



The Summary of Benefits and Coverage (SBC) document shows you how you and the [plan](#) would share the cost for covered health care services. **NOTE: This SBC applies to Wage Class II Eligible Participants.** If you are not sure what your wage classification is, reach out to the Fund Office Toll Free 1-800-227-4744 or Local 1-860-728-1100. Information about the cost of this [plan](#) (called the [premium](#)) including eligible spouse premium will be provided separately. This SBC is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, visit [www.1199.nefunds.org](http://www.1199.nefunds.org) or call the Fund Office. For general definitions of common terms, such as [allowed amount](#), [balance billing](#), [coinsurance](#), [copayment](#), [deductible](#), [provider](#), or other underlined terms, see the Glossary included in this packet. You can also view the Glossary at [www.1199.nefunds.org](http://www.1199.nefunds.org) or call the Fund Office to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall <a href="#">deductible</a> ?	\$900/Individual or \$1800 Family	Generally, you must pay all the costs from <a href="#">providers</a> up to the <a href="#">deductible</a> amount before this <a href="#">plan</a> begins to pay. If you have other family members on the <a href="#">plan</a> ; each family member must meet their own individual <a href="#">deductible</a> until the total amount of <a href="#">deductible</a> expenses paid by all family members meet the overall family <a href="#">deductible</a> .
Are there services covered before you meet your <a href="#">deductible</a> ?	Yes. <a href="#">Preventive care, and primary care services are covered before you meet your deductible</a>	This <a href="#">plan</a> covers some items and services even if you haven't yet met the <a href="#">deductible</a> amount. But a <a href="#">copayment</a> or <a href="#">coinsurance</a> may apply for some services even if you did not meet the <a href="#">deductible</a> amount. You can access a list of covered preventive services at <a href="https://www.healthcare.gov/coverage/preventive-care-benefits/">https://www.healthcare.gov/coverage/preventive-care-benefits/</a> .
What is the <a href="#">out-of-pocket limit</a> for this <a href="#">plan</a> ?	\$3,700/Individual/\$7,400/Family	The <a href="#">out-of-pocket limit</a> is the most you would pay in a year for covered services. If you have other family members in this <a href="#">plan</a> , they must meet their own <a href="#">out-of-pocket limits</a> until the overall family <a href="#">out-of-pocket limit</a> has been met.
What is not included in the <a href="#">out-of-pocket limit</a> ?	<a href="#">Premiums, balance billing, penalty fees and healthcare not covered by this plan</a>	These types of expenses, while considered out of pocket, do not count toward the <a href="#">out-of-pocket limit</a> .
Will you pay less if you use a <a href="#">network provider</a> ?	Yes. Network Providers can be found at <a href="http://www.anthem.com">www.anthem.com</a> or by calling Toll Free 1-800-810-2583	Services provided by an <a href="#">out-of-network provider</a> are not covered by this <a href="#">plan</a> . Always check to see if your provider is in the Anthem/BC/BS network including any other providers and/or lab facilities you are referred to for services.
Do you need a <a href="#">referral</a> to see a <a href="#">specialist</a> ?	No	You can see the <a href="#">specialist</a> you choose without a referral if they are in the network. Otherwise, you will pay out of pocket for any expenses incurred by an <a href="#">out-of-network provider</a> .



