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 Summary Plan Description, go to http://www.ctironworkers.org/ or call (203) 238-1204. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms see the Glossary at https://www.dol.gov/sites/dolgov/files/EBSA/laws-and-regulations/laws/affordable-care-act/for-employers-and-advisers/sbc-uniform-glossary-of-coverage-and-medical-terms-3.pdf or call (203) 238-1204 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	In-network: Individual $500/Family $1,000; Out-of-network: Individual $2,000/Family $4,000.	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 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?	No.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	In-network: Individual $3,000/Family $6,000; Out-of-network: Individual $4,000/Family $8,000 (Medical). Individual $1,000/Family $2,000 (Prescription Drug).	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-billed charges, expenses that are reimbursed at less the Plan rate coinsurance, 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.
Will you pay less if you use a network provider?	Yes - See www.anthem.com or call 1-833-899-7070 for a list of In-Network Providers.	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 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	The deductible and then 20% coinsurance until the Maximum out-of-pocket expense is met.*	The deductible and then 40% coinsurance until the Maximum out-of-pocket expense is met.	None.
	Specialist visit			
	Preventive care/screening/ immunization	No Charge		Age and frequency schedules may apply. You may have to pay for services that aren't 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)	The deductible and then 20% coinsurance until the Maximum out-of-pocket expense is met.*	The deductible and then 40% coinsurance until the Maximum out-of-pocket expense is met.	No copayment with respect to a blood test, or blood tests, associated solely with a routine physical examination of a Member and his or her Spouse.
	Imaging (CT/PET scans, MRIs)			None.
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at anthem.com	Generic drugs	20% of the prescription's cost	20% of the prescription's cost	Covers up to 30-day supply (retail); 31-90 day supply (mail order). Viagra and related drugs are limited to 10 tablets per month. Mandatory generic with Dispense as Written (DAW) override. If brand requested when generic available and doctor has not specified that the brand is Medically Necessary, then you pay the difference in drug cost. No charge for formulary generic FDA-approved women's contraceptives in-network.
	Preferred brand drugs			
	Non-preferred brand drugs			
	Specialty drugs			
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	The deductible and then 20% coinsurance until the	The deductible and then 40% coinsurance until the	None.

*This SBC applies to those that met the Fund's Health Enhancement Program (HEP) requirements.

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)	
	Physician/surgeon fees	Maximum out-of-pocket expense is met*	Maximum out-of-pocket expense is met.	
If you need immediate medical attention	Emergency room care	$150 copay per visit, plus deductible and 20% coinsurance*	$150 copay per visit, plus deductible and 20% coinsurance	Copay waived if admitted.
	Emergency medical transportation	The deductible and then 20% coinsurance until the Maximum out-of-pocket expense is met.*	The deductible and then 40% coinsurance until the Maximum out-of-pocket expense is met.	For both Network and Out-of-Network providers of ground ambulance only, you will pay the deductible and then 20% coinsurance until the Maximum out-of-pocket expense is met.
	Urgent care			
If you have a hospital stay	Facility fee (e.g., hospital room)	The deductible and then 20% coinsurance until the Maximum out-of-pocket expense is met.*	The deductible and then 40% coinsurance until the Maximum out-of-pocket expense is met.	Pre-certification required for out-of-network care.
	Physician/surgeon fees			None.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	The deductible and then 20% coinsurance until the Maximum out-of-pocket expense is met.*	The deductible and then 40% coinsurance until the Maximum out-of-pocket expense is met.	None.
	Inpatient services			Pre-certification required for out-of-network care.
If you are pregnant	Office visits	The deductible and then 20% coinsurance until the Maximum out-of-pocket expense is met.*	The deductible and then 40% coinsurance until the Maximum out-of-pocket expense is met.	None.

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For more information about limitations and exceptions, see the Plan or Policy Document at: http://www.ctironworkers.org/ or call the Fund Office.

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)	
	Childbirth/delivery professional services			
	Childbirth/delivery facility services			
If you need help recovering or have other special health needs	Home health care	The deductible and then 20% coinsurance until the Maximum out-of-pocket expense is met.*	The deductible and then 40% coinsurance until the Maximum out-of-pocket expense is met.	Coverage is limited to 80 visits per calendar year. Pre-certification required for out-of-network care.
	Rehabilitation services	The deductible and then 20% coinsurance until the Maximum out-of-pocket expense is met.*	The deductible and then 40% coinsurance until the Maximum out-of-pocket expense is met.	Coverage is limited to 60 visits for Speech, Physical and Occupational Therapy combined.
	Habilitation services	Not Covered	Not Covered	You must pay 100% of these costs.
	Skilled nursing care	The deductible and then 20% coinsurance until the Maximum out-of-pocket expense is met.*	The deductible and then 40% coinsurance until the Maximum out-of-pocket expense is met.	Coverage is limited to 60 days per calendar year. Pre-certification required for out-of-network care.
	Durable medical equipment	The deductible and then 20% coinsurance until the Maximum out-of-pocket expense is met.*	The deductible and then 40% coinsurance until the Maximum out-of-pocket expense is met.	None.
	Hospice services			Lifetime maximum of 90 days. Pre-certification required for out-of-network care.
If your child needs dental or eye care	Children's eye exam (provided through EyeMed; (https://eyemed.com/en-us)	No Charge	Anything over $40 per exam.	Limited to 1 routine vision exam every plan year.
	Children's glasses (also provided through EyeMed)	20% of balance over $200 allowance for the frames. Copay amounts vary based on the lenses type.	Anything over $105 for frames and reimbursement amounts vary based on the lenses type.	Limited to 1 pair of glasses every other plan year.
	Children's dental check-up (provided through Delta Dental; (800) 452-9310 or www.deltadentalct.com)	No Charge	Any balance billing	Coverage is provided under Active program only. Limit: two cleanings/exams per calendar year, subject to certain exceptions.

*This SBC applies to those that met the Fund's Health Enhancement Program (HEP) requirements.

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.)

- Cosmetic Surgery
- Routine foot care
- Long-term Care
- Weight loss programs
- Habilitation services
- Non-emergency care when traveling outside the U.S.

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

- Acupuncture (18 visits/calendar year)
- Dental Care (Adult); Active program only
- Private-duty nursing
- Bariatric Surgery
- Hearing aids - Active program only; provided through UConn Speech & Hearing
- Chiropractic Care (35 visits /calendar year)
- Infertility treatment
- Routine Eye Care (Adult)

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 the 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 the plan at (203) 238-1204. 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 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 (203) 238-1204

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa (203) 238-1204

Chinese (中文): 如果需要中文的帮助，请拨打这个号码 (203) 238-1204

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' (203) 238-1204

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

*This SBC applies to those that met the Fund's Health Enhancement Program (HEP) requirements.

For more information about limitations and exceptions, see the Plan or Policy Document at: http://www.ctironworkers.org/ or call the Fund Office.

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 *copayment*	$0

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	$500
Copayments	$0
Coinsurance	$2,340
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$2,900**

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 *copayment*	$0

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	$500
Copayments	$0
Coinsurance	$740
What isn't covered	
Limits or exclusions	$0
The total Joe would pay is	**$1,240**

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 *copayment*	$150

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	$150
Coinsurance	$430
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,080**

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