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 III 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. 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 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 or call the Fund Office to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	**$900/Individual**	Generally, you must pay all the costs from providers up to the deductible amount before this plan begins to pay.
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 some services even if you did not meet the deductible amount. You can access a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/.
Are there other deductibles for specific services	**No**	
What is the out-of-pocket limit for this plan?	**$3,700/Individual**	The out-of-pocket limit is the most you would pay in a year for covered services.
What is not included in the out-of-pocket limit?	**Premiums, balance billing, penalty fees and healthcare not covered by this plan**	These types of expenses, while considered out of pocket, do not count toward the out-of-pocket limit.
Will you pay less if you use a network provider?	**Yes. Network Providers can be found at www.Anthem.com or by calling Toll Free 1-800-810-2583**	Services provided by an out-of-network provider are not covered by this plan. 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 referral to see a specialist?	**No**	You can see the specialist you choose without a referral if they are in the network. Otherwise, you will pay out of pocket for any expenses incurred by an out-of-network provider.

All **copayment** and **coinsurance** costs shown in this chart are after your **deductible** has been met, if a **deductible** applies.

What You Will Pay				
Common Medical Event	**Services You May Need**	**Network Provider (You will pay the least)**	**Out-of-Network Provider (You will pay the most)**	**Limitations, Exceptions, & Other Important Information**
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	Out of network providers are not covered except in case of medical emergency.
	Specialist visit	Tier 1 - $30 copay* Tier 1 – 10% coinsurance Tier 2 – 35% coinsurance	Not Covered	You can choose any Network Specialist without a referral – Out of network providers are not covered.
	Preventive care/screening/ immunization	No Charge	Not Covered	Ask your provider to make sure the services being provided are preventive; if they are not preventive, check your plan to understand your cost and what the plan pays.
	Other Provider Services	Tier 1 - $30 copay* Tier 2 – 35% coinsurance	Not Covered	Coverage is limited to 30 visits per calendar year for Chiropractic services. Occupational, Physical, Speech Therapy and acupuncture are not covered in this plan.
If you have a test	**Diagnostic test (x-ray, blood work)**	Site of Service No Charge Non-Designated – 35% coinsurance	Not Covered	Services provided at Site of Service/Designated lab/x-ray providers – are paid at 100% including office-based x-ray/lab. CT/PET scans, MRIs, Capsule Endoscopy, Genetic Testing, and Sleep Study require pre-certification. Call HealthLink for approval at 1-877-284-0102. A 20% penalty for a maximum of $500 applies for failure to obtain pre-approval
	Imaging (CT/PET scans, MRIs)	Site of Service No Charge Non-Designated – 35% coinsurance	Not Covered	
If you need drugs to treat your illness or condition More information about **prescription drug coverage**	**Tier 1** Generic drugs	Not Covered	Not Covered	
	Tier 2 Formulary brand drugs	Not Covered	Not Covered	
	Tier 3 Non-Formulary brand drugs	Not Covered	Not Covered	

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

What You Will Pay				
Common Medical Event	**Services You May Need**	**Network Provider (You will pay the least)**	**Out-of-Network Provider (You will pay the most)**	**Limitations, Exceptions, & Other Important Information**
	Specialty drugs	Not Covered	Not Covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	**Tier 1** – 10% coins **Tier 2** – $200 copay 35% coins	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 for approval at 1-877-284-0102.
	Physician/surgeon fees	**Tier 1** – 10% coins **Tier 2** – 35% coins	Not Covered	
If you need immediate medical attention	Emergency room care	**Tier 1** – $250 copay 10% coins **Tier 2** – $250 copay 35% coins	**Treated as:** **Tier 1**- $250 copay 10% coins	**Emergency services** 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.
	Emergency medical transportation	**Tier 1** - 10% coins **Tier 2** – 35% coins	**Treated as:** **Tier 1**- 10%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	If admitted inpatient because of an emergency room visit, $250 copay that applies to emergency room visits will be waived.
	Physician/surgeon fees	**Tier 1** – 10% coins	Not Covered	

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

What You Will Pay				
Common Medical Event	**Services You May Need**	**Network Provider (You will pay the least)**	**Out-of-Network Provider (You will pay the most)**	**Limitations, Exceptions, & Other Important Information**
		Tier 2 – 35% coins		
If you need mental health, behavioral health, or substance abuse services	Outpatient services	**Tier 1** – 10% coins **Tier 2** – 35% coins	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% coins **Tier 2** – 35% coins	Not Covered	
If you are pregnant	Office visits	**Tier 1** – $10 copay **Tier 2** – $30 copay	Not Covered	There may be some services where a copay, deductible may apply. **Spouse and dependent children are not covered under this plan.**
	Childbirth/delivery professional services	**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	Not Covered	Not Covered	
	Rehabilitation services	Not Covered	Not Covered	
	Habilitation services	Not Covered	Not Covered	
	Skilled nursing care	Not Covered	Not Covered	
	Durable medical equipment	Not Covered	Not Covered	
	Hospice services	Not Covered	Not Covered	
If your child needs	Children's eye exam	Not Covered	Not Covered	Dependent Children not covered with his plan

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

What You Will Pay				
Common Medical Event	**Services You May Need**	**Network Provider (You will pay the least)**	**Out-of-Network Provider (You will pay the most)**	**Limitations, Exceptions, & Other Important Information**
dental or eye care	Children's glasses	Not Covered	Not Covered	Dependent Children not covered with his plan
	Children's dental check-up	Not Covered	Not Covered	No Dental Coverage with this plan

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.)

- Acupuncture
- Convalescent facilities, group homes, halfway houses, nursing homes, rest homes
- Cardiac and Pulmonary Rehab
- Cosmetic surgery
- Custodial care
- Dental Care (Adults and Children)
- Dialysis
- Dietician services
- Hospice Care
- Infant Formula, nutritional supplements, and liquid food (except Total Parenteral Nutrition with pre-authorization
- Infertility treatment
- Long Term care
- Medical service 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 unless done in conjunction with a covered diagnosis
- Occupational Therapy
- Off-label use of a drug
- Organ transplant considered to be experimental, investigational, or unproven
- 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
- Services not medically necessary
- 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 with pre-authorization
- Chiropractic care services limited to 30 visits per calendar year
- Education (except diabetic education) training programs with pre-authorization, training and bed and board while confined in an institution that is mainly a school or other institution for training
- Out of Network medical providers only in case of medical emergency
- Routine eye care
  - Adult

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 coinsurance) For more information about limitation and exclusions, see the plan or policy document at (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 1-877-696-6775t, Department of Labor(DOL) Employee Benefits Security Administration at 1-866-444-3272 or 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 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, 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, kwiijigo holne' [1-804-673-1177].]

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* Specialist copay applies to Office Visit only. All other services are subject to deductible and coinsurance) For more information about limitation and exclusions, see the plan or policy document at (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)*

Total Example Cost	**$12,800**
In this example, Peg would pay:	
Cost Sharing	
Deductibles	$900
Copayments	$30
Coinsurance	$1190
What isn't covered	
Limits or exclusions	$
The total Peg would pay is	**$2120**

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)*

Total Example Cost	**$7,400**
In this example, Joe would pay:	
Cost Sharing	
Deductible	$900
Copayment	$30
Coinsurance	$2275
What isn't covered	
Limits or exclusions	$0
The total Joe would pay is	**$3205**

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)*

Total Example Cost	**$2,800**
In this example, Mia would pay:	
Cost Sharing	
Deductibles	$900
Copayments	$250
Coinsurance	$665
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1815**