
 **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>medical deductible</u> ?	<u>Deductible</u> \$ 900/Individual	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 preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/ .
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> ?	\$3,700 individual	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> . 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
		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	Tier 1 - \$10 <u>copay</u> Tier 2 - \$30 <u>copay</u>	Not covered	Spouse and dependent children are not eligible for benefits under this plan. Each participant should designate a Primary Care Physician (PCP) by contacting the Welfare Fund at toll-free 1-800-227-4744 Option 1 or by mail or fax. <u>Out of Network providers</u> are not covered except in case of medical emergency.
	<u>Specialist</u> (Office) visit	Tier 1 - \$30 <u>copay</u> * Tier 2 - 35% <u>coins</u>	Not covered	You can see the <u>specialist</u> you choose without a <u>referral</u> . *Specialist copay applies to OV only all other services are subject to deductible and coinsurance.
	<u>Preventive care/screening/immunization</u>	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. Spouse and dependent children are not eligible for benefits under this plan.
	Other Practitioner Office visit	Tier 1 - \$30 <u>copay</u> * Tier 2 - 35% <u>coins</u>	Not covered	Chiropractic services are limited to 30 visits per calendar year (PCY). *Specialist copay applies to OV only all other services are subject to deductible and coinsurance. Occupational (OT), Physical (PT) and Speech therapy (ST) and Acupuncture are not covered under this plan.
If you have a test	<u>Diagnostic test</u> (x-ray, blood work)	*Site of Service - <u>No charge</u> Non Designated - 35% <u>coins</u>	Not covered	* Site of service : Services provided at designated lab/xray providers - 100% coverage. CT/PET scans, MRIs, Capsule Endoscopy, Genetic Testing (including BRCA), and Sleep Study require precertification. Please contact Anthem at 1-877-284-0102. The pre-cert penalty of 20% of charges up to a \$500 maximum applies for failure to pre-certify.
	Imaging (CT/PET scans, MRIs)	*Site of Service - <u>No charge</u> Non Designated - 35% <u>coins</u>	Not covered	

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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)	
If you need drugs to treat your illness or condition More information about <u>prescription drug coverage</u> is available through EmpiRx	Tier 1 Generic drugs	Not covered	Not covered	-----NONE-----
	Tier 2 Formulary Brand Drugs	Not covered	Not covered	
	Tier 3 Non-Formulary Brand Drugs	Not covered	Not covered	
	<u>Specialty drugs</u>	Not covered	Not covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	Tier 1 – 10% <u>coins</u> Tier 2 – 35% <u>coins</u> <u>Tier 2 - \$200 Copay</u>	Not covered	All inpatient hospital admission (excluding hospice), chemotherapy, radiation therapy, hyperbaric oxygen, inpatient and certain 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 <u>copay</u> will apply to all ER visits. The copay will be waived if you are admitted into Hospital. <u>Out-of-Network providers</u> are only covered in case of a medical emergency. To pre-certify Inpatient/outpatient mental health and substance abuse contact 1-800-934-0331.
	Physician/surgeon fees	Tier 1 – 10% <u>coins</u> Tier 2 – 35% <u>coins</u>	Not covered	
If you need immediate medical attention	<u>Emergency room care (ER)</u>	\$250 <u>copay</u> * Coins will apply	\$250 <u>copay</u> * Coins will apply	
	<u>Emergency medical transportation</u>	Not covered	Not covered	
	<u>Urgent care</u>	\$50 <u>copay</u>	Not covered	
If you have a hospital stay	Facility fee (e.g., hospital room)	Tier 1 – 10% <u>coins</u> Tier 2 – 35% <u>coins</u> <u>Tier 2 - \$500 Copay</u>	Not covered	
	Physician/surgeon fees	Tier 1 – 10% <u>coins</u> Tier 2 – 35% <u>coins</u>	Not covered	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Tier 1 – 10% <u>coins</u> Tier 2 – 35% <u>coins</u>	Not covered	
	Inpatient services	Tier 1 – 10% <u>coins</u> Tier 2 – 35% <u>coins</u>	Not covered	
If you are pregnant	Office visits	Tier 1 - \$10 <u>copay</u> Tier 2 - \$30 <u>copay</u>	Not covered	Depending on the type of services, a <u>copayment</u> , <u>deductible</u> , and/or <u>coinsurance</u> may apply. Spouse and dependent children are not eligible for benefits under this plan.
	Childbirth/delivery professional services (Global charge)	Tier 1 – 10% <u>coins</u> Tier 2 – 35% <u>coins</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)	
	Childbirth/delivery facility services	Tier 1 – 10% <u>coins</u> Tier 2 – 35% <u>coins</u>	Not covered	
If you need help recovering or have other special health needs	<u>Home health care</u>	Not covered	Not covered	-----NONE-----
	<u>Rehabilitation services</u>	Not covered	Not covered	
	<u>Habilitation services</u>	Not covered	Not covered	
	<u>Skilled nursing care</u>	Not covered	Not covered	
	<u>Durable medical equipment</u>	Not covered	Not covered	
	<u>Hospice services</u>	Not covered	Not covered	This <u>plan</u> does not provide benefits for home hospice care.
If your child needs dental or eye care	Children's eye exam	Not covered	Not covered	Dependent children are not eligible for benefits under this plan.
	Children's glasses			
	Children's dental check-up	Not covered	Not covered	This <u>plan</u> does not provide Dental benefits.

