
 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 www.1199nefunds.org or call 1-800-227-4744. 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 1-800-227-4744 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall <u>deductible</u> ?	<u>Deductible</u> \$ 500/Individual or \$1000/family	Generally, you must pay all of the costs from providers 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> .
Are there services covered before you meet your <u>deductible</u> ?	Yes. <u>Preventive care</u> and primary care services are covered before you meet your <u>deductible</u> .	This plan 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. For example, this plan 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 https://www.healthcare.gov/coverage/preventive-care-benefits/ .
Are there other <u>deductibles</u> for specific services?	Yes. Dental \$ 50/Individual or \$150/family	You must pay all costs for these services up to the specific <u>deductible</u> amount before this <u>plan</u> begins to pay for these services.
What is the <u>out-of-pocket limit</u> for this <u>plan</u> ?	\$1,250 individual/family; <u>Prescription Drugs</u> \$5,350 individual/ \$11,950 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> , 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.
What is not included in the <u>out-of-pocket limit</u> ?	<u>Premiums</u> , <u>balance-billing</u> , penalty fees, and healthcare 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 www.anthem.com or call toll-free 1-800-810-2583 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 plan's <u>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 provider's 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.
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.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		<u>In-Network Provider</u> (You will pay the least)	<u>Out-of-Network Provider</u> (You will pay the most)	
If you visit a health care <u>provider's</u> office or clinic	Primary care visit to treat an injury or illness	\$10 <u>copay</u> /office visit <u>deductible</u> does not apply	Not covered	Each participant is encouraged to designate a Primary Care Physician (PCP) by contacting the Welfare Fund at toll-free 1-800-227-4744 Option 4 or by mail or fax. <u>Out of Network providers</u> are not covered except in case of medical emergency.
	<u>Specialist</u> visit	20% <u>coinsurance</u>	Not covered	You can see the <u>specialist</u> you choose without a <u>referral</u> .
	<u>Preventive care/screening/</u> Immunization	No charge	Not covered	You may have to pay for services that aren't <u>preventive</u> . Ask your <u>provider</u> if the services you need are <u>preventive</u> . Then check what your <u>plan</u> will pay for.
	Other Practitioner Office visit	20% <u>coinsurance</u>	Not covered	Physical Therapy, Chiropractic services, and Acupuncture – Coverage is limited to 30 visits per calendar year (PCY). Occupational and Speech Therapy - Coverage is limited to combined 30 visit max PCY for both therapies.
If you have a test	<u>Diagnostic test</u> (x-ray, blood work)	20% <u>coinsurance</u>	Not covered	CT/PET scans, MRIs, Capsule Endoscopy, Genetic Testing (including BRCA), and Sleep Study require precertification. Contact the Welfare Fund at toll 1-800-227-4744 Option 4 to precertify. The precertification penalty of 20% of charges up to a \$500 maximum applies for failure to precertify.
	Imaging (CT/PET scans, MRIs)	20% <u>coinsurance</u>	Not covered	
If you need drugs to treat your illness or condition More information about <u>prescription drug coverage</u> is available at www.OptumRx.com	Generic drugs	\$10 <u>copay</u> /prescription (retail & mail order)	\$10 <u>copay</u> /prescription (retail* & mail order)	Covers up to a 30-day supply (retail prescription); 31-90 day supply (mail order prescription). OTC limited to <i>prescribed</i> Proton Pump Inhibitors and Non-Sedating Antihistamines, iron supplements, fluoride supplements for children ages 6 to 12 months, and aspirin therapy for the prevention of cardiovascular disease. *Subject to copay plus any amount over the network-allowed charge for non-participating pharmacies.
	Preferred brand drugs	\$30 <u>copay</u> /prescription (retail & mail order)	\$30 <u>copay</u> /prescription (retail* & mail order)	
	Over-the-Counter (OTC)	Lesser of \$10 <u>copay</u> / <u>prescription or Cost of the drug</u>	Lesser of \$10 <u>copay</u> / prescription or Cost of the drug*	

