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?	**$750** individual/**$2,250** 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 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 for prescription drugs. 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?	PPO Provider: **$2,500** individual/**$7,500** family; Out-of-Network Provider: Unlimited. Prescription Drugs: **$5,600** individual/**$9,450** 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	20% coinsurance	40% coinsurance	Pre-certification is required for all out-of-network providers.
	Specialist visit	20% coinsurance	40% coinsurance	Pre-certification is required for all out-of-network providers.
	Preventive care/screening/ immunization	No charge. Deductible does not apply.	40% 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. Onsite medical clinic preventive care visits 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)	20% coinsurance	40% coinsurance	Pre-certification is required for all out-of-network providers.
	Imaging (CT/PET scans, MRIs)	20% coinsurance	40% coinsurance	

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 drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.expressscripts.com.	Generic drugs (Tier 1)	15% coinsurance after $50 individual deductible (retail and mail order)	Not covered	A separate deductible applies to prescription drug coverage ($50/individual). Some over-the-counter drugs and supplements are covered as preventive services with a prescription. Covers up to a 34-day supply retail and a 3-month supply through mail order. No charge for FDA-approved generic preventive 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.
	Preferred brand drugs (Tier 2)	25% coinsurance after $50 individual deductible (retail and mail order)	Not covered	
	Non-preferred brand drugs (Tier 3)	40% coinsurance after $50 individual deductible (retail and mail order)	Not covered	
	Specialty drugs (Tier 4)	40% coinsurance after $50 individual deductible	Not covered	Prescribed specialty drugs must be acquired from Accredo.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance	40% coinsurance	Pre-certification is required for all out-of-network providers.
	Physician/surgeon fees	20% coinsurance	40% coinsurance	
If you need immediate medical attention	Emergency room care	$150 copay/visit plus 20% coinsurance	$150 copay/visit plus 20% coinsurance	None
	Emergency medical transportation	20% coinsurance	40% coinsurance; except 20% coinsurance for air ambulance services	
	Urgent care	20% coinsurance	40% 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)	20% coinsurance	40% coinsurance	Pre-certification is required for all out-of-network providers.
	Physician/surgeon fees	20% coinsurance	40% coinsurance	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	20% coinsurance	40% coinsurance	Pre-certification is required for all out-of-network providers.
	Inpatient services	20% coinsurance	40% coinsurance	
If you are pregnant	Office visits	20% coinsurance	40% 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	20% coinsurance	40% coinsurance	
	Childbirth/delivery facility services	20% coinsurance	40% coinsurance	

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	Home health care	20% coinsurance	40% 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	20% coinsurance	40% coinsurance	Exercise or physical therapy to prevent falls in community-dwelling adults age 65 years and older who are at increased risk for falls is covered as a preventive service. Pre-certification is required for all out-of-network providers.
	Habilitation services	20% coinsurance	40% coinsurance	
	Skilled nursing care	20% coinsurance	40% coinsurance	Pre-certification is required for all out-of-network providers.
	Durable medical equipment	20% coinsurance	40% 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.	40% coinsurance	Limited to 180 days per three-year period. 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)	
If your child needs dental or eye care	Children's eye exam	Not covered.	Not covered.	None
	Children's glasses	Not covered.	Not covered.	None
	Children's dental check-up	Not covered.	Not covered.	None

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)
- Dental care (Adult)
- Hearing aids
- Long-term care
- Non-emergency when traveling outside the U.S.
- Private-duty nursing
- Routine eye care (Adult)
- 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, or licensed Chiropractor or otherwise defined by the Plan, up to $2,000 per individual per calendar year combined with chiropractic care)
- 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)
- Infertility treatment (attempt limits apply, up to $20,000 for related prescription drug coverage per individual 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	$750
Specialist coinsurance	20%
Hospital (facility) coinsurance	20%
Other coinsurance	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*	$760
Copayments	$0
Coinsurance	$1,750
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$2,570**

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

The plan's overall deductible	$750
Specialist coinsurance	20%
Hospital (facility) coinsurance	20%
Other coinsurance	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*	$800
Copayments	$0
Coinsurance	$1,040
What isn't covered	
Limits or exclusions	$240
The total Joe would pay is	**$2,080**

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

The plan's overall deductible	$750
Specialist coinsurance	20%
Hospital (facility) coinsurance	20%
Other coinsurance	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*	$760
Copayments	$150
Coinsurance	$380
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,290**

*NOTE: This plan has other deductibles for specific services included in this coverage example. See "Are there other deductibles for specific services?" row above
The **plan** would be responsible for the other costs of these EXAMPLE covered services.