



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 <u>deductible</u>?	\$200 individual/ \$600 family (January 1 – December 31)	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 care, dental care, vision care, hearing care, and pre-admission testing are covered before you meet your <u>deductible</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 https://www.healthcare.gov/coverage/preventive-care-benefits/ .
Are there other <u>deductibles</u> for specific services?	Yes. \$50 individual/ \$150 family for dental (<u>deductible</u> does not apply to routine oral exams or Union Wellness Center services). 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/ \$3,000 family (January 1 – December 31)	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 www.bcbil.com 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</u> charge 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	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% <u>coinsurance</u> for expenses exceeding \$1,000	30% <u>coinsurance</u>	\$1,000 calendar year limit combined for office visits and <u>diagnostic tests/imaging</u> . Pre-certification is required for all <u>out-of-network providers</u> .
	<u>Specialist</u> visit	No charge for the first \$1,000 per individual per calendar year and 20% <u>coinsurance</u> for expenses exceeding \$1,000	30% <u>coinsurance</u>	\$1,000 calendar year limit combined for office visits and <u>diagnostic tests/imaging</u> . Pre-certification is required for all <u>out-of-network providers</u> .
	<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 preventive. Then check what your <u>plan</u> will pay for. Visits at a Union Wellness Center are paid at same rate as PPO <u>Provider</u> visit. Pre-certification is required for all <u>out-of-network providers</u> .
If you have a test	<u>Diagnostic test</u> (x-ray, blood work)	No charge for the first \$1,000 per individual per calendar year and 20% <u>coinsurance</u> for expenses exceeding \$1,000	30% <u>coinsurance</u>	\$1,000 calendar year limit combined for office visits and <u>diagnostic tests/imaging</u> . Pre-admission testing is covered at 100% if accepted by the Hospital and is not subject to the <u>deductible</u> . Pre-certification is required for all <u>out-of-network providers</u> .
	Imaging (CT/PET scans, MRIs)	No charge for the first \$1,000 per individual per calendar year and 20% <u>coinsurance</u> for expenses exceeding \$1,000	30% <u>coinsurance</u>	
If you need drugs to treat	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.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		PPO <u>Provider</u> (You will pay the least)	<u>Out-of-Network Provider</u> (You will pay the most)	
your illness or condition More information about <u>prescription drug coverage</u> is available at www.expressscripts.com .	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	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. Prescribed <u>specialty drugs</u> must be acquired from Accredo.
	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	
	<u>Specialty drugs</u> (Tier 4)	\$20 <u>copay</u> /prescription. <u>Deductible</u> does not apply.	Not covered	
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% <u>coinsurance</u> for expenses exceeding \$1,000	30% <u>coinsurance</u>	Pre-certification is required for all <u>out-of-network providers</u> .
	Physician/surgeon fees	No charge	30% <u>coinsurance</u>	

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 need immediate medical attention	<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 20% <u>coinsurance</u> for covered expenses exceeding \$1,000	None
	<u>Emergency medical transportation</u>	No charge for the first \$1,000 per individual per calendar year and 20% <u>coinsurance</u> for covered expenses exceeding \$1,000	30% <u>coinsurance</u> ; except no charge for the first \$1,000 per individual per calendar year and 20% <u>coinsurance</u> for covered expenses exceeding \$1,000 for air ambulance services	
	<u>Urgent care</u>	No charge for the first \$1,000 per individual per calendar year and 20% <u>coinsurance</u> for covered expenses exceeding \$1,000	30% <u>coinsurance</u>	None
If you have a hospital stay	Facility fee (e.g., hospital room)	No charge for the first \$2,000 per individual per calendar year and 10% <u>coinsurance</u> for covered expenses exceeding \$2,000	30% <u>coinsurance</u>	Eligible costs for Surgical Assistants will be covered at 16% of the cost of the Surgeon's charge. Pre-certification is required for all <u>out-of-network providers</u> .
	Physician/surgeon fees	After <u>deductible</u> , no charge.	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 individual per calendar year and 20% <u>coinsurance</u> for covered expenses exceeding \$1,000	30% <u>coinsurance</u>	Pre-certification is required for all <u>out-of-network providers</u> .
	Inpatient services	No charge for the first \$2,000 per individual per calendar year and 10% <u>coinsurance</u> for covered expenses exceeding \$2,000	30% <u>coinsurance</u>	

