PLUMBERS' WELFARE FUND
LOCAL 130, U.A.

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May 6, 2026

Summary of Benefits and Coverage

Dear Active Participant:

On behalf of the Board of Trustees of the Plumbers' Welfare Fund, Local 130 U.A. ("Fund"), we are pleased to provide you with the enclosed Summary of Benefits and Coverage (SBC) effective June 1, 2026. This document includes a summary of benefits and cost-sharing requirements under the Fund's Preferred Provider Option (PPO) Plan. It reflects the latest benefit improvements to the PPO Plan approved by the Board of Trustees.

The Fund developed the SBC in accordance with the requirements set forth in the Patient Protection and Affordable Care Act, also known as the Health Care Reform law. In the event there is a discrepancy between the SBC and the governing Plan documents, the Plan document will control. You may request additional copies of the SBC at any time.

In addition to the benefits described in the SBC, the Plumbers' Local 130 Welfare Fund provides health care and vision benefits through the Union Wellness Centers (UWC) which opened in August 2019. We hope that you and your family will utilize the UWC since they provide office visits, various wellness services, physical therapy treatments, vision services and the most frequently prescribed generic drugs at no cost to you. By going to the UWC, you may obtain many basic and wellness services under one roof.

In addition to the SBC, enclosed is a Notice pursuant to the Illinois Consumer Coverage Disclosure Act which was signed into law by Governor Pritzker in 2021. If you have any questions about the enclosed Notices, please contact the Fund Office at 312-226-5000.

Sincerely,

Board of Trustees
Plumbers' Welfare Fund, Local 130 U.A.

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 or call 1-312-226-5000 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	**$200** individual/**$600** family (January 1 – December 31)	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. Preventive care, wellness medical benefits, prescription drugs, hospice care, dental care, vision care, hearing care, and pre-admission testing are covered before you meet your deductible.	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost sharing and before you meet your deductible. See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/.
Are there other deductibles for specific services?	Yes. **$50** individual/**$150** family for dental (deductible does not apply to routine oral exams or Union Wellness Center services). 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?	**$1,500** individual/**$3,000** family (January 1 – December 31)	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.
What is not included in the out-of-pocket limit?	Premiums, balance-billing charges, out-of-network benefits, 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.bcbil.com or call 1-800-810-BLUE (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
		PPO 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	No charge for the first $1,000 per individual per calendar year and 20% coinsurance for expenses exceeding $1,000	30% coinsurance	$1,000 calendar year limit combined for office visits and diagnostic tests/imaging. Pre-certification is required for all out-of-network providers.
	Specialist visit	No charge for the first $1,000 per individual per calendar year and 20% coinsurance for expenses exceeding $1,000	30% coinsurance	$1,000 calendar year limit combined for office visits and diagnostic tests/imaging. Pre-certification is required for all out-of-network providers.
	Preventive care/screening/ immunization	No charge. Deductible does not apply.	30% coinsurance	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. Visits at a Union Wellness Center are paid at same rate as PPO Provider visit. Pre-certification is required for all out-of-network providers.
If you have a test	Diagnostic test (x-ray, blood work)	No charge for the first $1,000 per individual per calendar year and 20% coinsurance for expenses exceeding $1,000	30% coinsurance	$1,000 calendar year limit combined for office visits and diagnostic tests/imaging. Pre-admission testing is covered at 100% if accepted by the Hospital and is not subject to the deductible. Pre-certification is required for all out-of-network providers.
	Imaging (CT/PET scans, MRIs)	No charge for the first $1,000 per individual per calendar year and 20% coinsurance for expenses exceeding $1,000	30% coinsurance	
If you need drugs to treat your	Generic drugs (Tier 1)	$10 copay/prescription (retail); no charge (mail order). Deductible does not apply.	Not covered	Some over-the-counter drugs and supplements are covered as preventive services with a prescription.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		PPO Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
illness or condition More information about **prescription drug coverage** is available at www.expressscripts.com.	Preferred brand drugs (Tier 2)	$20 copay/prescription (retail); $10 copay/prescription (mail order). Deductible does not apply.	Not covered	Covers up to a 34-day supply retail and a 3-month supply through mail order. No charge for FDA-approved mail order generic drugs such as FDA-approved contraceptives (or brand name drugs if a generic is medically inappropriate). Prescribed self-administered injectable drugs may be obtained at retail pharmacies.
	Non-preferred brand drugs (Tier 3)	$40 copay/prescription (retail); $20 copay/prescription (mail order). Deductible does not apply.	Not covered	
	Specialty drugs (Tier 4)	$20 copay/prescription. Deductible does not apply.	Not covered	Prescribed specialty drugs must be acquired from Accredo.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	No charge for the first $1,000 per individual per calendar year and 20% coinsurance for expenses exceeding $1,000	30% coinsurance	Pre-certification is required for all out-of-network providers.
	Physician/surgeon fees	No charge	30% coinsurance	
If you need immediate medical attention	Emergency room care	$150 copay/visit plus 20% coinsurance for covered expenses exceeding $1,000	$150 copay/visit plus 20% coinsurance for covered expenses exceeding $1,000	Copay waived if you are admitted to a hospital.
	Emergency medical transportation	No charge for the first $1,000 per individual per calendar year and 20% coinsurance for covered expenses exceeding $1,000	30% coinsurance; except no charge for the first $1,000 per individual per calendar year and 20% coinsurance for covered expenses exceeding $1,000 for air ambulance services	
	Urgent care	No charge for the first $1,000 per individual per calendar year and 20% coinsurance for covered expenses exceeding $1,000	30% coinsurance	None

