



Connecticut Pipe Trades Health Fund

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SUMMARY OF BENEFITS AND COVERAGE (SBC) 2018 PLAN YEAR

MAY 2018

Dear Participant:

Enclosed you will find the Connecticut Pipe Trades Health Fund's Summary of Benefits and Coverage (SBC) for the Plan Year commencing July 1, 2018. This document provides a general description of the health benefits provided by the Fund. SBCs are required to be issued on an annual basis in accordance with the Affordable Care Act (ACA).

The federal government developed the SBC form primarily to help people who will be shopping for individual/family coverage under the ACA health care Exchanges. They are designed so that individuals can compare "apples to apples" when comparing plans. For that reason, we are not permitted to customize the attached SBC. Our records reflect that you already have coverage through the Connecticut Pipe Trades Health Fund. **Assuming you maintain your coverage, you likely won't need to shop for coverage through an Exchange.** For your information, Connecticut's Exchange is known as "AccessHealthCT" (on the web: www.accesshealthct.com; tel. #1-855-805-HEAL (1-855-805-4325)).

ACA Requirements for SBCs - To best understand the benefits provided by the Fund, we recommend that you refer to your Summary Plan Description or SPD (booklet) and the announcement letters issued by the Fund Office describing your benefits. You may also contact the Fund Office.

The ACA has some very strict requirements for producing the SBCs—the maximum number of pages, the font size, the colors, etc. Also included in the SBC are three coverage examples—one for having a baby, one for managing Type 2 diabetes, and one for fracturing a bone. The examples show the health care costs for you and the Fund associated with each of these three situations. **As you read these examples, it is very important to note that these costs are national averages; they do not reflect what the actual services might cost you or your family.** Similarly, your course of treatment might also be very different depending on your doctor's approach, whether your doctor is in-network or not (the examples show only in-network provider costs), your age, your other health issues, and many other factors. These examples are included to help compare how different health plans might cover the same condition—not for predicting your own actual health care expenses.

You may also find that the SBC discusses the Fund's benefits in ways that may seem unfamiliar to you. For instance, there may be terms you haven't seen before or terms that you have seen before that are being used differently. The SBC defaults to terms used in a "Glossary of Health Coverage and Medical Terms," which the ACA does not allow us to alter. If you read the SBC or the Glossary and find yourself confused at any time, we recommend that you refer to the Fund's SPD (booklet) and the other materials describing your benefits that you have received from the Fund.

For More Information - Please keep this 2018 SBC with your SPD (booklet) and other Fund materials for easy reference. Receipt of this document and/or the SBC is not a determination of your eligibility, or that of any of your dependents, in the Fund now or in the future. If you have any questions about the Fund's eligibility rules or coverage, please contact the Fund Office. If you have general questions about the SBC or the Glossary, you may want to contact the Employee Benefits Security Administration of the U.S. Department of Labor at (866) 444-3272 or www.dol.gov/ebsa, or the U.S. Department of Health and Human Services at (877) 267-2323 Ext. 61565 or www.cciio.cms.gov.

Sincerely,

Board of Trustees

⚠ 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, call 1-800-848-2129 or visit www.connecticutpipetrades.com. 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.dol.gov/ebsa/healthreform.com or call 1-800-848-2129 to request a copy.

