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, go to www.ualocal1funds.org or call 1-718-223-4313. 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.dol.gov/ebsa/healthreform.com or call 1-718-223-4313 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	Network providers: $0 Out-of-network providers: $2,000/individual or $5,000/family	In-network: See the Common Medical Events chart below for services this plan covers. Out-of-Network: 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?	In-Network: Not applicable Out-of-Network: Yes. Home health care and prescription drugs are covered before you meet your deductible.	In-Network: This plan does not have a deductible. Out of-Network: This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply.
Are there other deductibles for specific services?	No.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	Medical/hospital network providers: $5,100/individual, $10,200/family Medical/hospital out-of-network providers: $4,000/individual, $10,000/family Prescription drugs (in-network): $1,500/individual, $3,000/family	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, penalties for failure to obtain preauthorization and health care this plan doesn't cover. Prescription drugs: Cost sharing for certain non-essential specialty drugs does not count toward the prescription drug out-of-pocket limit.	Even though you pay these expenses, they don't count toward the out-of-pocket limit.

* For more information about limitations and exceptions, see the plan or policy document at www.ualocal1funds.org.

Important Questions	Answers	Why This Matters:
Will you pay less if you use a network provider?	Yes. See www.ualocal1funds.org 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
		Network 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	$25 copay /visit	20% coinsurance	None
	Specialist visit	$35 copay /visit	20% coinsurance	None
	Preventive care/screening/ immunization	No charge	20% coinsurance	Age and frequency limits apply. 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.
If you have a test	Diagnostic test (x-ray, blood work)	No charge	20% coinsurance	None
	Imaging (CT/PET scans, MRIs)	No charge	20% coinsurance	Benefits may be reduced by 50% up to $2,500 if you do not obtain preauthorization for services.
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.caremark.com or	Generic drugs	CVS Retail Pharmacy:1st 3 fills $10 copay/script for 30-day supply; 4th fill and after $25 copay/script for 30-day supply; 1st fill and after $25 copay/script for 84-90-day supply. Other Retail Pharmacies: 1st 3 fills $10 copay/script for 30-day supply;	Retail only: $10 copay/script plus the difference between In- and Out-of-Network costs. Deductible does not apply.	You cannot get an 84-90-day supply at a Non-CVS Pharmacy. No charge for generic contraceptives (or brand name if a generic is medically inappropriate) and certain preventive prescriptions required under ACA. If a drug is available over-the-counter and covered under

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
via phone at 1-800-824-6349.		4th fill and after $25 copay/script for 30-day supply. Mail order: $10 copay/script for 30-day supply; $17 copay/script for 60-day supply; $25 copay/script for 90-day supply.		this provision, a prescription must be presented at the time of purchase in order for the drug to be covered under the plan. The plan only covers mail order and maintenance fills at network pharmacies.
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.caremark.com or 1-800-824-6349.	Preferred Brand Drugs	CVS Retail Pharmacy:1st 3 fills $35 copay/script for 30-day supply; 4th fill and after $55 copay/script for 30-day supply; 1st fill and after $80 copay/script for 84-90-day supply. Other Retail Pharmacies: 1st 3 fills $35 copay/script for 30-day supply; 4th fill and after $55 copay/script for 30-day supply. Mail order: $35 copay/script for 30-day supply; $75 copay/script for 60-day supply; $80 copay/script for 90-day supply.	Retail only: $35 copay/script plus the difference between In- and Out-of-Network costs. Deductible does not apply.	You cannot get an 84-90-day supply at a Non-CVS Pharmacy. No charge for generic contraceptives (or brand name if a generic is medically inappropriate) and certain preventive prescriptions required under ACA. If a drug is available over-the-counter and covered under this provision, a prescription must be presented at the time of purchase in order for the drug to be covered under the plan. The plan only covers mail order and maintenance fills at network pharmacies.
	Non-Preferred Brand Drugs	CVS Retail Pharmacy:1st 3 fills $60 copay/script for 30-day supply; 4th fill and after $80 copay/script for 30-day supply; 1st fill and after $135 copay/script for 84-90-day supply. Other Retail Pharmacies: 1st 3 fills $60 copay/script for 30-day supply; 4th fill and after $80 copay/script for 30-day supply. Mail order: $60 copay/script for 30-day supply; $120 copay/script for 60-day supply; $135 copay/script for 90-day supply.	Retail only: $60 copay/script plus the difference between In- and Out-of-Network costs. Deductible does not apply.	