Common Medical Event	Services You May Need	What You Will Pay		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 and no deductible for room and board charges. Any other facility charges: no charge for the first $2,000 per individual per calendar year and 10% coinsurance for covered expenses exceeding $2,000	Room and board charges: 30% coinsurance, no deductible Any other facility charges: 30% coinsurance after deductible	Eligible costs for Surgical Assistants will be covered at 16% of the cost of the Surgeon's charge. Pre-certification is required for all out-of-network providers.
	Physician/surgeon fees	Surgeon: After deductible, no charge. Other professional charges: no charge for the first $2,000 per individual per calendar year and 10% coinsurance for covered expenses exceeding $2,000	30% coinsurance	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	No charge for the first $1,000 per individual per calendar year and 20% coinsurance for covered expenses exceeding $1,000	30% coinsurance	Pre-certification is required for all out-of-network providers.
	Inpatient services	No charge and no deductible for room and board charges. Any other facility charges: no charge for the first $2,000 per individual per calendar year and 10% coinsurance for covered expenses exceeding $2,000	Room and board charges: 30% coinsurance, no deductible Any other facility charges: 30% coinsurance after deductible	

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		PPO Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you are pregnant	Office visits	No charge for the first $1,000 per individual per calendar year and 20% coinsurance for expenses exceeding $1,000	30% coinsurance	Cost sharing does not apply for preventive services. Maternity care may include tests and services described somewhere else in the SBC (i.e., ultrasound). Pre-certification is required for all out-of-network providers.
	Childbirth/delivery professional services	No charge for the first $2,000 per individual per calendar year and 10% coinsurance for covered expenses exceeding $2,000	30% coinsurance	
	Childbirth/delivery facility services	No charge for the first $2,000 per individual per calendar year and 10% coinsurance for covered expenses exceeding $2,000	30% coinsurance	
If you need help recovering or have other special health needs	Home health care	No charge for the first $1,000 per individual per calendar year and 20% coinsurance for covered expenses exceeding $1,000	30% coinsurance	Maximum of 365 days minus the number of days spent as inpatient in a hospital for some sickness/injury. Pre-certification is required for all out-of-network providers.
	Rehabilitation services	No charge for the first $1,000 per individual per calendar year and 20% coinsurance for covered expenses exceeding $1,000	30% coinsurance	Pre-certification is required for all out-of-network providers.
	Habilitation services	No charge for the first $1,000 per individual per calendar year and 20% coinsurance for covered expenses exceeding $1,000	30% coinsurance	
	Skilled nursing care	No charge for the first $2,000 per individual per calendar year and 10% coinsurance for covered expenses exceeding $2,000	30% coinsurance	Pre-certification is required for all out-of-network providers.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		PPO Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
	Durable medical equipment	No charge for the first $1,000 per individual per calendar year and 20% coinsurance for covered expenses exceeding $1,000	30% coinsurance	Prior approval required for amounts exceeding $1,500 or not covered. Pre-certification is required for all out-of-network providers.
	Hospice services	20% coinsurance. Deductible does not apply.	30% coinsurance. Deductible does not apply.	Limited to 180 days per three-year period. Pre-certification is required for all out-of-network providers.
If your child needs dental or eye care	Children's eye exam	No charge up to $40 per exam. Deductible does not apply.	No charge up to $40 per exam. Deductible does not apply.	Limited to one examination in any Calendar Year. Dollar limit not applicable to individuals under age 19.
	Children's glasses	No charge up to $350 per individual. Deductible does not apply.	No charge up to $350 per individual. Deductible does not apply.	Limited to one pair of glasses and corrective contact lenses in any Calendar Year. Dollar limit not applicable to individuals under age 19.
	Children's dental check-up	No charge. Dental and medical deductibles do not apply.	No charge. Dental and medical deductibles do not apply.	Annual maximum of $4,000 per individual (not applicable to individuals under 19).

