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	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?	No.	You will have to meet the deductible before the plan pays for any services.
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?	Not applicable.	This plan does not have an out-of-pocket limit on your expenses.
What is not included in the out-of-pocket limit?	Not applicable.	This plan does not have an out-of-pocket limit on your expenses.
Will you pay less if you use a network provider?	Yes, for prescription drugs ONLY. For more information see www.optumrx.com or call 1-800-788-7871 or 1-800-797-9791	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	Primary care visit to treat an injury or illness	20% of Medicare's coinsurance after deductible	20% of Medicare's coinsurance after deductible	Plan pays second to Medicare only on Medicare allowed amounts.

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)	
or clinic	Specialist visit	20% of Medicare's coinsurance after deductible	20% of Medicare's coinsurance after deductible	
	Preventive care/screening/ immunization	20% of Medicare's coinsurance after deductible	20% of Medicare's coinsurance after deductible	
If you have a test	Diagnostic test (x-ray, blood work)	20% of Medicare's coinsurance after deductible	20% of Medicare's coinsurance after deductible	Plan pays second to Medicare only on Medicare allowed amounts.
	Imaging (CT/PET scans, MRIs)	20% of Medicare's coinsurance after deductible	20% of Medicare's coinsurance after deductible	Plan pays second to Medicare only on Medicare allowed amounts.
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.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% of Medicare's coinsurance after deductible	20% of Medicare's coinsurance after deductible	Plan pays second to Medicare only on Medicare allowed amounts.
	Physician/surgeon fees	20% of Medicare's coinsurance after deductible	20% of Medicare's coinsurance after deductible	
If you need immediate medical attention	Emergency room care	20% of Medicare's coinsurance after deductible	20% of Medicare's coinsurance after deductible	Plan pays second to Medicare only on Medicare allowed amounts.

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)	
	Emergency medical transportation	20% of Medicare's coinsurance after deductible	20% of Medicare's coinsurance after deductible	
	Urgent care	20% of Medicare's coinsurance after deductible	20% of Medicare's coinsurance after deductible	
If you have a hospital stay	Facility fee (e.g., hospital room)	20% of Medicare's coinsurance after deductible	20% of Medicare's coinsurance after deductible	Plan pays second to Medicare only on Medicare allowed amounts.
	Physician/surgeon fees	20% of Medicare's coinsurance after deductible	20% of Medicare's coinsurance after deductible	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	20% of Medicare's coinsurance after deductible	20% of Medicare's coinsurance after deductible	Plan pays second to Medicare only on Medicare allowed amounts.
	Inpatient services	20% of Medicare's coinsurance after deductible	20% of Medicare's coinsurance after deductible	
If you are pregnant	Office visits	20% of Medicare's coinsurance after deductible	20% of Medicare's coinsurance after deductible	Plan pays second to Medicare only on Medicare allowed amounts.
	Childbirth/delivery professional services	20% of Medicare's coinsurance after deductible	20% of Medicare's coinsurance after deductible	
	Childbirth/delivery facility services	20% of Medicare's coinsurance after deductible	20% of Medicare's coinsurance after deductible	
If you need help recovering or have other special health needs	Home health care	20% of Medicare's coinsurance after deductible	20% of Medicare's coinsurance after deductible	Plan pays second to Medicare only on Medicare allowed amounts.
	Rehabilitation services	20% of Medicare's coinsurance after deductible	20% of Medicare's coinsurance after deductible	
	Habilitation services	20% of Medicare's coinsurance after deductible	20% of Medicare's coinsurance after deductible	
	Skilled nursing care	20% of Medicare's coinsurance after deductible	20% of Medicare's coinsurance after deductible	
	Durable medical equipment	20% of Medicare's coinsurance after deductible	20% of Medicare's coinsurance after deductible	
	Hospice services	20% of Medicare's coinsurance after deductible	20% of Medicare's coinsurance after deductible	
If your child needs dental or eye care	Children's eye exam	Not Covered	Not Covered	You must pay 100% of these costs.
	Children's glasses	Not Covered	Not Covered	
	Children's dental check-up	Not Covered	Not Covered	

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

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.)
The following services are NOT covered under this Plan if they are NOT covered under Medicare.

- Acupuncture
- Bariatric Surgery
- Chiropractic care
- Cosmetic surgery
- Dental care (Adult)
- Hearing aids
- Infertility treatment
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing
- Routine eye care (Adult)
- Routine foot care
- Weight loss program

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)
The following services are ONLY covered under the Plan to the extent they ARE covered under Medicare.

- Acupuncture
- Bariatric surgery
- Chiropractic care
- Cosmetic surgery
- Dental care (Adult)
- Hearing aids
- Infertility treatment
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing
- Routine eye care (Adult)
- Routine foot care
- Weight loss program

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? No.

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? No.

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 coverage examples on this page do not take into account that this plan pays secondary to Medicare. As a result, these coverage examples do not reflect your actual out-of-pocket costs when you incur these types of medical expenses.

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