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
	Specialty drugs	Retail: Not Covered Mail Order: Applicable copay above No charge for certain non-essential specialty drugs on the PrudentRx Specialty Drug List if you enroll in the program. You pay 30% coinsurance on the cost of these non-essential specialty drugs if you do not enroll in the program.	Not covered	Specialty drugs are available from Caremark's SpecialtyRx Pharmacy. You can receive up to a 30-day supply of specialty drugs at a time. These drugs require preapproval from Caremark. Your cost sharing for certain non-essential specialty drugs, as well as any amount paid by the drug manufacturer through its copay assistance program, do not count toward your out-of-pocket limit
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	No charge	20% coinsurance	Benefits may be reduced by 50% up to $2,500 if you do not obtain preauthorization for services.
	Physician/surgeon fees	No charge	20% coinsurance	
If you need immediate medical attention	Emergency room care	$150 copay/visit	$150 copay/visit	Copay waived if admitted to hospital within 24 hours. Professional/physician charges may be billed separately.
	Emergency medical transportation	No charge	No charge	Air ambulance limited to $7,500 for airlift charges resulting from emergency medical treatment. Deductible waived if admitted to hospital within 24 hours.
	Urgent care	$25 copay/visit	20% coinsurance	None
If you have a hospital stay	Facility fee (e.g., hospital room)	No charge	20% coinsurance	Benefits may be reduced by 50% up to $2,500 if you do not obtain preauthorization for services.
	Physician/surgeon fees	No charge	20% coinsurance	

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Office visits: $25 copay/visit; Other outpatient services: No charge	20% coinsurance	None
	Inpatient services	No charge	20% coinsurance	Benefits may be reduced by 50% up to $2,500 if you do not obtain preauthorization for services.
If you are pregnant	Office visits	First visit: $25 copay All other visits: No charge	20% 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). Depending on the type of services and provider, a copayment, coinsurance, or deductible may apply.
	Childbirth/delivery professional services	No charge	20% coinsurance	
	Childbirth/delivery facility services	No charge	20% coinsurance	
If you need help recovering or have other special health needs	Home health care	No charge	20% coinsurance; Deductible does not apply	Limited to 200 visits per calendar year.
	Rehabilitation services	Inpatient: No charge Outpatient: $25 copay/visit	20% coinsurance	Inpatient physical therapy limited to 30 days per calendar year. Outpatient physical therapy limited to 30 visits per calendar year. Outpatient speech and vision therapies limited to 30 combined visits per calendar year. Benefits may be reduced by 50% up to $2,500 if you do not obtain preauthorization for services.
	Habilitation services	Not covered	Not covered	You must pay 100% of charges, even In-Network.
	Skilled nursing care	No charge	20% coinsurance	Limited to 60 days per calendar year in lieu of hospitalization. Benefits may be reduced by 50% up to $2,500 if you do not obtain preauthorization for services.
	Durable medical equipment	No charge	20% coinsurance	Benefits may be reduced by 50% up to $2,500 if you do not obtain preauthorization for services.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
	Hospice services	No charge	20% coinsurance	Limited to 210 days per lifetime. Benefits may be reduced by 50% up to $2,500 if you do not obtain preauthorization for services.
If your child needs dental or eye care	Children's eye exam	No charge	Amount over $20 plan allowance	Separately administered by Vision Screening, Inc. / Comprehensive Professional Systems, Inc. Once every 12 months for eligible individuals to age 18; once every 24 months for eligible individuals over age 18
	Children's glasses	Amount over $100 for frames and lenses.	Amount over $100 plan allowance for frames and lenses combined	
	Children's dental check-up	No charge	Amount over plan allowance	Dental benefits are separately administered by CIGNA Dental Services. Limited to $3,000 maximum benefit/calendar year; maximum does not apply to children up to age 18.

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 when medically necessary) • Habilitation services • Long-term care	• Non-emergency care when traveling outside the U.S. • Private-duty nursing	• Routine foot care • Weight loss programs (except as required by the ACA)

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)		
• Acupuncture (Limited to 15 visits per year) • Bariatric surgery • Chiropractic care	• Dental care (Adult)(Limited to $3,000 per calendar year) • Hearing aids (20% discount on provider and retail costs/Limited to a maximum $500 once every 36 months)	• Infertility treatment • Routine eye care (Adult) (Eye exam covered every 24 months; glasses limited to maximum $100 once every 24 months)

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, Employee Benefits Security Administration at 1-866-444-EBSA (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 Local Union No. 1 Welfare Fund Office at 1-718-223-4313. You may also contact the Department of Labor's Employees Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform. Additionally, a consumer assistance program can help you file your appeal. Contact: Community Service Society of New York, Community Health Advocates, 105 East 22nd Street, 8th floor, New York, NY 10010, (888) 614-5400, www.communityhealthadvocates.org.

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:

Spanish (Español): Para obtener asistencia en Español, llame al 1-718-223-4313

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To see examples of how this plan might cover costs for a sample medical situation, see the next section.

* For more information about limitations and exceptions, see the plan or policy document at www.ualocal1funds.org.

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** **$0**
- **Primary Care Physician copayment** **$25**
- **Hospital (facility) cost sharing** **$0**
- **Other coinsurance** **0%**

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	$0
Copayments	$10
Coinsurance	$0
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$70**

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

- **The plan's overall deductible** **$0**
- **Specialist copayment** **$35**
- **Hospital (facility) cost sharing** **$0**
- **Other coinsurance** **0%**

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	$0
Copayments	$720
Coinsurance	$0
What isn't covered	
Limits or exclusions	$230
The total Joe would pay is	**$950**

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

- **The plan's overall deductible** **$0**
- **Specialist copayment** **$35**
- **Hospital (facility) cost sharing** **$150**
- **Other coinsurance** **0%**

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	$0
Copayments	$400
Coinsurance	$0
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.