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 www.ctcarpentersfunds.org or call (203) 281-5511 or 1-800-922-6026 (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 www.dol.gov/ebsa/pdf/SBCUniformGlossary.pdf or call (203) 281-5511 or 1-800-922-6026 (toll-free) to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	$300 Individual/$600 Family. $300 total for common accident involving Family.	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.
Are there services covered before you meet your deductible?	Yes.	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply.
Are there other deductibles for specific services?	No.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	$4,000 Individual/$6,000 Family	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, the overall family out-of-pocket limit must be met.
What is not included in the out-of-pocket limit?	Dental benefits; co-pays; penalties for failure to pre-certify; balance-billing charges; premiums; and health care this Plan doesn't cover.	Even though you pay these expenses, they don't count toward the out-of-pocket limit.
Will you pay less if you use a network provider?	Yes. See www.ctcarpentersfunds.org or call (203) 281-5511 or 1-800-922-6026 (toll-free) for a list of network providers.	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware, your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist?	No.	You can see the specialist you choose without a referral.

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 co-pay/visit	$20 co-pay/visit	None
	Specialist visit	$20 co-pay/visit	$20 co-pay/visit	
	Preventive care/screening/ immunization	No charge adults. $20 co-pay/well child	No charge adults. $20 co-pay/well child	Adult physical and gynecological exams limited to one each/calendar year, including routine mammograms and pap smears. Well-child visits subject to schedule. 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)	20% coinsurance after deductible	20% coinsurance after deductible	None
	Imaging (CT/PET scans, MRIs)	20% coinsurance after deductible	20% coinsurance after deductible	Prior authorization required.
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.optumrx.com or by calling 1-800-788-7871 or 1-800-797-9791. More information on prior authorization for specialty drugs is available by calling The Fund Office at 1-800-922-6026	Generic drugs	$10 co-pay/ 30 day retail supply. $15 co-pay/90 day mail order supply.	Not Covered	No coverage for experimental, investigational, unproven drugs. Some medications have quantity limits, age limitations, and prior authorization requirements. Some brand name medications require participation in step-therapy. No coverage for two or more Class II controlled substances for longer than 180 days without case management. Generic dispensed unless physician specified "Brand Drug only". If brand requested when generic available, the member pays the brand co-pay PLUS the difference in drug cost. All maintenance medications must be filled or refilled through the mail service pharmacy.
	Preferred brand drugs	$15 co-pay/ 30 day retail supply. $25 co-pay/90 day mail order supply.	Not Covered	
	Non-preferred brand drugs	$30 co-pay/30 day retail supply. $55 co-pay/90 day mail order supply.	Not Covered	
	Specialty drugs	$30 co-pay/30 day supply when purchased through OptumRx's Specialty Drug Pharmacy.	Not Covered	No coverage for experimental, investigational, unproven drugs. Depending on the drug, prior authorization required through either Telligen or OptumRx. You must utilize the OptumRx Specialty Drug Pharmacy, except if purchased through your Anthem medical provider, then the cost is 20% coinsurance after deductible.

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 outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance after deductible	20% coinsurance after deductible	None
	Physician/surgeon fees	20% coinsurance after deductible	20% coinsurance after deductible	None
If you need immediate medical attention	Emergency room care	$75 co-pay/visit plus 20% coinsurance after deductible	$75 co-pay/visit plus 20% coinsurance after deductible	Co-pay waived if admitted.
	Emergency medical transportation	20% coinsurance after deductible	20% coinsurance after deductible	Only for emergencies or medical necessity. Ground ambulance only for transportation to the nearest facility or between two facilities. Air ambulance must be pre-certified.
	Urgent care	$20 co-pay/visit	$20 co-pay/visit	Applies only to freestanding urgent care or walk-in facilities.
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance after deductible	20% coinsurance after deductible	Private room excluded and 10% penalty if not pre-certified (or within 48 hours after emergency).
	Physician/surgeon fees	20% coinsurance after deductible	20% coinsurance after deductible	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	6 total outpatient visits at no charge through Member Assistance Plan, otherwise $20 co-pay/visit	$20 co-pay/visit	Limited to care by Psychologist, Psychiatrist, Master's in Social Work, Master of Science in Counseling, Professional Counselor, Alcohol & Drug Counselor, Marriage & Family Therapist. Biofeedback subject to deductible also. PHP (partial hospitalization) and IOP (intense outpatient) covered as inpatient treatment.
	Inpatient services	20% coinsurance after deductible	20% coinsurance after deductible	Private room excluded and 10% penalty if not pre-certified (or within 48 hours after emergency).
If you are pregnant	Office visits	$20 co-pay/visit	$20 co-pay/visit	Coverage for member or spouse only.
	Childbirth/delivery professional services	20% coinsurance after deductible	20% coinsurance after deductible	Coverage for member or spouse only.
	Childbirth/delivery facility services	20% coinsurance after deductible	20% coinsurance after deductible	Coverage for member or spouse only. Private room excluded and certain pre-certification requirements may apply.
If you need help recovering or have	Home health care	20% coinsurance after deductible	20% coinsurance after deductible	Up to 80 visits of 4 hours/calendar year. Limited to care by R.N., P.T, or O.T or non-custodial care by

