
 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 1-312-226-5000. 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.local130ua.org](http://www.local130ua.org) or call 1-312-226-5000 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall <u>deductible</u> ?	\$200/individual or \$600/family Calendar year basis	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> .
Are there services covered before you meet your <u>deductible</u> ?	Yes. <u>Preventive care</u> , wellness medical benefits, <u>prescription drugs</u> , hospice, dental, vision, hearing, pre-admission testing are covered before you meet your <u>deductible</u> when you use a <u>network provider</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. For example, this <u>plan</u> covers certain <u>preventive services</u> without <u>cost sharing</u> and before you meet your <u>deductible</u> . See a list of covered <u>preventive services</u> at <a href="https://www.healthcare.gov/coverage/preventive-care-benefits/">https://www.healthcare.gov/coverage/preventive-care-benefits/</a> .
Are there other <u>deductibles</u> for specific services?	Yes. \$50/individual or \$150/family for dental. There are no other specific <u>deductibles</u> .	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.
What is the <u>out-of-pocket limit</u> for this <u>plan</u> ?	\$1,500/individual or \$3,000/family per calendar year	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.
What is not included in the <u>out-of-pocket limit</u> ?	<u>Premiums</u> , <u>balance-billing</u> charges, <u>out-of-network</u> benefits, and health care this <u>plan</u> doesn't cover.	Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u> .
Will you pay less if you use a <u>network provider</u> ?	Yes. See <a href="http://www.bcbil.com">www.bcbil.com</a> or call 1-800-810-BLUE (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			Limitations, Exceptions, & Other Important Information
		PPO Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care <u>provider's</u> office or clinic	Primary care visit to treat an injury or illness	No charge for the first \$1,000 per calendar year and 20% <u>coinsurance</u> for expenses exceeding \$1,000	30% <u>coinsurance</u>	Pre-Certification is required for all out-of-network services.
	<u>Specialist</u> visit	No charge for the first \$1,000 per calendar year and 20% <u>coinsurance</u> for expenses exceeding \$1,000	30% <u>coinsurance</u>	Pre-Certification is required for all out-of-network services.
	<u>Preventive care/screening/immunization</u>	No charge, <u>deductible</u> does not apply	30% <u>coinsurance</u>	You may have to pay for services that aren't preventive. Ask your <u>provider</u> if the services needed are <u>preventive</u> . Then check what your <u>plan</u> will pay for.  Pre-Certification is required for all out-of-network services.
If you have a test	<u>Diagnostic test</u> (x-ray, blood work)	No charge for the first \$1,000 per calendar year and 20% <u>coinsurance</u> for expenses exceeding \$1,000	30% <u>coinsurance</u>	Pre-admission testing is covered at 100% if accepted by the Hospital and is not subject to the <u>deductible</u> .
	Imaging (CT/PET scans, MRIs)	No charge for the first \$1,000 per calendar year and 20% <u>coinsurance</u> for expenses exceeding \$1,000	30% <u>coinsurance</u>	Pre-Certification is required for all out-of-network services.