Important Questions	Answers	Why This Matters:
<p>What is the overall deductible?</p>	<p>In-Network: \$0. Out-of-network: \$200/individual; \$400/family</p>	<p>In-Network: See the Common Medical Events chart below for your costs for services this plan covers. <u>Out-of-network</u>: 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.</p>
<p>Are there services covered before you meet your deductible?</p>	<p>In-Network: Not applicable. <u>Out-of-network</u>: Yes. <u>Emergency room care</u> and eye care services are covered before you meet your deductible.</p>	<p>In-Network: This plan does not have an <u>in-network deductible</u>. <u>Out-of-network</u>: This plan covers some items and services even if you haven't yet met the deductible amount. But a <u>copayment</u> or <u>coinsurance</u> may apply.</p>
<p>Are there other deductibles for specific services?</p>	<p>Yes. \$50/individual; \$150/family for basic and major dental services only. There are no other specific deductibles.</p>	<p>You must pay all of the costs for these services up to the specific deductible amount before this plan begins to pay for these services.</p>
<p>What is the out-of-pocket limit for this plan?</p>	<p>In-Network: Medical: \$1,500/individual; \$7,150/family; Prescription drugs: \$1,500/individual; \$7,150/family. <u>Out-of-network</u>: No <u>out-of-pocket limit</u>.</p>	<p>In-Network: 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 plan, 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. <u>Out-of-network</u>: This plan does not have an <u>out-of-network out-of-pocket limit</u> on your expenses.</p>
<p>What is not included in the out-of-pocket limit?</p>	<p><u>Copayments</u> on dental, vision, hearing; <u>premiums</u>; <u>balance-billing charges</u>; health care this plan doesn't cover; and penalties for failure to obtain <u>preauthorization</u>.</p>	<p>Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u>.</p>

Important Questions	Answers	Why This Matters:
Will you pay less if you use a <u>network provider</u> ?	Yes. See www.anthem.com or call 1-800-810-2583 for a list of <u>network providers</u> .	This <u>plan</u> uses a <u>provider network</u> . You will pay less if you use a <u>provider</u> in the <u>plan's 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 <u>provider's charge</u> 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	\$20 <u>copay/visit</u> . \$200 <u>copay/visit</u> if charges exceed \$2,000	20% <u>coinsurance</u> plus <u>balance billing</u> charges	None
	<u>Specialist</u> visit	\$20 <u>copay/visit</u> . \$200 <u>copay/visit</u> if charges exceed \$2,000	20% <u>coinsurance</u> plus <u>balance billing</u> charges	None
	<u>Preventive care/screening/immunization</u>	No charge	20% <u>coinsurance</u> plus <u>balance billing</u> charges	Limit: one (1) routine physical exam per year unless otherwise directed by physician. You may have to pay for services that aren't preventive. Ask your <u>provider</u> if the services needed are preventive. Then check the services for which the <u>plan</u> will pay.
If you have a test	<u>Diagnostic test</u> (x-ray, blood work)	\$20 <u>copay/test</u> . \$200 <u>copay/test</u> if charges exceed \$2,000	20% <u>coinsurance</u> plus <u>balance billing</u> charges	No charge in-network when part of routine <u>preventive care</u>
	Imaging (CT/PET scans, MRIs)	\$20 <u>copay/test</u> . \$200 <u>copay/test</u> if charges exceed \$2,000	20% <u>coinsurance</u> plus <u>balance billing</u> charges	Some tests require <u>preauthorization</u> or benefits are reduced by 20%. Obtain <u>preauthorization</u> by calling 1-877-284-0102