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 <a href="#">provider's</a> office or clinic	<b>Primary care visit to treat an injury or illness</b>	Tier 1 - \$10 <u>copay</u> Tier 2 - \$30 <u>copay</u>	Not Covered	<u>Out of network providers</u> are not covered except in case of medical emergency.
	<b><a href="#">Specialist</a> visit</b>	Tier 1 - \$30 <u>copay*</u> Tier 2 – 35% <u>coinsurance</u>	Not Covered	You can choose any Network <u>Specialist</u> without a <u>referral</u> – <u>Out of network providers</u> are not covered.
	<b><a href="#">Preventive care/screening/immunization</a></b>	No Charge	Not Covered	Ask your <u>provider</u> to make sure the services being provided are <u>preventive</u> ; if they are not <u>preventive</u> , check your <u>plan</u> to understand your cost and what the <u>plan</u> pays.
	<b>Other <u>Provider</u> Services</b>	Tier 1 - \$30 <u>copay*</u> Tier 2 – 35% <u>coinsurance</u>	Not Covered	Coverage is limited to 30 visits per calendar year for Physical Therapy, Chiropractic services, and Acupuncture. Coverage is limited to 30 visits max per calendar year for both Occupational and Speech Therapy. Prior Authorization is required for Occupational, Physical and Speech Therapy. Call HealthLink to obtain approval at 1-877-284-0102.
If you have a test	<b><a href="#">Diagnostic test</a> (x-ray, blood work)</b>	Site of Service No Charge Non-Designated – 35% <u>coinsurance</u>	Not Covered	Services provided at Site of Service/Designated lab/x-ray <u>providers</u> – are paid at 100%. CT/PET scans, MRIs, Capsule Endoscopy, Genetic Testing, and Sleep Study require pre-certification. Call HealthLink to obtain approval at 1-877-284-0102. A 20% penalty for a maximum of \$500 applies for failure to obtain pre-approval.
	<b>Imaging (CT/PET scans, MRIs)</b>	Site of Service No Charge Non-Designated – 35% <u>coinsurance</u>	Not Covered	

[\* Specialist copay applies to Office Visit only. All other services are subject to deductible and coins) For more information about limitation and exclusions, see the [plan](#) or policy document at ([www.1199.nefunds.org](http://www.1199.nefunds.org))

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)	
<b>If you need drugs to treat your illness or condition</b> More information about <a href="#">prescription drug coverage</a>	<b>Tier 1</b> Generic drugs	Not Covered	Not Covered	
	<b>Tier 2</b> Formulary brand drugs	Not Covered	Not Covered	
	<b>Tier 3</b> Non-Formulary brand drugs	Not Covered	Not Covered	
	<a href="#">Specialty drugs</a>	Not Covered	Not Covered	
<b>If you have outpatient surgery</b>	Facility fee (e.g., ambulatory surgery center)	<b>Tier 1</b> – 10% <u>coins</u> <b>Tier 2</b> – 35% <u>coins</u> <b>Tier 2</b> - \$200 <u>copay</u>	Not Covered	Certain outpatient surgery requires prior authorization. Refer to the plan document for a list of services. A 20% penalty for a maximum of \$500 applies for failure to obtain pre-approval. . Call HealthLink to obtain approval at 1-877-284-0102.
	Physician/surgeon fees	<b>Tier 1</b> – 10% <u>coins</u> <b>Tier 2</b> – 35% <u>coins</u>	Not Covered	
<b>If you need immediate medical attention</b>	<a href="#">Emergency room care</a>	\$250 <u>copay</u> 10% <u>coins</u>	\$250 <u>copay</u> 10% <u>coins</u>	<b>Emergency services</b> means screening (to evaluate a medical condition) and stabilization (medical examination and treatment needed to stabilize the patient) services with respect to a medical condition that is characterized by acute symptoms of sufficient severity (including severe pain) that a reasonable layperson would expect the absence of medical attention to place the health of the individual in serious jeopardy.
	<a href="#">Emergency medical transportation</a>	10% <u>coins</u>	10% <u>coins</u>	

[\* Specialist copay applies to Office Visit only. All other services are subject to deductible and coins) For more information about limitation and exclusions, see the [plan](#) or policy document at ([www.1199.nefunds.org](http://www.1199.nefunds.org))

