



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.healthcare.gov/glossary or call 1-800-848-2129 to request a copy.

Important Questions	Answers	Why This Matters:
<p>What is the overall <u>deductible</u>?</p>	<p><u>In-Network</u>: \$0. <u>Out-of-network</u>: \$200/individual; \$400/family</p>	<p><u>In-Network</u>: See the Common Medical Events chart below for your costs for services this <u>plan</u> covers. <u>Out-of-network</u>: Generally, you must pay all of the costs from <u>providers</u> 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>.</p>
<p>Are there services covered before you meet your <u>deductible</u>?</p>	<p><u>In-Network</u>: Not applicable. <u>Out-of-network</u>: Yes. <u>Emergency room care</u> and eye care services are covered before you meet your <u>deductible</u>.</p>	<p><u>In-Network</u>: This <u>plan</u> does not have an <u>in-network deductible</u>. <u>Out-of-network</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.</p>
<p>Are there other <u>deductibles</u> for specific services?</p>	<p>Yes. \$50/individual; \$150/family for basic and major dental services only. There are no other specific <u>deductibles</u>.</p>	<p>You must pay all of the costs for these services up to the specific <u>deductible</u> amount before this <u>plan</u> begins to pay for these services.</p>
<p>What is the <u>out-of-pocket limit</u> for this <u>plan</u>?</p>	<p><u>In-Network</u>: Medical: \$1,500/individual; \$7,150/family; <u>Prescription drugs</u>: \$1,500/individual; \$7,150/family. <u>Out-of-network</u>: No <u>out-of-pocket limit</u>.</p>	<p><u>In-Network</u>: 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. <u>Out-of-network</u>: This <u>plan</u> does not have an <u>out-of-network out-of-pocket limit</u> on your expenses.</p>
<p>What is not included in the <u>out-of-pocket limit</u>?</p>	<p><u>Copayments</u> on dental, vision, hearing; <u>premiums</u>; <u>balance-billing</u> charges; health care this <u>plan</u> 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
		<u>Network Provider</u> (You will pay the least)	<u>Out-of-Network Provider</u> (You will pay the most)	
If you visit a health care <u>provider's office</u> or clinic	Primary care visit to treat an injury or illness	\$20 <u>copay</u> /visit. \$200 <u>copay</u> /visit if charges exceed \$2,000	20% <u>coinsurance</u> plus <u>balance billing</u> charges	None
	<u>Specialist</u> visit	\$20 <u>copay</u> /visit. \$200 <u>copay</u> /visit 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</u> /test. \$200 <u>copay</u> /test 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</u> /test. \$200 <u>copay</u> /test 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
		<u>Network Provider</u> (You will pay the least)	<u>Out-of-Network Provider</u> (You will pay the most)	
If you need drugs to treat your illness or condition More information about <u>prescription drug coverage</u> is available at www.optumrx.com or by calling 1-855-408-2312	Generic drugs	Retail: \$10 <u>copay</u> /prescription; Mail order: \$15 <u>copay</u> /prescription	Not covered	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). 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> .
	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	
	<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	
If you have outpatient surgery	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	<u>Preauthorization</u> required or benefits are reduced by 20%. Obtain <u>preauthorization</u> by calling 1-877-284-0102.
	Physician/surgeon fees	Included in facility fee One <u>copay</u> per outpatient surgery	20% <u>coinsurance</u> plus <u>balance billing</u> charges	
If you need immediate medical attention	<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.	\$300 <u>copay</u> applies if diagnosis is not considered an <u>emergency medical condition</u> by the <u>plan</u> (using the prudent layperson standard); emergency room <u>copay</u> waived if admitted. Professional/physician charges may be billed separately.
	<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>	None
	<u>Urgent care</u>	\$30 <u>copay</u> /visit at freestanding medical center	20% <u>coinsurance</u> plus <u>balance billing</u> charges	None