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)	
<p>If you need drugs to treat your illness or condition</p> <p>More information about <u>prescription drug coverage</u> is available at www.optumrx.com or by calling 1-855-408-2312</p>	Generic drugs	Retail: \$10 <u>copay</u> /prescription; Mail order: \$15 <u>copay</u> /prescription	Not covered	<p>Limited to a 30-day supply retail and a 90-day supply mail order. Mandatory generic or you pay the brand name <u>copay</u> plus the difference in cost. Some drugs are subject to quantity or dollar limits. Some drugs require <u>preauthorization</u> or no benefits are provided. No charge for FDA-approved generic contraceptives (or brand name contraceptives if a generic is medically inappropriate).</p>
	Preferred brand drugs	Retail: \$25 <u>copay</u> /prescription; Mail order: \$40 <u>copay</u> /prescription	Not covered	
	Non-preferred brand drugs	Retail: \$40 <u>copay</u> /prescription; Mail order: \$80 <u>copay</u> /prescription	Not covered	
<p>If you have outpatient surgery</p>	<u>Specialty drugs</u>	Your <u>copay</u> is based on whether the drug is generic, preferred brand or non-preferred brand, as shown above	Not covered	<p>Some <u>specialty drugs</u> may also be covered under your medical benefit. Contact the <u>plan</u> at 860-571-9191 if you need a <u>specialty drug</u>.</p>
	Facility fee (e.g., ambulatory surgery center)	\$20 <u>copay</u> ; \$200 <u>copay</u> if charges exceed \$2,000	20% <u>coinsurance</u> plus <u>balance billing</u> charges	
	Physician/surgeon fees	Included in facility fee One <u>copay</u> per outpatient surgery	20% <u>coinsurance</u> plus <u>balance billing</u> charges	
<p>If you need immediate medical attention</p>	<u>Emergency room care</u>	\$150 <u>copay</u> /visit. \$300 <u>copay</u> /visit for non-emergency services	\$150 <u>copay</u> /visit. \$300 <u>copay</u> /visit for non-emergency services. <u>Deductible</u> does not apply.	<p>\$300 <u>copay</u> applies if diagnosis is not considered an <u>emergency medical condition</u> by the plan; <u>emergency room copay</u> waived if admitted. Professional/physician charges may be billed separately.</p>
	<u>Emergency medical transportation</u>	No charge up to \$4,000, then 20% <u>coinsurance</u>	No charge up to \$4,000, then 20% <u>coinsurance</u>	
	<u>Urgent care</u>	\$30 <u>copay</u> /visit at freestanding medical center	20% <u>coinsurance</u> plus <u>balance billing</u> charges	

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 have a hospital stay	Facility fee (e.g., hospital room)	\$500 copay/admission	20% coinsurance plus balance billing charges	<u>Preauthorization</u> required or benefits are reduced by 20%. Obtain <u>preauthorization</u> by calling 1-877-284-0102. The difference between semi-private and private room rates is not covered unless <u>medically necessary</u> to isolate patient to prevent contagion.
	Physician/surgeon fees	Included in facility fee. One <u>copay</u> per hospital admission	20% coinsurance plus balance billing charges	<u>Preauthorization</u> required or benefits are reduced by 20%. Obtain <u>preauthorization</u> by calling 1-877-284-0102.
	Outpatient services	\$20 <u>copay</u> /visit. \$200 <u>copay</u> /visit if charges exceed \$2,000	20% coinsurance plus balance billing charges	None
If you need mental health, behavioral health, or substance abuse services	Inpatient services	\$500 copay/admission	20% coinsurance plus balance billing charges	<u>Preauthorization</u> required or benefits are reduced by 20%. Obtain <u>preauthorization</u> by calling 1-877-284-0102.
	Office visits	\$20 <u>copay</u> /initial visit only. \$200 <u>copay</u> if charges exceed \$2,000	20% coinsurance plus balance billing charges	Prenatal care (other than preventive services required under the Affordable Care Act) is not covered for dependent children. Delivery expenses are not covered for dependent children. <u>Cost sharing</u> does not apply to ACA-required <u>preventive services</u> . Depending on the type of services, a <u>copayment</u> , <u>coinsurance</u> , or <u>deductible</u> may apply.
	Childbirth/delivery professional services	Included in facility fee. One <u>copay</u> per hospital admission	20% coinsurance plus balance billing charges	Maternity care may include tests and services described in another section in the SBC (e.g., ultrasound).
If you are pregnant	Childbirth/delivery facility services	\$500 copay/admission	20% coinsurance plus balance billing charges	Limit of 120 visits/year. <u>Preauthorization</u> required or benefits are reduced by 20%. Obtain <u>preauthorization</u> by calling 1-877-284-0102.
	Home health care	No charge	20% coinsurance plus balance billing charges	Combined limit of 60 sessions/year for physical, speech and occupational therapy. Obtain <u>preauthorization</u> by calling 1-877-284-0102
	Rehabilitation services	\$20 <u>copay</u> /visit. \$200 <u>copay</u> if charges exceed \$2,000	20% coinsurance plus balance billing charges	You must pay 100% of these expenses, even in-network.
If you need help recovering or have other special health needs	Habilitation services	Not covered	Not covered	

