient separation period coverage is limited to 90 days.
	Habilitation services	10% coinsurance	30% coinsurance, after deductible.	
	Skilled nursing care	10% coinsurance	30% coinsurance, after deductible.	Requires pre-approval; 50% penalty applies for non-compliance. Inpatient skilled nursing facility following direct admission. In-network & Out-of-network inpatient skilled nursing facility day limit coverage is limited to 120 days a year.
	Durable medical equipment	20% coinsurance after supplemental services and supplies deductible.	30% coinsurance, after supplemental services and supplies deductible.	Prior authorization required for DME purchases over $500. 50% penalty applies for non-compliance. The out-of-network Supplemental Services Deductible is combined with the basic expenses out-of-network deductible.
	Hospice services	10% coinsurance	30% coinsurance, after deductible.	Requires pre-approval; 50% penalty applies for non-compliance. Limit to 10 Respite Days.
If your child needs dental or eye care	Children's eye exam	No charge	Out-of-network routine eye exam and glasses combined is reimbursable up to $250	This benefit is administered by Davis vision.
	Children's glasses	$130.00 Plus 20% discount on any overage or $180.00		

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
		Plus 20% discount at Visionworks location.	per covered person every 2 years.	
	Children's dental check-up	No charge for preventive and diagnostic benefits.	Reimbursable to member based on Delta Dental's PPO Network allowance.	This benefit is administered by Delta Dental PPO.

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
- Long-term care
- Non-emergency or emergency care when traveling outside the U.S.
- Weight Loss Programs

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

- Bariatric Surgery
- Chiropractic care
- Hearing aids (Plan pays up to a maximum of $2,200 per ear for hearing aids, every 36 months).
- Infertility Treatment
- Private-duty nursing
- 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: 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 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: 1-800-355-BLUE (2583) or visit www.Horizonblue.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. You may also contact the NJ Department of Banking and Insurance Consumer Protection Services at 1-888-393-1062 ext 50998.

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

[Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa

[Chinese (中文): **如果需要中文的帮助，**请拨打这个号码

[Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne'

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

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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** **$0**
- **Specialist *[cost sharing]*** **$30**
- **Hospital (facility) *[cost sharing]*** **10%**
- **Other *[cost sharing]*** **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:	
Cost Sharing	
Deductibles	$0
Copayments	$0
Coinsurance	$500
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$560**

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

- **The plan's overall deductible** **$0**
- **Specialist *[cost sharing]*** **$30**
- **Hospital (facility) *[cost sharing]*** **10%**
- **Other *[cost sharing]*** **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)*

Total Example Cost	**$5,600**
In this example, Joe would pay:	
Cost Sharing	
Deductibles	$200
Copayments	$200
Coinsurance	$100
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$520**

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

- **The plan's overall deductible** **$0**
- **Specialist *[cost sharing]*** **$30**
- **Hospital (facility) *[cost sharing]*** **10%**
- **Other *[cost sharing]*** **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)*

Total Example Cost	**$2,800**
In this example, Mia would pay:	
Cost Sharing	
Deductibles	$500
Copayments	$0
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$500**

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