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
- Convalescent facilities, group homes, halfway houses, nursing homes, rest homes and skilled nursing facilities.
- Cardiac and Pulmonary Rehab
- Cosmetic surgery
- Custodial Care
- Dental Care (Adults and Children)
- Dialysis
- 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
- Home Hospice Care
- Infant Formula, nutritional supplements and liquid food (except Total Parenteral Nutrition precertified by the Welfare Fund), regardless of age
- Infertility treatment
- Long Term Care.
- Medical services that are not performed in the physician's office and/or not performed in conjunction with inpatient hospitalization or outpatient surgery
- Non- Emergency care when traveling outside the U.S.
- Nutritionists – Covered only when ordered for a covered medical diagnosis
- Occupational Therapy
- 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 (OTC) or non-prescription drugs (including non-prescription prenatal vitamins, Proton Pump Inhibitors and Non-Sedating Antihistamines).
- Physical Therapy
- Prescription Drugs
- Private Duty Nursing
- Rehabilitation Facilities (unless precertified by the Welfare Fund)
- Routine Eye Care (Children)
- Routine foot care
- Services not medically necessary
- Speech Therapy
- Weight Loss Programs
- Wigs

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

- Bariatric Surgery –covered when precertified by the Welfare Fund according to InterQual national guidelines and performed at a Blue Distinction Center.
- Chiropractic care - limited to 30 visits per calendar year
- Medical services when performed in the physician's office (e.g. office visits, X-rays, laboratory services, etc.)
- Hearing aids – Coverage limited to one appliance every 24 months up to \$200 per appliance per ear.
- Routine Eye Care (Adult)
- Telemedicine- web-based covered through Anthem BC/BS

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	\$900
■ Specialist coinsurance	10%
■ Hospital (facility) coinsurance	10%
■ Other coinsurance	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	\$12,800
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In this example, Peg would pay:

<i>Cost Sharing</i>	
Deductibles	\$900
Copayments	\$0
Coinsurance	\$1,190
<i>What isn't covered</i>	
Limits or exclusions	\$0
The total Peg would pay is	\$2,090

Managing Joe's type 2 Diabetes

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

■ The plan's overall deductible	\$900
■ Specialist coinsurance	35%
■ Hospital (facility) coinsurance	35%
■ Other coinsurance	35%

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	\$900
Copayments	\$30
Coinsurance	\$160
<i>What isn't covered</i>	
Limits or exclusions	\$500
The total Joe would pay is	\$1,590

Mia's Simple Fracture

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

■ The plan's overall deductible	\$900
■ Specialist coinsurance	35%
■ Hospital (facility) coinsurance	35%
■ Other coinsurance	35%

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	\$900
Copayments	\$30
Coinsurance	\$60
<i>What isn't covered</i>	
Limits or exclusions	\$0
The total Mia would pay is	\$990

The [plan](#) would be responsible for the other costs of these EXAMPLE covered services.