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 for reconstructive surgery following mastectomy and panniculectomy surgery to remove excess skin for individuals who have had significant weight loss)
- Gene Therapy Services
- Long-term care
- Non-emergency when traveling outside the U.S.
- Private-duty nursing
- Routine foot care
- Weight loss programs (except as required by the health reform law)

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, licensed Chiropractor or otherwise defined by the Plan, up to $2,000 per individual per calendar year combined with chiropractic care, naprapathy services, holistic medicine and other related services performed by a licensed Physician)
- Bariatric surgery
- Chiropractic care (up to $2,000 per individual per calendar year combined with acupuncture, naprapathy services, holistic medicine and other related services performed by a licensed Physician)
- Dental care (Adult) (up to $4,000 per individual per calendar year; limit does not apply to individuals under age 19)
- Hearing aids (up to $1,500 per individual with limit of one instrument in 60-month period)
- Infertility treatment (attempt limits apply, up to $20,000 for related prescription drug coverage per individual per lifetime)
- Routine eye care (Adult) (up to $40 per eye exam and up to $350 per individual for lenses and frames and contact lenses in any 12-month period; limits do not apply to individuals under age 19; Lasik corrective surgery available up to $1,000 on both eyes per lifetime)

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. 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 on how 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.

Does this plan provide Minimum Essential Coverage? **Yes**

Minimum Essential Coverage generally includes plans, health insurance available through the Marketplace or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of Minimum Essential Coverage, you may not be eligible for the premium tax credit.

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 PPO pre-natal care and a hospital delivery)

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

Total Example Cost	**$12,700**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$200
Copayments	$10
Coinsurance	$750
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$1,020**

Managing Joe's Type 2 Diabetes
(a year of routine PPO care of a well-controlled condition)

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

Total Example Cost	**$5,600**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$200
Copayments	$760
Coinsurance	$430
What isn't covered	
Limits or exclusions	$240
The total Joe would pay is	**$1,630**

Mia's Simple Fracture
(PPO emergency room visit and follow up care)

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

Total Example Cost	**$2,800**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$200
Copayments	$160
Coinsurance	$40
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$400**

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

ILLINOIS CONSUMER COVERAGE DISCLOSURE ACT NOTICE	
Issuer and Plan Name:	**Plumbers Welfare Fund, Local 130, U.A.**
Plan Year:	**June 2026-May 2027**

Ten (10) Essential Health Benefit (EHB) Categories:

- Ambulatory patient services (outpatient care you get without being admitted to a hospital)
- Emergency services
- Hospitalization (like surgery and overnight stays)
- Laboratory services
- Mental health and substance use disorder (MH/SUD) services, including behavioral health treatment (this includes counseling and psychotherapy)
- Pediatric services, including oral and vision care (but adult dental and vision coverage aren't essential health benefits)
- Pregnancy, maternity, and newborn care (both before and after birth)
- Prescription drugs
- Preventive and wellness services and chronic disease management
- Rehabilitative and habilitative services and devices (services and devices to help people with injuries, disabilities, or chronic conditions gain or recover mental and physical skills)

2020-2026 Illinois Essential Health Benefit (EHB) Listing (P.A. 102-0630)

Item	EHB Benefit	EHB Category	Benchmark Page # Reference	Employer Plan Covered Benefit?
1	Accidental Injury -- Dental	Ambulatory	Pgs. 10 & 17	Yes
2	Allergy Injections and Testing	Ambulatory	Pg. 11	Yes
3	Bone anchored hearing aids	Ambulatory	Pgs. 17 & 35	Yes
4	Durable Medical Equipment	Ambulatory	Pg. 13	Yes
5	Hospice	Ambulatory	Pg. 28	Yes
6	Infertility (Fertility) Treatment	Ambulatory	Pgs. 23 - 24	Yes
7	Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	Ambulatory	Pg. 21	Yes
8	Outpatient Surgery Physician/Surgical Services (Ambulatory Patient Services)	Ambulatory	Pgs. 15 - 16	Yes
9	Private-Duty Nursing	Ambulatory	Pgs. 17 & 34	Yes