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)	
	<u>Skilled nursing care</u>	\$500 copay/admission	20% coinsurance plus balance billing charges	Limit of 120 visits/year. <u>Preauthorization</u> required or benefits are reduced by 20%. Obtain <u>preauthorization</u> by calling 1-877-284-0102.
	<u>Durable medical equipment</u>	20% coinsurance	20% coinsurance plus balance billing charges	Purchase or rental of <u>medically necessary</u> equipment subject to review by <u>plan</u> .
	<u>Hospice services</u>	\$500 copay	20% coinsurance plus balance billing charges	<u>Hospice services</u> covered for terminally ill patients only. <u>Preauthorization</u> required or benefits are reduced by 20%. Obtain <u>preauthorization</u> by calling 1-877-284-0102.
If your child needs dental or eye care	Children's eye exam	No charge	No charge up to \$75, then 100% of balance. <u>Deductible</u> does not apply.	One exam every 12 months for dependents age 18 and younger. These benefits are administered separately from the <u>medical plan</u> . <u>Cost sharing</u> for these services is not included in the <u>out-of-pocket limit</u> .
	Children's glasses	No charge for select frames and lenses	No charge up to \$175, then 100% of balance. <u>Deductible</u> does not apply.	One pair of glasses every 12 months for dependents age 18 and younger. These benefits are administered separately from the <u>medical plan</u> . <u>Cost sharing</u> for these services is not included in the <u>out-of-pocket limit</u> .
	Children's dental check-up	No charge	No charge up to <u>allowed</u> amount, then 100% of balance	Limited to one exam and one cleaning every six months. These benefits are administered separately from the <u>medical plan</u> . <u>Cost sharing</u> for these services is not included in the <u>out-of-pocket limit</u> .

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.)
<ul style="list-style-type: none"> • Cosmetic surgery (except as required under federal law) • <u>Habilitation services</u>
<ul style="list-style-type: none"> • Long-term care • Non-emergency care when traveling outside the U.S. • Routine foot care • Weight loss programs (except as required under the Affordable Care Act)

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)
<ul style="list-style-type: none"> • Acupuncture (requires preapproval) • Bariatric surgery (requires preapproval) • Chiropractic care (subject to plan limits) • Dental care (Adult) (subject to plan limits) • Hearing aids (subject to plan limits; not covered for retirees) • Private duty nursing (requires preapproval) • Routine eye care (Adult) (subject to plan limits) • Infertility treatment (subject to plan limits)

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 860-571-9191. 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 the State of Connecticut Office of the Health Care Advocate, 153 Market Street, Hartford, CT 06144, (866) 466-4446, www.ct.gov/oha.

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** \$0
- **Specialist copay** \$20
- **Hospital (facility) copay** \$500
- **Other copay** \$20

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:

<i>Cost Sharing</i>	
Deductibles	\$0
Copayments	\$750
Coinsurance	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$60
The total Peg would pay is	\$810

Managing Joe's type 2 Diabetes

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

- **The plan's overall deductible** \$0
- **Specialist copay** \$20
- **Hospital (facility) copay** \$500
- **Other copay** \$20

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:

<i>Cost Sharing</i>	
Deductibles	\$0
Copayments	\$1,470
Coinsurance	\$50
<i>What isn't covered</i>	
Limits or exclusions	\$20
The total Joe would pay is	\$1,540

Mia's Simple Fracture

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

- **The plan's overall deductible** \$0
- **Specialist copay** \$20
- **Hospital (facility) copay** \$500
- **Other copay** \$20

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:

<i>Cost Sharing</i>	
Deductibles	\$0
Copayments	\$310
Coinsurance	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$0
The total Mia would pay is	\$310