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, 2016

Re: Summary of Benefits and Coverage (SBC)

Dear Participant and Family;

Enclosed you will find the Ironworkers 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 two examples—one for having a baby and one for managing type 2 diabetes. The examples show the health care costs for you and the Fund that are involved with getting care for each of these two 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's 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's a national glossary and it may explain things differently than we usually do. But the government won't let us change any of the definitions or even add some that might be helpful.

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.

Sincerely,

The Board of Trustees

Ironworkers Local 11 Benefit Funds and Training Facility

Coverage Period: 07/01/2016 - 06/30/2017

Summary of Benefits and Coverage: What this Plan Covers & What it Costs | **Coverage for:** All Coverage Types | **Plan Type:** DA

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, including coverage details and out-of-pocket costs at **www.HorizonBlue.com/members** or by calling **1-800-355–BLUE(2583)** or the number on the back of your ID card. If you do not currently have coverage with Horizon BCBSNJ you can view a sample policy here, **HorizonBlue.com/sample-benefit-booklets.** For additional coverage information, please see your Summary Plan Description (SPD), which is distributed by the Ironworkers Local 11 Welfare Fund and is also available on their website at www.ironnj.com.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	**$500** individual / **$1,000** family for out-of-network.	You must pay all the costs up to the **deductible** amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the **deductible** starts over (usually, but not always, January 1st). See the Common Medical Events chart for how much you pay for covered services after you meet the **deductible.**
Are there other deductibles for specific services?	Yes. Supplemental Services and Supplies, **$500** individual / **$1,000** family	This deductible is combined with the out-of-network deductible, then 20% coinsurance for In-Network and 30% coinsurance for out-of-network services applies. You must pay all of the costs for these services up to the specific **deductible** amount before this plan begins to pay for these services.
Is there an out-of-pocket limit on my expenses?	Yes. 10% of the allowable charges up to **$500** per individual per year for services that do not require a copayment for **In-Network services only.**	The **out-of-pocket limit** is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.
What is not included in the out-of-pocket limit?	Premiums, balance-billed charges, copayments, penalties for failure to obtain pre-authorization for services and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the **out–of–pocket limit**.
Is there an overall annual limit on what the plan pays?	No.	The Common Medical Events chart 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.HorizonBlue.com **or call 1-800-355-BLUE (2583)**	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 Common Medical Events chart for how this plan pays different kinds of **providers.**
Do I 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 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 the Services Your Plan Does Not Cover chart. See your policy or plan document for additional information about **excluded services**.

- **Co-payments** are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.
- **Co-insurance** 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 **co-insurance** payment of 20% would be $200. 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**.)
- This plan may encourage you to use participating **providers** by charging you lower **deductibles**, **co-payments** and **co-insurance** amounts.

Common Medical Event	Services 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	Primary care visit to treat an injury or illness	$25.00 Copayment per Office visit.	30% Coinsurance after deductible.	none
	Specialist visit	$30.00 Copayment per Specialist visit.	30% Coinsurance after deductible.	none
	Other practitioner office visit	$30.00 Copayment per visit.	30% Coinsurance after deductible.	In-network & Out-of-network chiropractic care / therapeutic manipulation, 30 visit annual limit.
	Preventive care/screening/immunization	$25.00 Copayment per Office visit. $30.00 Copayment per Specialist visit.	30% Coinsurance for after deductible.	One well visit/ physical per calendar year.
If you have a test	Diagnostic test (x-ray, blood work)	10% Coinsurance, up to $500 per indiv. / per year, for Office, Independent Laboratory, Inpatient Hospital, Outpatient Hospital.	30% Coinsurance for Office, Inpatient Hospital, Outpatient Hospital, Independent Laboratory after deductible.	Laboratory Corporation of America (LabCorp) is the only participating Lab in this Network in New Jersey.
	Imaging (CT/PET scans, MRIs)	10% Coinsurance, up to $500 p/indiv. p/year, for Office, Inpatient Hospital, Outpatient Hospital.	30% Coinsurance for Office, Inpatient Hospital, Outpatient Hospital after deductible.	Must be medically necessary.