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		<u>In-Network Provider</u> (You will pay the least)	<u>Out-of-Network Provider</u> (You will pay the most)	
	<u>Specialty drugs</u>	\$30 <u>copay</u> /prescription (retail & mail order)	Not covered	All Specialty drugs have a quantity limitation and require prior authorization through the Prescription Solutions by OptumRx Specialty Pharmacy. Your doctor can call toll-free 1-800-711-4555, Option 1 for prior authorization. Quantity limitations apply to other medications as well.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% <u>coinsurance</u>	Not covered	All inpatient hospital admissions (excluding hospice) transplants, chemotherapy, radiation therapy, hyperbaric oxygen, and inpatient and outpatient surgery require precertification. You will have to pay a precertification penalty of 20% of charges up to a maximum of \$500 for failure to precertify. Contact the Welfare Fund at toll-free 1-800-227-4744 Option 4 to precertify. Emergency admission requires precertification notification by the next business day after an emergency or within 48 hours of admission for delivery of a newborn. A \$250 penalty applies for non-emergency use of the emergency room. <u>Out-of-network providers</u> are only covered in case of a medical emergency.
	Physician/surgeon fees	20% <u>coinsurance</u>	Not covered	
If you need immediate medical attention	<u>Emergency room care</u>	20% <u>coinsurance</u>	20% <u>coinsurance</u>	
	<u>Emergency medical transportation</u>	20% <u>coinsurance</u>	20% <u>coinsurance</u>	
	<u>Urgent care</u>	20% <u>coinsurance</u>	Not covered	
If you have a hospital stay	Facility fee (e.g., hospital room)	20% <u>coinsurance</u>	Not covered	
	Physician/surgeon fees	20% <u>coinsurance</u>	Not covered	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	20% <u>coinsurance</u>	Not covered	
	Inpatient services	20% <u>coinsurance</u>	Not covered	
If you are pregnant	Office visits	20% <u>coinsurance</u>	Not covered	Depending on the type of services, a <u>copayment</u> , <u>deductible</u> , and/or <u>coinsurance</u> may apply. Maternity expenses for dependent children <u>are not covered</u> .
	Childbirth/delivery professional services	20% <u>coinsurance</u>	Not covered	
	Childbirth/delivery facility services	20% <u>coinsurance</u>	Not covered	

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		<u>In-Network Provider</u> (You will pay the least)	<u>Out-of-Network Provider</u> (You will pay the most)	
If you need help recovering or have other special health needs	<u>Home health care</u>	20% <u>coinsurance</u>	Not covered	All skilled nursing care, home health care (excluding home hospice care), and DME rentals and purchases for electric/motorized wheelchairs or scooters require precertification. You will have to pay a precertification penalty of 20% of charges up to a maximum of \$500 for failure to precertify. Contact the Welfare Fund at toll-free 1-800-227-4744 Option 4 to precertify. Private Duty Nursing is not covered.
	<u>Rehabilitation services</u>	20% <u>coinsurance</u>	Not covered	
	<u>Habilitation services</u>	20% <u>coinsurance</u>	Not covered	
	<u>Skilled nursing care</u>	20% <u>coinsurance</u>	Not covered	
	<u>Durable medical equipment</u>	20% <u>coinsurance</u>	Not covered	
	<u>Hospice services</u>	20% <u>coinsurance</u>	Not covered	
If your child needs dental or eye care	Children's eye exam	No Charge	Excess over network allowable charge (allowable charge varies by type of lens)	<p>Up to age 13 – 1 exam/1 pair of glasses per yr. 13 & Over – 1 exam /1 pair of glasses every two years. If you choose an <u>out-of-network provider</u>, you must pay the provider directly for all charges and then submit a claim to Davis Vision for reimbursement.</p> <p>\$1000 annual maximum per individual. If you choose to visit a non-participating dentist, you will be responsible for payment. Delta Dental will reimburse you for the portion of your services covered by your program.</p>
	Children's glasses			
	Children's dental check-up	No Charge	No Charge unless over the network allowable charge or the procedure is not covered.	