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		<u>Network Provider</u> (You will pay the least)	<u>Out-of-Network Provider</u> (You will pay the most)	
If you have a hospital stay	Facility fee (e.g., hospital room)	\$500 <u>copay</u> /admission	20% <u>coinsurance</u> plus <u>balance billing</u> 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% <u>coinsurance</u> plus <u>balance billing</u> charges	<u>Preauthorization</u> required or benefits are reduced by 20%. Obtain <u>preauthorization</u> by calling 1-877-284-0102.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	\$20 <u>copay</u> /visit. \$200 <u>copay</u> /visit if charges exceed \$2,000	20% <u>coinsurance</u> plus <u>balance billing</u> charges	None
	Inpatient services	\$500 <u>copay</u> /admission	20% <u>coinsurance</u> plus <u>balance billing</u> charges	<u>Preauthorization</u> required or benefits are reduced by 20%. Obtain <u>preauthorization</u> by calling 1-877-284-0102.
If you are pregnant	Office visits	\$20 <u>copay</u> /initial visit only. \$200 <u>copay</u> if charges exceed \$2,000	20% <u>coinsurance</u> plus <u>balance billing</u> charges	Prenatal care (other than <u>preventive services</u> 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. Maternity care may include tests and services described in another section in the SBC (e.g., ultrasound).
	Childbirth/delivery professional services	Included in facility fee. One <u>copay</u> per hospital admission	20% <u>coinsurance</u> plus <u>balance billing</u> charges	
	Childbirth/delivery facility services	\$500 <u>copay</u> /admission	20% <u>coinsurance</u> plus <u>balance billing</u> charges	
If you need help recovering or have other special health needs	<u>Home health care</u>	No charge	20% <u>coinsurance</u> plus <u>balance billing</u> 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>Rehabilitation services</u>	\$20 <u>copay</u> /visit. \$200 <u>copay</u> if charges exceed \$2,000	20% <u>coinsurance</u> plus <u>balance billing</u> charges	Combined limit of 60 sessions/year for physical, speech and occupational therapy. 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)	
	<u>Habilitation services</u>	\$20 <u>copay</u> /visit. \$200 <u>copay</u> if charges exceed \$2,000	20% <u>coinsurance</u> plus <u>balance billing</u> charges	Only speech therapy covered and limited to 12 speech therapy sessions/year. Obtain preauthorization by calling 1-877-284-0102. You must pay 100% of all other <u>habilitation services</u> expenses, even in-network.
	<u>Skilled nursing care</u>	\$500 copay/admission	20% <u>coinsurance</u> plus <u>balance billing</u> 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% <u>coinsurance</u>	20% <u>coinsurance</u> plus <u>balance billing</u> charges	Purchase or rental of <u>medically necessary</u> equipment subject to review by <u>plan</u> .
	<u>Hospice services</u>	\$500 <u>copay</u>	20% <u>coinsurance</u> plus <u>balance billing</u> 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 medical <u>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 medical <u>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 amount</u> , then 100% of balance	Limited to one exam and one cleaning every six months. These benefits are administered separately from the medical <u>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 <u>Plan</u> Generally Does NOT Cover (Check your policy or <u>plan</u> 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)	<ul style="list-style-type: none">• Long-term care• Non-emergency care when traveling outside the U.S.	<ul style="list-style-type: none">• 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 <u>plan</u> document.)		
<ul style="list-style-type: none">• Acupuncture (requires preapproval)• Bariatric surgery (requires preapproval)• Chiropractic care (subject to <u>plan</u> limits)	<ul style="list-style-type: none">• Dental care (Adult) (subject to <u>plan</u> limits)• Hearing aids (subject to <u>plan</u> limits; not covered for retirees)	<ul style="list-style-type: none">• Private duty nursing (requires preapproval)• Routine eye care (Adult) (subject to <u>plan</u> limits)• Infertility treatment (subject to <u>plan</u> 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
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In this example, Peg would pay:

<u>Cost Sharing</u>	
<u>Deductibles</u>	\$0
<u>Copayments</u>	\$750
<u>Coinsurance</u>	\$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
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In this example, Joe would pay:

<u>Cost Sharing</u>	
<u>Deductibles</u>	\$0
<u>Copayments</u>	\$1,470
<u>Coinsurance</u>	\$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
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In this example, Mia would pay:

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