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% <u>coinsurance</u> for expenses exceeding \$1,000	30% <u>coinsurance</u>	<p><u>Cost sharing</u> does not apply for <u>preventive services</u>. Maternity care may include tests and services described somewhere else in the SBC (i.e., ultrasound).</p> <p>Pre-certification is required for all <u>out-of-network providers</u>.</p>
	Childbirth/delivery professional services	No charge for the first \$2,000 per individual per calendar year 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 per individual per calendar year and 10% <u>coinsurance</u> for covered expenses exceeding \$2,000	30% <u>coinsurance</u>	
If you need help recovering or have other special health needs	<u>Home health care</u>	No charge for the first \$1,000 per individual per calendar year and 20% <u>coinsurance</u> for covered expenses exceeding \$1,000	30% <u>coinsurance</u>	<p>Maximum of 365 days minus the number of days spent as inpatient in a hospital for some sickness/injury.</p> <p>Pre-certification is required for all <u>out-of-network providers</u>.</p>
	<u>Rehabilitation services</u>	No charge for the first \$1,000 per individual per calendar year and 20% <u>coinsurance</u> for covered expenses exceeding \$1,000	30% <u>coinsurance</u>	<p>Pre-certification is required for all <u>out-of-network providers</u>.</p>
	<u>Habilitation services</u>	No charge for the first \$1,000 per individual 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 per individual per calendar year and 10% <u>coinsurance</u> for covered expenses exceeding \$2,000	30% <u>coinsurance</u>	<p>Pre-certification is required for all <u>out-of-network providers</u>.</p>

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		PPO <u>Provider</u> (You will pay the least)	<u>Out-of-Network Provider</u> (You will pay the most)	
	<u>Durable medical equipment</u>	No charge for the first \$1,000 per individual 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 or not covered. Pre-certification is required for all <u>out-of-network providers</u> .
	<u>Hospice services</u>	20% <u>coinsurance</u> . <u>Deductible</u> does not apply.	30% <u>coinsurance</u> . <u>Deductible</u> does not apply.	Limited to 180 days per three-year period. Pre-certification is required for all <u>out-of-network providers</u> .
If your child needs dental or eye care	Children's eye exam	No charge up to \$40 per exam. <u>Deductible</u> does not apply.	No charge up to \$40 per exam. <u>Deductible</u> 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. <u>Deductible</u> does not apply.	No charge up to \$350 per individual. <u>Deductible</u> 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 <u>deductibles</u> do not apply.	No charge. Dental and medical <u>deductibles</u> 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)
- Bariatric surgery (subject to conditions)
- 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 <u>plan's</u> overall <u>deductible</u>	\$200
■ <u>Specialist coinsurance</u>	20%
■ <u>Hospital (facility) coinsurance</u>	10%
■ <u>Other coinsurance</u>	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
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In this example, Peg would pay:

<i>Cost Sharing</i>	
<u>Deductibles</u>	\$200
<u>Copayments</u>	\$10
<u>Coinsurance</u>	\$750
<i>What isn't covered</i>	
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 <u>plan's</u> overall <u>deductible</u>	\$200
■ <u>Specialist coinsurance</u>	20%
■ <u>Hospital (facility) coinsurance</u>	10%
■ <u>Other coinsurance</u>	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
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In this example, Joe would pay:

<i>Cost Sharing</i>	
<u>Deductibles</u>	\$200
<u>Copayments</u>	\$760
<u>Coinsurance</u>	\$430
<i>What isn't covered</i>	
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 <u>plan's</u> overall <u>deductible</u>	\$200
■ <u>Specialist coinsurance</u>	20%
■ <u>Hospital (facility) coinsurance</u>	10%
■ <u>Other coinsurance</u>	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
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In this example, Mia would pay:

<i>Cost Sharing</i>	
<u>Deductibles</u>	\$200
<u>Copayments</u>	\$160
<u>Coinsurance</u>	\$40
<i>What isn't covered</i>	
Limits or exclusions	\$0
The total Mia would pay is	\$400