Common Medical Event	Services You May Need			Limitations, Exceptions, & Other Important Information
		PPO Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
<b>If you need drugs to treat your illness or condition</b> More information about <b>prescription drug coverage</b> is available at <a href="http://www.expressscripts.com">www.expressscripts.com</a>	Generic drugs (Tier 1)	\$10 <u>copay</u> /prescription (retail) No charge (mail order); <u>deductible</u> does not apply.	Not covered	Some over-the-counter drugs and supplements are covered as <u>preventive services</u> with a prescription. Refer to the SPD for more information.
	Preferred brand drugs (Tier 2)	\$20 <u>copay</u> /prescription (retail) \$10 <u>copay</u> /prescription (mail order); <u>deductible</u> does not apply.	Not covered	
	Non-preferred brand drugs (Tier 3)	\$40 <u>copay</u> /prescription (retail) \$20 <u>copay</u> /prescription (mail order); <u>deductible</u> does not apply.	Not covered	Covers up to a 34-day supply for retail and a 3-month supply for mail order.
	<u>Specialty drugs</u> (Tier 4)	\$20 <u>copay</u> /prescription; <u>deductible</u> does not apply.	Not covered	No charge for FDA-approved generic contraceptives (or brand name contraceptives if a generic is medically inappropriate). Prescribed specialty and self-administered injectable drugs (except insulin) must be acquired from Accredo.
<b>If you have outpatient surgery</b>	Facility fee (e.g., ambulatory surgery center)	No charge for the first \$2,000 and 10% <u>coinsurance</u> for expenses exceeding \$2,000	30% <u>coinsurance</u>	Pre-Certification is required for all out-of-network services.
	Physician/surgeon fees	No charge	30% <u>coinsurance</u>	
<b>If you need immediate medical attention</b>	<u>Emergency room care</u>	\$150 <u>copay</u> /visit plus 20% <u>coinsurance</u> for covered expenses exceeding \$1,000	\$150 <u>copay</u> /visit plus 30% <u>coinsurance</u>	Pre-Certification is required for all out-of-network services.
	<u>Emergency medical transportation</u>	No charge for the first \$1,000 per calendar year and 20% <u>coinsurance</u> for covered expenses exceeding \$1,000	30% <u>coinsurance</u>	
	<u>Urgent care</u>	No charge for the first \$1,000 per calendar year and 20% <u>coinsurance</u> for covered expenses exceeding \$1,000	30% <u>coinsurance</u>	Pre-Certification is required for all out-of-network services.

Common Medical Event	Services You May Need			Limitations, Exceptions, & Other Important Information
		PPO 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)	No charge for the first \$2,000 and 10% <u>coinsurance</u> for covered expenses exceeding \$2,000	30% <u>coinsurance</u>	Pre-Certification is required for all out-of-network services.
	Physician/surgeon fees	No charge for the first \$2,000 and 10% <u>coinsurance</u> for covered expenses exceeding \$2,000	30% <u>coinsurance</u>	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	No charge for the first \$1,000 per calendar year and 20% <u>coinsurance</u> for covered expenses exceeding \$1,000	30% <u>coinsurance</u>	Pre-Certification is required for all out-of-network services.
	Inpatient services	No charge for the first \$2,000 and 10% <u>coinsurance</u> for covered expenses exceeding \$2,000	30% <u>coinsurance</u>	
If you are pregnant	Office visits	No charge for the first \$1,000 per calendar year and 20% <u>coinsurance</u> for expenses exceeding \$1,000	30% <u>coinsurance</u>	The <u>plan</u> does not cover maternity and obstetrical care for dependent children.  Pre-Certification is required for all out-of-network services.
	Childbirth/delivery professional services	No charge for the first \$2,000 and 10% <u>coinsurance</u> for covered expenses exceeding \$2,000	30% <u>coinsurance</u>	
	Childbirth/delivery facility services	No charge for the first \$2,000 and 10% <u>coinsurance</u> for covered expenses exceeding \$2,000	30% <u>coinsurance</u>	

Common Medical Event	Services You May Need			Limitations, Exceptions, & Other Important Information
		PPO Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need help recovering or have other special health needs	<u>Home health care</u>	No charge for the first \$1,000 per calendar year and 20% <u>coinsurance</u> for covered expenses exceeding \$1,000	30% <u>coinsurance</u>	Maximum of 365 days minus the number of days spent as inpatient in a hospital for same sickness/injury.  Pre-Certification is required for all out-of-network services.
	<u>Rehabilitation services</u>	No charge for the first \$1,000 per calendar year and 20% <u>coinsurance</u> for covered expenses exceeding \$1,000	30% <u>coinsurance</u>	Pre-Certification is required for all out-of-network services.
	<u>Habilitation services</u>	No charge for the first \$1,000 per calendar year and 20% <u>coinsurance</u> for covered expenses exceeding \$1,000	30% <u>coinsurance</u>	
	<u>Skilled nursing care</u>	No charge for the first \$2,000 and 10% <u>coinsurance</u> for covered expenses exceeding \$2,000	30% <u>coinsurance</u>	Pre-Certification is required for all out-of-network services.
	<u>Durable medical equipment</u>	No charge for the first \$1,000 per calendar year and 20% <u>coinsurance</u> for covered expenses exceeding \$1,000	30% <u>coinsurance</u>	Prior approval required for amounts exceeding \$1,500.  Pre-Certification is required for all out-of-network services.
	<u>Hospice services</u>	20% <u>coinsurance</u> ; <u>deductible</u> does not apply.	30% <u>coinsurance</u>	Limited to 180 days per three-year period.  Pre-Certification is required for all out-of-network services.

