
 **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 or 1-800-982-3709 (toll free). 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/default/files/ebsa/laws-and-regulations/laws/affordable-care-act/for-employers-and-advisers/sbc-uniform-glossary-of-coverage-and-medical-terms-final.pdf> or call (203) 238-1204 or 1-800-982-3709 (toll free) to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall <u>deductible</u>?	In-network: Individual \$1,500/Family \$3,000; Out-of-network: Individual \$3,000/Family \$6,000.	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> services are covered before you meet your <u>deductible</u> .	This <u>plan</u> 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 <u>plan</u> 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?	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>?	In-network: Individual \$4,500/Family \$9,000; Out-of-network: Individual \$6,000/Family \$12,000 (Medical). Individual \$2,000/Family \$4,000 (Prescription Drug).	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>?	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 <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 1-888-287-0032 for a list of In-Network Providers.	This <u>plan</u> uses a provider <u>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
		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 30% coinsurance until the Maximum out-of-pocket expense is met.*	The deductible and then 50% 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 30% coinsurance until the Maximum out-of-pocket expense is met.*	The deductible and then 50% 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	30% of the prescription's cost	30% 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 30% coinsurance until the Maximum out-of-pocket expense is met.*	The deductible and then 50% coinsurance until the Maximum out-of-pocket expense is met.	None.
	Physician/surgeon fees			
If you need immediate medical attention	Emergency room care	\$300 copay per visit, plus deductible and 30% coinsurance *	\$300 copay per visit, plus deductible and 30% coinsurance	Copay waived if admitted.
	Emergency medical	The deductible and then	The deductible and then 50%	None.

*This SBC applies to those that did not meet 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.

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)	
	transportation	30% coinsurance until the Maximum out-of-pocket expense is met.*	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 30% coinsurance until the Maximum out-of-pocket expense is met.*	The deductible and then 50% 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 30% coinsurance until the Maximum out-of-pocket expense is met.*	The deductible and then 50% 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 30% coinsurance until the Maximum out-of-pocket expense is met.*	The deductible and then 50% coinsurance until the Maximum out-of-pocket expense is met.	None.
	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 30% coinsurance until the Maximum out-of-pocket expense is met.*	The deductible and then 50% 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 30% coinsurance until the Maximum out-of-pocket expense is met.*	The deductible and then 50% 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 30% coinsurance until the Maximum out-of-pocket expense is met.*	The deductible and then 50% 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 30% coinsurance until the Maximum out-of-pocket expense is met.*	The deductible and then 50% 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;	No Charge	Anything over \$40 per exam.	Limited to 1 routine vision exam every plan year.

*This SBC applies to those that did not meet 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.

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)	
	(https://eyemed.com/en-us)			
	Children's glasses (also provided through EyeMed)	20% off 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.deltadental.com)	No Charge	Any balance billing	Coverage is provided under Active program only and is limited to 2 exams every calendar year.

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
- 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 or 1-800-982-3709 (toll free). 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](#).

*This SBC applies to those that did not meet 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.

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 or 1-800-982-3709 (toll free)

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa (203) 238-1204 or 1-800-982-3709 (toll free)

Chinese (中文): 如果需要中文的帮助, 请拨打这个号码 (203) 238-1204 or 1-800-982-3709 (toll free)

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijigo holne' (203) 238-1204 or 1-800-982-3709 (toll free)

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 did not meet 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	\$1,500
■ Specialist coinsurance	30%
■ Hospital (facility) coinsurance	30%
■ 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	\$1,500
Copayments	\$0
Coinsurance	\$3,000
What isn't covered	
Limits or exclusions	\$60
The total Peg would pay is	\$4,560

Managing Joe's type 2 Diabetes

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

■ The plan's overall deductible	\$1,500
■ Specialist coinsurance	30%
■ Hospital (facility) coinsurance	30%
■ 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	\$1,500
Copayments	\$0
Coinsurance	\$290
What isn't covered	
Limits or exclusions	\$0
The total Joe would pay is	\$1,790

Mia's Simple Fracture

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

■ The plan's overall deductible	\$1,500
■ Specialist coinsurance	30%
■ Hospital (facility) coinsurance	30%
■ Other copayment	\$0

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	\$1,500
Copayments	\$0
Coinsurance	\$390
What isn't covered	
Limits or exclusions	\$0
The total Mia would pay is	\$1,890