Common Medical Event	Services 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 drugs to treat your illness or condition	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% coinsurance ($60 minimum copayment)	Not Covered	
	Specialty drugs	$50 minimum copayment and $100 maximum copay.	Not Covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	10% Coinsurance, up to $500 per indiv. per year, for Outpatient Hospital, Ambulatory Surgical Center.	30% Coinsurance for Outpatient Hospital, Ambulatory Surgical Center after deductible.	_____none_____
	Physician/surgeon fees	10% Coinsurance, up to $500 per individual per year, for Outpatient Hospital, Ambulatory Surgical Center.	30% Coinsurance for Outpatient Hospital, Ambulatory Surgical Center after deductible.	_____none_____

Common Medical Event	Services 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 immediate medical attention	Emergency room services	$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 deductible.	30% Coinsurance after Supplemental deductible.	Coinsurance after the Supplemental Services & Supplies Deductible has been met.
	Urgent care	$25.00 Copay per office visit, $30.00 Copay per Specialist visit.	30% Coinsurance for Office visit after deductible.	Applies only to out of hospital urgently needed care. Copayment will be assessed based on the provider type.
If you have a hospital stay	Facility fee (e.g., hospital room)	10% Coinsurance, up to $500 per individual per year, for Inpatient Hospital.	30% Coinsurance for Inpatient Hospital after deductible.	Requires pre-approval; 50% penalty applies for non-compliance. In-network & Out-of-network inpatient day limit is 365 days. In-network & Out-of-network inpatient separation period is 90 days.
	Physician/surgeon fee	10% Coinsurance, up to $500 p/indiv. per year, for Inpatient Hospital.	30% Coinsurance for Inpatient Hospital after deductible.	——none——
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	$25 copayment per visit	30% coinsurance after deductible	Treatment must be medically necessary. For in-patient services, whether in or out of network, pre-authorization is required by calling Managed Health Network (MHN) at 1-800-327-6517. Failure to obtain pre-authorization will result in non-payment of claim. Out of network deductible is combined with Medical out of network deductible. In-network in-patient services' coinsurance combined w/medical out-of-pocket maximum.
	Mental/Behavioral health inpatient services	10% coinsurance, up to $500 p/indiv. p/year	30% coinsurance after deductible	
	Substance use disorder outpatient services	$25 copayment per visit	30% coinsurance after deductible	
	Substance use disorder inpatient services	10% coinsurance, up to $500 p/indiv. p/year	30% coinsurance after deductible	

Common Medical Event	Services 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 are pregnant	Prenatal and postnatal care	$30.00 Copayment per initial Specialist visit.	30% Coinsurance for Office visit after ded.	Copay applies to initial visit only.
	Delivery and all inpatient services	10% Coinsurance, up to $500 per indivi. per year for Inpatient Hospital.	30% Coinsurance for Inpatient Hospital after deductible.	In-network & Out-of-network inpatient day limit is 365 days. In-network & Out-of-network inpatient separation period is 90 days.
If you need help recovering or have other special health needs	Home health care	10% Coinsurance, up to $500 per indiv. per year for Freestanding Facility.	30% Coinsurance for Freestanding Facility after deductible.	Requires pre-approval; 50% penalty applies for non-compliance. In-network & Out-of-network Home health care visit limit is 90 days.
	Rehabilitation services	10% Coinsurance, up to $500 per indiv. per year.	30% Coinsurance after deductible.	Requires pre-approval; 50% penalty applies for non-compliance. In-network & Out-of-network inpatient separation period is 90 days.
	Habilitative services	10% Coinsurance, up to $500 per indiv. per year, for Inpatient Hospital.	30% Coinsurance after deductible.	Requires pre-approval; 50% penalty applies for non-compliance. In-network & Out-of-network inpatient separation period is 90 days.
	Skilled nursing care	10% Coinsurance, up to $500 per indiv. per year for Inpatient Hospital.	30% Coinsurance for Inpatient Hospital after deductible.	Requires pre-approval; 50% penalty applies for non-compliance. Inpatient skilled nursing facility prior hospital day is limited to 3 days. In-network and out-of-network inpatient skilled nursing facility day limit is limited to 120 days.
	Durable medical equipment	20% Coinsurance after Supplemental Services deductible.	30% Coinsurance after Supplemental Services deductible.	Prior authorization required for DME purchases over $500.00. 50% penalty applies for non-compliance.
	Hospice service	10% Coinsurance, up to $500 per indiv. per year for Inpatient Hospital, Freestanding Facility.	30% Coinsurance for Inpatient Hospital, Freestanding Facility after deductible.	Requires pre-approval; 50% penalty applies for non-compliance. Limit to 10 respite days.