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)	
	<a href="#">Urgent care</a>	\$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> Tier 2 - \$500 <u>copay</u>	Not Covered	If admitted inpatient because of an <u>emergency room visit</u> , \$250 copay that applies to emergency room visits will be waived.
	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	Certain services require prior authorization. Refer to the plan document for a list of services. If a service requires pre-authorization, it must be pre-approved by calling HealthLink Behavioral Health Utilization Services at 1-877-284-0102. A 20% penalty for a maximum of \$500 applies for failure to obtain pre-approval.
	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	There may be some services where a copay, deductible may apply. <b>Maternity expenses for dependent children are not covered.</b>
	Childbirth/delivery professional services	Tier 1 – 10% <u>coins</u> Tier 2 – 35% <u>coins</u>	Not Covered	
	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	<a href="#">Home health care</a>	Tier 1 – 10% <u>coins</u> Tier 2 – 35% <u>coins</u>	Not Covered	All <u>skilled nursing care</u> and <u>home health care</u> (excluding home hospice care) require <u>pre-authorization</u> . . A 20% penalty for a maximum of \$500 applies for failure to
	<a href="#">Rehabilitation services</a>	Tier 1 – 10% <u>coins</u>	Not Covered	

[\* Specialist copay applies to Office Visit only. All other services are subject to deductible and coins) For more information about limitation and exclusions, see the [plan](#) or policy document at ([www.1199.nefunds.org](http://www.1199.nefunds.org))

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)	
		Tier 2 – 35% <u>coins</u>		obtain pre-approval. . Call HealthLink to obtain approval at 1-877-284-0102.
	<a href="#">Habilitation services</a>	Tier 1 – 10% <u>coins</u> Tier 2 – 35% <u>coins</u>	Not Covered	
	<a href="#">Skilled nursing care</a>	Tier 1 – 10% <u>coins</u> Tier 2 – 35% <u>coins</u>	Not Covered	
	<a href="#">Durable medical equipment</a>	Tier 1 – 10% <u>coins</u> Tier 2 – 35% <u>coins</u>	Not Covered	
	<a href="#">Hospice services</a>	Tier 1 – 10% <u>coins</u> Tier 2 – 35% <u>coins</u>	Not Covered	
<b>If your child needs dental or eye care</b>	Children’s eye exam	Zero copay	Services are paid by you when rendered – with limited allowable amounts for the services	When you use <u>out of network providers</u> you submit the claim directly to the vision carrier after you have directly paid the <u>provider</u> . For more detailed plan information call Davis Vision at 1-877-923-2847.
	Children’s glasses	Zero copay	Services are paid by you when rendered – with limited allowable amounts for the services	When you use <u>out of network providers</u> you submit the claim directly to the vision carrier after you have directly paid the <u>provider</u> . For more detailed plan information call Davis Vision at 1-877-923-2847.
	Children’s dental check-up	Not Covered	Not Covered	No Dental Coverage with this Plan.

[\* Specialist copay applies to Office Visit only. All other services are subject to deductible and coins) For more information about limitation and exclusions, see the [plan](#) or policy document at ([www.1199.nefunds.org](http://www.1199.nefunds.org))

## Excluded Services & Other Covered Services:

### Services Your [Plan](#) Generally Does NOT Cover (Check your policy or [plan](#) document for more information and a comprehensive list of any other excluded services.)

- Convalescent facilities, group homes, halfway houses, nursing homes, rest homes
- Custodial care
- Cosmetic surgery
- Dental care
- Dietician services
- Infertility treatment
- Long Term care
- Non-Emergency care when traveling outside the U.S.
- Nutritionists unless done in conjunction with a covered diagnosis
- Organ transplant
- Over the counter drugs
- Prescription drug Coverage
- Private duty nursing
- Services not medically necessary
- Weight loss programs
- Wigs – unless 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 Medical Doctor, Doctor of Osteopathy or Licensed Acupuncturist
- Skilled nursing facilities for short term rehabilitation and pre-authorization
- Bariatric surgery with pre-authorization
- Genetic testing with pre-authorization and meets plan criteria
- Chiropractic care services limited to 30 visits per calendar year
- Hearing aids – limited to one appliance every 24 months up to \$200 per appliance per ear
- Out of Network medical providers only in case of medical emergency
- Routine eye care
  - **Up to age 13** – 1 exam/1 pair of glasses per year
  - **13 & Over** – 1 exam/1 pair of glasses every two years.
  - If you chose an out-of-network provider, you must pay the provider directly for all charges and then submit a claim to Davis Vision directly for reimbursement
- Telemedicine covered only using LiveHealth services through Anthem