Common Medical Event	Services You May Need			Limitations, Exceptions, & Other Important Information
		PPO Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If your child needs dental or eye care	Children's eye exam	100% of charges up to \$40; <u>deductible</u> does not apply.	100% charges up to \$40	Limit one examination in any 12-month period. Dollar limits not applicable to individuals under age 19.
	Children's glasses	100% of charges up to \$350; <u>deductible</u> does not apply.	100% charges up to \$350	Limit one pair of glasses or corrective contact lenses in any 12-month period. Dollar limits not applicable to individuals under age 19.
	Children's dental check-up	No charge. Dental <u>deductible</u> does not apply.	No charge. Dental <u>deductible</u> does not apply.	Annual maximum of \$4,000

## 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
- Long-Term Care
- Non-emergency when traveling outside the U.S.
- Private-duty Nursing
- Routine Foot Care

### Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

- Acupuncture (if performed by Physician, Surgeon, or licensed Chiropractor)
- Bariatric Surgery
- Chiropractic Care (up to \$2,000 in calendar year)
- Dental Care (Adults)
- Hearing Aids (up to \$1,500 with limit of one instrument in 60-month period)
- Infertility Treatment
- Routine Eye Care (Adults)
- Weight Loss Programs (except as required by the health reform law)
- Genetic Testing

**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 U.S. Department of Labor's Employee Benefits Security Administration at 1-866-444-3272 or [www.dol.gov/ebsa/healthreform](http://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](http://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 Plumbers' Welfare Fund, Local 130, U.A., 1340 West Washington Boulevard, Chicago, Illinois 60607, 1-312-226-5000. 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](http://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:

Para obtener asistencia en Español, llame al 312-226-5000.

-----*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 \$200
- Specialist coinsurance 20%
- Hospital (facility) coinsurance 10%
- Other 10%

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*)

<b>Total Example Cost</b>	<b>\$12,800</b>
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In this example, Peg would pay:

<i>Cost Sharing</i>	
Deductibles	\$200
Copayments	\$30
Coinsurance	\$710
<i>What isn't covered</i>	
Limits or exclusions	\$60
<b>The total Peg would pay is</b>	<b>\$1,000</b>

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

- The plan's overall deductible \$200
- Specialist coinsurance 20%
- Hospital (facility) coinsurance 10%
- Other 10%

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*)

<b>Total Example Cost</b>	<b>\$7,400</b>
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In this example, Joe would pay:

<i>Cost Sharing</i>	
Deductibles	\$200
Copayments	\$710
Coinsurance	\$590
<i>What isn't covered</i>	
Limits or exclusions	\$380
<b>The total Joe would pay is</b>	<b>\$1,880</b>

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

- The plan's overall deductible \$200
- Specialist coinsurance 20%
- Hospital (facility) coinsurance 10%
- Other 10%

This EXAMPLE event includes services like:  
Emergency room care (*including medical supplies*)  
Diagnostic test (*x-ray*)  
Durable medical equipment (*crutches*)  
Rehabilitation services (*physical therapy*)

<b>Total Example Cost</b>	<b>\$1,900</b>
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In this example, Mia would pay:

<i>Cost Sharing</i>	
Deductibles	\$200
Copayments	\$150
Coinsurance	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$0
<b>The total Mia would pay is</b>	<b>\$350</b>