Common Medical Event	Services 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 your child needs dental or eye care	Eye exam	No charge when an in-network Davis Vision Network Provider is used.	Out-of-network routine eye exam and glasses combined is reimbursable up to $250 per covered person every 2 years.	This benefit is administered by Davis vision.
	Glasses	$130.00 Plus 20% discount on any overage or $180.00 Plus 20% discount at Visionworks location.		
	Dental check-up	No charge for preventive and diagnostic benefits when an in-network Delta Dental PPO Network Provider is used	No out-of-network coverage provided.	This benefit is administered by Delta Dental PPO.

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.)

- Acupuncture
- Cosmetic surgery
- Long-term care
- Non-emergency care when traveling outside the U.S. (or emergency care)
- Weight loss programs

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

- Bariatric surgery
- Chiropractic care
- Dental care (Adult & child)
- Hearing aids (Plan pays up to a maximum of $1,200 per ear for hearing aid, every 36 months. Effective 7/1/16, the benefit will increase to $2,200 per ear every 36 months)
- Infertility treatment
- Private-duty nursing
- Routine eye care (Adult & child)
- Routine foot care

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 plan at 1-800-355-BLUE (2583). 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** or file a **grievance**. For questions about your rights, this notice, or assistance, you can contact: Call **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**.

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 or policy 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.**

Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al **1-800-355-BLUE (2583)**.
Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa **1-800-355-BLUE (2583)**.
Chinese (中文): 如果需要中文的帮助，请拨打这个号码**1-800-355-BLUE (2583)**.
Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' **1-800-355-BLUE (2583)**.

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 three 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 also will be different.

See the next page for important information about these examples.

Having a baby
(normal delivery)

- **Amount owed to providers: $7,540.00**
- **Plan pays** $6,870.00
- **You pay** $670.00

Sample care costs:

Hospital charges (mother)	$2,700.00
Routine obstetric care	$2,100.00
Hospital charges (baby)	$900.00
Anesthesia	$900.00
Laboratory tests	$500.00
Prescriptions	$200.00
Radiology	$200.00
Vaccines, other preventive	$40.00
Total	**$7,540.00**

Patient pays:

Deductibles	$0.00
Co-pays	$30.00
Co-insurance	$470.00
Limits or exclusions	$170.00
Total	**$670.00**

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

- **Amount owed to providers: $5,400.00**
- **Plan pays** $1,970.00
- **You pay** $3,430.00

Sample care costs:

Prescriptions	$2,900.00
Medical Equipment and Supplies	$1,300.00
Office Visits and Procedures	$700.00
Education	$300.00
Laboratory tests	$100.00
Vaccines, other preventive	$100.00
Total	**$5,400.00**

Patient pays:

Deductibles	$0.00
Co-pays	$270.00
Co-insurance	$230.00
Limits or exclusions	$2,930.00
Total	**$3,430.00**

Questions and answers about Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

- Costs don't include **premiums**.
- 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.
- 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**, **co-payments**, and **co-insurance** 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 for each example. The smaller that number, the more coverage the plan provides.

Are there other costs I should consider when comparing plans?

✔ Yes. An important cost is the **premium** you pay. Generally, the lower your **premium**, the more you'll pay in out-of-pocket costs, such as **co-payments**, **deductibles**, and **co-insurance**. You should consider also 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.