



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% <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> . Telemedicine office visits paid same as PPO Provider during the Public Health Emergency. Pre-certification is required for all <u>out-of-network providers</u> .
	Specialist 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 Provider visit. Pre-certification is required for all <u>out-of-network providers</u> except services related to COVID-19 testing and preventive care.
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> .
	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>	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> .

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)	
<p>If you need drugs to treat your illness or condition More information about <u>prescription drug coverage</u> is available at www.expressscripts.com.</p>	Generic drugs (Tier 1)	\$10 <u>copay</u> /prescription (retail); no charge (mail order). <u>Deductible</u> does not apply.	Not covered	<p>Some over-the-counter drugs and supplements are covered as <u>preventive services</u> with a prescription.</p> <p>Covers up to a 34-day supply retail and a 3-month supply through mail order.</p> <p>No charge for FDA-approved mail order generic drugs such as FDA-approved contraceptives (or brand name drugs if a generic is medically inappropriate).</p> <p>Prescribed specialty and self-administered injectable drugs (except insulin) must be acquired from Accredo.</p>
	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	
	<u>Specialty drugs</u> (Tier 4)	\$20 <u>copay</u> /prescription. <u>Deductible</u> does not apply.	Not covered	
<p>If you have outpatient surgery</p>	Facility fee (e.g., ambulatory surgery center)	No charge for the first \$2,000 per individual per calendar year and 10% <u>coinsurance</u> for expenses exceeding \$2,000	30% <u>coinsurance</u>	<p>Pre-certification is required for all <u>out-of-network providers</u>.</p>
	Physician/surgeon fees	No charge	30% <u>coinsurance</u>	
<p>If you need immediate medical attention</p>	<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>	<p>None</p>
	<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>	
	<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>	

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 for the first \$2,000 per individual per calendar year and 10% coinsurance 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 deductible, 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% coinsurance 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% coinsurance for covered expenses exceeding \$2,000	30% <u>coinsurance</u>	
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% <u>coinsurance</u>	Other than ACA-required preventive screenings for pregnant women, the <u>plan</u> does not cover maternity and obstetrical care for dependent children. <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). Pre-certification is required for all <u>out-of-network providers</u> .
	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% <u>coinsurance</u>	
	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% <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 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>	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 <u>out-of-network providers</u> .
	<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>	Pre-certification is required for all <u>out-of-network providers</u> .
	<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>	Pre-certification is required for all <u>out-of-network providers</u> .
	<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> .

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 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)
- Bariatric surgery
- Chiropractic care (up to \$2,000 per individual per calendar year)
- 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 (up to \$20,000 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.