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 medical deductible?	Deductible **$** 900/Individual or $1800/Family	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.
Are there services covered before you meet your deductible?	Yes. Preventive care and primary care services are covered before you meet your deductible.	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost-sharing and before you meet your deductible. See a list of covered preventive services **at https://www.healthcare.gov/coverage/preventive-care-benefits/.**
Are there other deductibles for specific services**?**	Yes. Dental **$** 50/Individual or $150/family	You must pay all 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?	Medical $3,700 individual/ $7,400 family; Prescription Drugs $4,850 individual/ $9,700 family	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.
What is not included in the out-of-pocket limit?	Premiums, balance-billing, penalty fees, and healthcare 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. See www.anthem.com or call toll-free 1-800-810-2583 for a list of network providers.	This plan uses a provider network. You will pay less if you use a provider in the plan's network. 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 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
		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 copay Tier 2 - $30 copay	Not covered	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. Out of Network providers are not covered except in case of medical emergency.
	Specialist (Office) visit charge	Tier 1 - $30 copay* Tier 2 – 35% coins	Not covered	You can see the specialist you choose without a referral. *Specialist copay applies to OV only all other services are subject to deductible and coinsurance.
	Preventive care/screening/ Immunization	No charge	Not covered	You may have to pay for services that aren't preventive. Ask your provider if the services you need are preventive. Then check what your plan will pay for.
	Other Practitioner Office visit	Tier 1 - $30 copay* Tier 2 – 35% coins	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. *Specialist copay applies to OV only all other services are subject to deductible and coinsurance. Prior Authorization is required for physical therapy and occupation therapy. Please contact Anthem to obtain precertification for these services at 1-877-284-0102.
If you have a test	Diagnostic test (x-ray, blood work)	*Site of Service – No charge Non Designated – 35% coins	Not covered	***Site of service**: Services provided at ***designated lab/x-ray providers*** - 100% coverage. CT/PET scans, MRIs, Capsule Endoscopy, Genetic Testing, and Sleep Study require pre-certification. Please contact Anthem at 1-877-284-0102. The precertification penalty of 20% of charges up to a $500 maximum applies for failure to pre-certify.
	Imaging (CT/PET scans, MRIs)	*Site of Service – No charge Non Designated – 35% coins	Not covered	

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 need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.EmpiRxhealth.com	Tier 1 Generic drugs	$15 copay/prescription (retail & mail order)	$15 copay/prescription (retail* & mail order)	Covers up to a 30-day supply (retail prescription); 31-90 day supply (mail order prescription). Over-the-Counter (OTC), including OTC Proton Pump Inhibitors and Non-Sedating Antihistamines, are not covered by the Fund except OTCs mandated under the Affordable Care Act (ACA). *Subject to copay plus any amount over the network-allowed charge for non-participating pharmacies. If you choose to use a branded medication instead of its generic equivalent, you will pay your plan's applicable brand copayment plus the difference between the brand and the equivalent generic alternative.
	Tier 2 Formulary Brand Drugs	$30 copay/prescription (retail & mail order)	$30 copay/prescription (retail* & mail order)	
	Tier 3 Non-Formulary Brand Drugs	$45 copay/prescription (retail & mail order)	$45 copay/prescription (retail* & mail order)	
	Specialty drugs	$45 copay/prescription (30-day supply)	Not covered	All Specialty drugs have a quantity limitation and require prior authorization through EmpiRx. Your doctor must call EmpiRx at toll-free 1-877-241-7123 to obtain prior authorization. Quantity limitations apply to other medications as well. All Specialty Drug Medications will be dispensed through EmpiRx Health Specialty Pharmacy.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	Tier 1 – 10% coins Tier 2 – 35% coins Tier 2 – $200 copay	Not covered	All inpatient hospital admissions (excluding hospice) transplants, chemotherapy, radiation therapy, hyperbaric oxygen, and 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 copay will apply to all ER visits. The copay will be waived if you are admitted into Hospital. Out-of-network providers are only covered in case of
	Physician/surgeon fees	Tier 1 – 10% coins Tier 2 – 35% coins	Not covered	
If you need immediate medical attention	Emergency room care (ER)	$250 copay* 35% coins	$250 copay* 35% coins	
	Emergency medical transportation	35% coins	35% coins	
	Urgent care	$50 copay	Not covered	
If you have a hospital stay	Facility fee (e.g., hospital room)	Tier 1 – 10% coins Tier 2 – 35% coins Tier 2 - $500 copay	Not covered	

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)	
	Physician/surgeon fees	Tier 1 – 10% coins Tier 2 – 35% coins	Not covered	a medical emergency. To pre-certify Inpatient/outpatient mental health and substance abuse contact 1-800-934-0331.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Tier 1 – 10% coins Tier 2 – 35% coins	Not covered	
	Inpatient services	Tier 1 – 10% coins Tier 2 – 35% coins	Not covered	
If you are pregnant	Office visits	Tier 1 - $10 copay Tier 2 - $30 copay	Not covered	Depending on the type of services, a copayment, deductible, and/or coinsurance may apply. (***Maternity expenses for dependent children are not covered***.)
	Childbirth/delivery professional services (Global charge)	Tier 1 – 10% coins Tier 2 – 35% coins	Not covered	
	Childbirth/delivery facility services	Tier 1 – 10% coins Tier 2 – 35% coins	Not covered	
If you need help recovering or have other special health needs	Home health care	Tier 1 – 10% coins Tier 2 – 35% coins	Not covered	All skilled nursing care, home health care (excluding home hospice care). 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.
	Rehabilitation services	Tier 1 – 10% coins Tier 2 – 35% coins	Not covered	
	Habilitation services	Tier 1 – 10% coins Tier 2 – 35% coins	Not covered	
	Skilled nursing care	Tier 1 – 10% coins Tier 2 – 35% coins	Not covered	
	Durable medical equipment	Tier 1 – 10% coins Tier 2 – 35% coins	Not covered	
	Hospice services	Tier 1 – 10% coins Tier 2 – 35% coins	Not covered	

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 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)	**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 out-of-network provider, you must pay the provider directly for all charges and then submit a claim to Davis Vision for reimbursement.
	Children's glasses			
	Children's dental check-up	No Charge	No Charge unless over the network allowable charge or the procedure is not covered.	**$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.

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 (OTC) or non-prescription drugs (including non-prescription prenatal vitamins, Proton Pump Inhibitors and Non-Sedating Antihistamines) except OTCs mandated under the Affordable Care Act (ACA).
- 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.

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 covered only 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 (Tier 1)*	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**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$900
Copayments	$0
Coinsurance	$1190
What isn't covered	
Limits or exclusions	$
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 (Tier 2)*	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**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$900
Copayments	$30
Coinsurance	$160
What isn't covered	
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 (Tier 2)*	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**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$900
Copayments	$30
Coinsurance	$60
What isn't covered	
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.