[\* Specialist copay applies to Office Visit only. All other services are subject to deductible and coins) For more information about limitation and exclusions, see the [plan](#) or policy document at ([www.1199.nefunds.org](http://www.1199.nefunds.org))

**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 US Department of Health and Human Services( HHS) at 1-877-267-2323, Department of Labor( DOL) Employee Benefits Security Administration at 1-866-444-3272 or [www.dol.gov/ebsa](http://www.dol.gov/ebsa). Other coverage options may be available to you, including buying individual insurance coverage through the [Health Insurance Marketplace](#). For more information about the [Marketplace](#), visit [www.HealthCare.gov](http://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 on how 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 Fund Office Toll Free at 1-800-227-4744 or Local at 1-860-728-1100.

**Additionally, a consumer assistance program** can help you file your appeal by contacting the Connecticut Office of the Healthcare Advocate at [www.ct.gov/oha](http://www.ct.gov/oha), [healthcare.advocate@ct.gov](mailto:healthcare.advocate@ct.gov) or Toll free at 1-866-466-4446. You can also write to them at:

Connecticut Office of the Healthcare Advocate  
P.O.Box 1543  
Hartford, CT 06144

**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 [insert telephone number 1-804-673-1177].]

[Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa [1-804-673-1177].]

[Chinese (中文): 如果需要中文的帮助, 请拨打这个号码[1-804-673-1177].]

[Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijigo holne' [1-804-673-1177].]

**PRA Disclosure Statement:** According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is **0938-1146**. The time required to complete this information collection is estimated to average **0.08** hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

*To see examples of how this [plan](#) might cover costs for a sample medical situation, see the next section.*

[\* Specialist copay applies to Office Visit only. All other services are subject to deductible and coins) For more information about limitation and exclusions, see the [plan](#) or policy document at ([www.1199.nefunds.org](http://www.1199.nefunds.org))

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](#). 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](#) [[copay Tier 1](#)] \$30
- Hospital (facility) [[coinsurance Tier 1](#)] 10%
- Other [[coinsurance Tier 1](#)] 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*)

<b>Total Example Cost</b>	<b>\$12,800</b>
---------------------------	-----------------

In this example, Peg would pay:

**Cost Sharing**

<a href="#">Deductibles</a>	\$900
<a href="#">Copayments</a>	\$30
<a href="#">Coinsurance</a>	\$1190

*What isn't covered*

Limits or exclusions	\$
----------------------	----

<b>The total Peg would pay is</b>	<b>\$2120</b>
-----------------------------------	---------------

**Managing Joe's Type 2 Diabetes**

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

- The [plan's](#) overall [deductible](#) \$900
- Primary Care [[coinsurance Tier 2](#)] \$30
- 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*)

<b>Total Example Cost</b>	<b>\$7,400</b>
---------------------------	----------------

In this example, Joe would pay:

**Cost Sharing**

<a href="#">Deductible</a>	\$900
<a href="#">Copayment</a>	\$30
<a href="#">Coinsurance</a>	\$2275

*What isn't covered*

Limits or exclusions	\$0
----------------------	-----

<b>The total Joe would pay is</b>	<b>\$3205</b>
-----------------------------------	---------------

**Mia's Simple Fracture**

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

- The [plan's](#) overall [deductible](#) \$900
- [Specialist](#) [[coinsurance Tier 2](#)] 35%
- Emergency room [[copayment](#)] \$250
- Other [[coinsurance Tier 2](#)] 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*)

<b>Total Example Cost</b>	<b>\$2,800</b>
---------------------------	----------------

In this example, Mia would pay:

**Cost Sharing**

<a href="#">Deductibles</a>	\$900
<a href="#">Copayments</a>	\$250
<a href="#">Coinsurance</a>	\$665

*What isn't covered*

Limits or exclusions	\$0
----------------------	-----

<b>The total Mia would pay is</b>	<b>\$1815</b>
-----------------------------------	---------------