10	Prosthetics/Orthotics	Ambulatory	Pg. 13	Yes
11	Sterilization (vasectomy men)	Ambulatory	Pg. 10	Yes
12	Temporomandibular Joint Disorder (TMJ)	Ambulatory	Pgs. 13 & 24	Yes
13	Emergency Room Services (Includes MH/SUD Emergency)	Emergency services	Pg. 7	Yes
14	Emergency Transportation/ Ambulance	Emergency services	Pgs. 4 & 17	Yes
15	Bariatric Surgery (Obesity)	Hospitalization	Pg. 21	Yes
16	Breast Reconstruction After Mastectomy	Hospitalization	Pgs. 24 - 25	Yes
17	Reconstructive Surgery	Hospitalization	Pgs. 25 - 26, & 35	Yes
18	Inpatient Hospital Services (e.g., Hospital Stay)	Hospitalization	Pg. 15	Yes
19	Skilled Nursing Facility	Hospitalization	Pg. 21	Yes
20	Transplants - Human Organ Transplants (Including transportation & lodging)	Hospitalization	Pgs. 18 & 31	Yes
21	Diagnostic Services	Laboratory services	Pgs. 6 & 12	Yes
22	Intranasal opioid reversal agent associated with opioid prescriptions	MH/SUD	Pg. 32	Yes
23	Mental (Behavioral) Health Treatment (Including Inpatient Treatment)	MH/SUD	Pgs. 8 -9, 21	Yes
24	Opioid Medically Assisted Treatment (MAT)	MH/SUD	Pg. 21	Yes
25	Substance Use Disorders (Including Inpatient Treatment)	MH/SUD	Pgs. 9 & 21	Yes
26	Tele-Psychiatry	MH/SUD	Pg. 11	Yes
27	Topical Anti-Inflammatory acute and chronic pain medication	MH/SUD	Pg. 32	Yes
28	Pediatric Dental Care	Pediatric Oral and Vision Care	See AllKids Pediatric Dental Document	Yes
29	Pediatric Vision Coverage	Pediatric Oral and Vision Care	Pgs. 26 - 27	Yes
30	Maternity Service	Pregnancy, Maternity, and Newborn Care	Pgs. 8 & 22	Yes
31	Outpatient Prescription Drugs	Prescription drugs	Pgs. 29 - 34	Yes
32	Colorectal Cancer Examination and Screening	Preventive and Wellness Services	Pgs. 12 & 16	Yes

33	Contraceptive/Birth Control Services	Preventive and Wellness Services	Pgs. 13 & 16	Yes
34	Diabetes Self-Management Training and Education	Preventive and Wellness Services	Pgs. 11 & 35	Yes
35	Diabetic Supplies for Treatment of Diabetes	Preventive and Wellness Services	Pgs. 31 - 32	Yes
36	Mammography - Screening	Preventive and Wellness Services	Pgs. 12, 15, & 24	Yes
37	Osteoporosis - Bone Mass Measurement	Preventive and Wellness Services	Pgs. 12 & 16	Yes
38	Pap Tests/ Prostate- Specific Antigen Tests/ Ovarian Cancer Surveillance Test	Preventive and Wellness Services	Pg. 16	Yes
39	Preventive Care Services	Preventive and Wellness Services	Pg. 18	Yes
40	Sterilization (women)	Preventive and Wellness Services	Pgs. 10 & 19	Yes
41	Chiropractic & Osteopathic Manipulation	Rehabilitative and Habilitative Services and Devices	Pgs. 12 - 13	Yes
42	Habilitative and Rehabilitative Services	Rehabilitative and Habilitative Services and Devices	Pgs. 8, 9, 11, 12, 22, & 35	Yes

Special Note: Under Pub. Act 102-0104, eff. July 22, 2021, any EHBs listed above that are clinically appropriate and medically necessary to deliver via telehealth services must be covered in the same manner as when those EHBs are delivered in person. The above notice is provided for informational purposes only pursuant to the Illinois Consumer Coverage Disclosure Act. Please consult your summary plan description for detailed information about your coverage under the Plumbers Welfare Fund, Local 130, U.A.