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)	
other special health needs				Home Health Aide.
	Rehabilitation services	20% coinsurance after deductible	20% coinsurance after deductible	Limited to 45 visits/calendar year for outpatient physical therapy or occupational therapy. Speech therapy limited to certain situations. Cardiac Rehab must be at an approved facility for only up to 6 months and must start within 26 weeks after diagnosis or event. Orthoptic therapy limited to 25 visits/calendar year.
	Habilitation services	Not covered	Not covered	You must pay 100% of these costs.
	Skilled nursing care	20% coinsurance after deductible	20% coinsurance after deductible	Limited to 120 days/calendar year. Custodial and skilled care excluded.
	Durable medical equipment	20% coinsurance after deductible	20% coinsurance after deductible	Limited to a $5,000 calendar year maximum for nonessential durable medical equipment. Letter of medical necessity required. Certain limitations apply.
	Hospice services	No charge	No charge	Only covered if have a terminal illness with a prognosis of death within 6 months.
If your child needs dental or eye care	Children's eye exam (provided through Davis Vision)	$25 co-pay/visit	Any billing with reimbursement of up to $95	Limited to one exam/calendar year. Exam does not include contact lens evaluation.
	Children's glasses (provided through Davis Vision)	No charge for frames in provided collection, otherwise $14 allowance. Lenses are subject to the specific allowances.	No charge for frames in provided collection, otherwise $14 allowance. Lenses are subject to specific allowances.	Limited to one pair of eyeglasses or contact lenses (with additional co-pays of $50 or $70) calendar year. One year breakage warranty on in-network glasses.
	Children's dental check-up (provided through Delta Dental)	No Charge	Any balance billing	Limited to two check-ups/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 (other than certain breast reconstruction)
- Non-emergency care when traveling outside the U.S.
- Weight loss programs
- Infertility treatment
- Hearing aids (except when hearing loss caused by accidental injury)
- Habilitation services
- Long-term care
- Private-duty nursing
- Routine foot care

* For more information about limitations and exceptions, see the plan or policy document at www.ctcarpentersfunds.org.

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)		
• Acupuncture • Dental Care (Adult)	• Bariatric surgery • Routine eye care (Adult)	• Chiropractic care

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 that agency 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) 281-5511 or 1-800-922-6026 (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
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.

Language Access Services:
[Spanish (Español): Para obtener asistencia en Español, llame al (203) 281-5511 or 1-800-922-6026
[Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa (203) 281-5511 or 1-800-922-6026
[Chinese (中文): 如果需要中文的帮助， **请拨打这个号码** (203) 281-5511 or 1-800-922-6026
[Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' (203) 281-5511 or 1-800-922-6026

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	$300
Specialist copayment	$20
Hospital (facility) coinsurance	20%
Other coinsurance	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:

Cost Sharing	
Deductibles	$300
Copayments	$20
Coinsurance	$2,496
What isn't covered	
Limits or exclusions	$0
The total Peg would pay is	$2,816

Managing Joe's type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

The plan's overall deductible	$300
Specialist copayment	$20
Hospital (facility) coinsurance	20%
Other coinsurance	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:

Cost Sharing	
Deductibles	$300
Copayments	$80
Coinsurance	$1,344
What isn't covered	
Limits or exclusions	$300
The total Joe would pay is	$2,024

Mia's Simple Fracture
(in-network emergency room visit and follow up care)

The plan's overall deductible	$300
Specialist copayment	$20
Hospital (facility) coinsurance	20%
Other coinsurance	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:

Cost Sharing	
Deductibles	$300
Copayments	$135
Coinsurance	$293
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	$728

The plan would be responsible for the other costs of these EXAMPLE covered services.