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.)

- Convalescent facilities, group homes, halfway houses, nursing homes, rest homes and skilled nursing facilities.
- Cosmetic surgery
- Custodial Care
- Dietician
- Education (except diabetic education and training programs precertified by the Welfare Fund), training, and bed and board while confined in an institution that is mainly a school or other institution for training
- Genetic Testing (including BRCA) – requires precertification by the Welfare Fund
- Infant Formula, nutritional supplements and liquid food (except Total Parenteral Nutrition precertified by the Welfare Fund), regardless of age
- Infertility treatment
- Long Term Care.
- Non- Emergency care when traveling outside the U.S.
- Nutritionists – Covered only when ordered for a covered medical diagnosis.
- Off-label use of a drug
- Organ Transplants considered to be experimental, investigational or unproven.
- Out-of-Network medical providers are not covered except in case of a medical emergency.
- Over-the-counter drugs or non-prescription drugs including non-prescription prenatal vitamins (except for iron supplements, fluoride supplements for children ages 6 to 12 months, aspirin therapy to prevent cardiovascular disease, standard diabetic supplies, Proton Pump Inhibitors and Non-Sedating Antihistamines)
- Private Duty Nursing
- Rehabilitation Facilities (unless precertified by the Welfare Fund)
- Routine foot care (unless patient is diabetic or on prescription blood thinners)
- Services not medically necessary
- Weight Loss Programs
- Wigs - (Except if needed due to chemotherapy or radiation therapy in which case coverage is limited to two wigs per calendar year \$350/per wig)

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

- Acupuncture treatment performed by a licensed MD or DO. Limited to 30 visits per calendar year.
- Bariatric Surgery –covered when precertified by the Welfare Fund according to InterQual national guidelines and performed at a Blue Distinction Center.
- Chiropractic care -services limited to 30 visits per calendar year
- Dental care
- Hearing aids – Coverage limited to one appliance every 24 months up to \$200 per appliance per ear
- Routine Eye Care (Adult)
- Telemedicine (web-based, non-emergency visits with participating PCP)

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: 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. 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, you can contact the Fund Office at toll-free 1-800-227-4744. You may also refer to the Claim Review and Appeal Procedures section of your Summary Plan Description.

- 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.
- Additionally, a consumer assistance program can help you file your appeal.

Contact:

Connecticut Office of the Healthcare Advocate
P.O. Box 1543 Hartford, CT 06144
(866) 466-4446
www.ct.gov/oha
healthcare.advocate@ct.gov

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](#) \$500
- [Specialist coinsurance](#) 20%
- Hospital (facility) [coinsurance](#) 20%
- Other [coinsurance](#) 20%

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
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In this example, Peg would pay:

<i>Cost Sharing</i>	
Deductibles	\$500
Copayments	\$70
Coinsurance	\$750
<i>What isn't covered</i>	
Limits or exclusions	\$600
The total Peg would pay is	\$1,920

Managing Joe's type 2 Diabetes

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

- The [plan's](#) overall [deductible](#) \$500
- [Specialist coinsurance](#) 20%
- Hospital (facility) [coinsurance](#) 20%
- Other [coinsurance](#) 20%

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
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In this example, Joe would pay:

<i>Cost Sharing</i>	
Deductibles	\$500
Copayments	\$1,300
Coinsurance	\$10
<i>What isn't covered</i>	
Limits or exclusions	\$200
The total Joe would pay is	\$2,010

Mia's Simple Fracture

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

- The [plan's](#) overall [deductible](#) \$500
- [Specialist coinsurance](#) 20%
- Hospital (facility) [coinsurance](#) 20%
- Other [coinsurance](#) 20%

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
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In this example, Mia would pay:

<i>Cost Sharing</i>	
Deductibles	\$500
Copayments	\$0
Coinsurance	\$300
<i>What isn't covered</i>	
Limits or exclusions	\$0
The total Mia would pay is	\$800