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:
What is the overall deductible?	In-Network: **$0**. Out-of-network: **$200**/individual; **$400**/family	In-Network: See the Common Medical Events chart below for your costs for services this plan covers. Out-of-network: 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?	In-Network: Not applicable. Out-of-network: Yes. Emergency room care and eye care services are covered before you meet your deductible.	In-Network: This plan does not have an in-network deductible. Out-of-network: 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?	Yes. **$50**/individual; **$150**/family for basic and major dental services only. There are no other specific deductibles.	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.
What is the out-of-pocket limit for this plan?	In-Network: Medical: **$1,500**/individual; **$7,150**/family; Prescription drugs: **$1,500**/individual; **$7,150**/family. Out-of-network: No out-of-pocket limit.	In-Network: 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, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met. Out-of-network: This plan does not have an out-of-network out-of-pocket limit on your expenses.
What is not included in the out-of-pocket limit?	Copayments on dental, vision, hearing; premiums; balance-billing charges; health care this plan doesn't cover; and penalties for failure to obtain preauthorization.	Even though you pay these expenses, they don't count toward the out-of-pocket limit.

Important Questions	Answers	Why This Matters:
Will you pay less if you use a network provider?	Yes. See www.anthem.com or call 1-800-810-2583 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 copay/visit. $200 copay/visit if charges exceed $2,000	20% coinsurance plus balance billing charges	None
	Specialist visit	$20 copay/visit. $200 copay/visit if charges exceed $2,000	20% coinsurance plus balance billing charges	None
	Preventive care/screening/ immunization	No charge	20% coinsurance plus balance billing 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 provider if the services needed are preventive. Then check the services for which the plan will pay.
If you have a test	Diagnostic test (x-ray, blood work)	$20 copay/test. $200 copay/test if charges exceed $2,000	20% coinsurance plus balance billing charges	No charge in-network when part of routine preventive care
	Imaging (CT/PET scans, MRIs)	$20 copay/test. $200 copay/test if charges exceed $2,000	20% coinsurance plus balance billing charges	Some tests require preauthorization or benefits are reduced by 20%. Obtain preauthorization 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)	
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 1-855-408-2312	Generic drugs	Retail: $10 copay/ prescription; Mail order: $15 copay/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 copay plus the difference in cost. Some drugs are subject to quantity or dollar limits. Some drugs require preauthorization or no benefits are provided. No charge for FDA-approved generic contraceptives (or brand name contraceptives if a generic is medically inappropriate).
	Preferred brand drugs	Retail: $25 copay/ prescription; Mail order: $40 copay/prescription	Not covered	
	Non-preferred brand drugs	Retail: $40 copay/ prescription; Mail order: $80 copay/prescription	Not covered	
	Specialty drugs	Your copay is based on whether the drug is generic, preferred brand or non-preferred brand, as shown above	Not covered	All specialty drugs must be filled at OptumRx's specialty pharmacy—BriovaRx. See www.briovarx.com. Some specialty drugs may also be covered under your medical benefit. Contact the plan at 860-571-9191 if you need a specialty drug.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	$20 copay; $200 copay if charges exceed $2,000	20% coinsurance plus balance billing charges	Preauthorization required or benefits are reduced by 20%. Obtain preauthorization by calling 1-877-284-0102.
	Physician/surgeon fees	Included in facility fee One copay per outpatient surgery	20% coinsurance plus balance billing charges	
If you need immediate medical attention	Emergency room care	$150 copay/visit. $300 copay/visit for non-emergency services	$150 copay/visit. $300 copay/visit for non-emergency services. Deductible does not apply.	$300 copay applies if diagnosis is not considered an emergency medical condition by the plan (using the prudent layperson standard); emergency room copay waived if admitted. Professional/physician charges may be billed separately.
	Emergency medical transportation	No charge up to $4,000, then 20% coinsurance	No charge up to $4,000, then 20% coinsurance	None
	Urgent care	$30 copay/visit at freestanding medical center	20% coinsurance plus balance billing charges	None

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	Preauthorization required or benefits are reduced by 20%. Obtain preauthorization by calling 1-877-284-0102. The difference between semi-private and private room rates is not covered unless medically necessary to isolate patient to prevent contagion.
	Physician/surgeon fees	Included in facility fee. One copay per hospital admission	20% coinsurance plus balance billing charges	Preauthorization required or benefits are reduced by 20%. Obtain preauthorization by calling 1-877-284-0102.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$20 copay/visit. $200 copay/visit if charges exceed $2,000	20% coinsurance plus balance billing charges	None
	Inpatient services	$500 copay/admission	20% coinsurance plus balance billing charges	Preauthorization required or benefits are reduced by 20%. Obtain preauthorization by calling 1-877-284-0102.
If you are pregnant	Office visits	$20 copay/initial visit only. $200 copay 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. Cost sharing does not apply to ACA-required preventive services. Depending on the type of services, a copayment, coinsurance, or deductible 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 copay per hospital admission	20% coinsurance plus balance billing charges	
	Childbirth/delivery facility services	$500 copay/admission	20% coinsurance plus balance billing charges	
If you need help recovering or have other special health needs	Home health care	No charge	20% coinsurance plus balance billing charges	Limit of 120 visits/year. Preauthorization required or benefits are reduced by 20%. Obtain preauthorization by calling 1-877-284-0102.
	Rehabilitation services	$20 copay/visit. $200 copay if charges exceed $2,000	20% coinsurance plus balance billing charges	Combined limit of 60 sessions/year for physical, speech and occupational therapy. Obtain preauthorization 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)	
	Habilitation services	$20 copay/visit. $200 copay if charges exceed $2,000	20% coinsurance plus balance billing 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 habilitation services expenses, even in-network.
	Skilled nursing care	$500 copay/admission	20% coinsurance plus balance billing charges	Limit of 120 visits/year. Preauthorization required or benefits are reduced by 20%. Obtain preauthorization by calling 1-877-284-0102.
	Durable medical equipment	20% coinsurance	20% coinsurance plus balance billing charges	Purchase or rental of medically necessary equipment subject to review by plan.
	Hospice services	$500 copay	20% coinsurance plus balance billing charges	Hospice services covered for terminally ill patients only. Preauthorization required or benefits are reduced by 20%. Obtain preauthorization 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. Deductible does not apply.	One exam every 12 months for dependents age 18 and younger. These benefits are administered separately from the medical plan. Cost sharing for these services is not included in the out-of-pocket limit.
	Children's glasses	No charge for select frames and lenses	No charge up to $250, then 100% of balance. Deductible does not apply.	One pair of glasses every 12 months for dependents age 18 and younger. These benefits are administered separately from the medical plan. Cost sharing for these services is not included in the out-of-pocket limit.
	Children's dental check-up	No charge	No charge up to allowed amount, then 100% of balance	Limited to one exam and one cleaning every six months. These benefits are administered separately from the medical plan. Cost sharing for these services is not included in the out-of-pocket limit.

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 (except as required under federal law)
- 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.)

- 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	**$12,700**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$0
Copayments	$600
Coinsurance	$0
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$660**

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	**$5,600**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$0
Copayments	$1,000
Coinsurance	$30
What isn't covered	
Limits or exclusions	$0
The total Joe would pay is	**$1,030**

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	**$2,800**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$0
Copayments	$360
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$360**

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