
 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](http://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](http://www.dol.gov/ebsa/healthreform.com) or call 1-718-223-4313 to request a copy.

Important Questions	Answers	Why This Matters:
<b>What is the overall <u>deductible</u>?</b>	<p><u>Network providers</u>: \$0  <u>Out-of-network providers</u>: \$2,000/individual or \$5,000/family</p>	<p><u>In-network</u>: See the Common Medical Events chart below for services this <u>plan</u> covers.  <u>Out-of-network</u>: 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>.</p>
<b>Are there services covered before you meet your <u>deductible</u>?</b>	<p><u>In-Network</u>: Not applicable  <u>Out-of-Network</u>: Yes. <u>Home health care services</u>, <u>emergency medical transportation</u> if admitted within 24 hours, and <u>prescription drugs</u> are covered before you meet your <u>deductible</u>.</p>	<p><u>In-Network</u>: This <u>plan</u> does not have a <u>deductible</u>.  <u>Out-of-Network</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.</p>
<b>Are there other <u>deductibles</u> for specific services?</b>	No.	You don't have to meet <u>deductibles</u> for specific services.
<b>What is the <u>out-of-pocket limit</u> for this <u>plan</u>?</b>	<p><u>Medical/hospital network providers</u>: \$5,100/individual, \$10,200/family  <u>Medical/hospital out-of-network providers</u>: \$4,000/individual, \$10,000/family  <u>Prescription drugs (in-network)</u>: \$1,500/individual, \$3,000/family</p>	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.
<b>What is not included in the <u>out-of-pocket limit</u>?</b>	<p><u>Premiums</u>, <u>balance-billing</u> charges, penalties for failure to obtain <u>preauthorization</u> and health care this <u>plan</u> doesn't cover.  <u>Prescription drugs</u>: <u>Cost sharing</u> for certain non-essential <u>specialty drugs</u> does not count toward the <u>prescription drug out-of-pocket limit</u>.</p>	Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u> .

\* For more information about limitations and exceptions, see the plan or policy document at [www.ualocal1funds.org](http://www.ualocal1funds.org).

Important Questions	Answers	Why This Matters:
<b>Will you pay less if you use a network provider?</b>	Yes. See <a href="http://www.ualocal1funds.org">www.ualocal1funds.org</a> 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.
<b>Do you need a <u>referral</u> to see a <u>specialist</u>?</b>	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
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
<b>If you visit a health care <u>provider's</u> office or clinic</b>	Primary care visit to treat an injury or illness	\$25 <u>copay</u> /visit	30% <u>coinsurance</u>	None
	<u>Specialist</u> visit	\$35 <u>copay</u> /visit	30% <u>coinsurance</u>	None
	<u>Preventive care/screening/immunization</u>	No charge	30% <u>coinsurance</u>	Age and frequency limits apply. 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.
<b>If you have a test</b>	<u>Diagnostic test</u> (x-ray, blood work)	No charge	30% <u>coinsurance</u>	None
	Imaging (CT/PET scans, MRIs)	10% <u>coinsurance</u>	30% <u>coinsurance</u>	Benefits may be reduced by 50% up to \$2,500 if you do not obtain <u>preauthorization</u> for services.

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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)	
<p><b>If you need drugs to treat your illness or condition</b> More information about <b><u>prescription drug coverage</u></b> is available at <a href="http://www.caremark.com">www.caremark.com</a> or 1-800-824-6349.</p>	Generic drugs	<p>CVS Retail Pharmacy: 1st 3 fills \$10 <u>copay</u>/script for 30-day supply; 4<sup>th</sup> fill and after \$25 <u>copay</u>/script for 30-day supply; 84-90-day supply 1st fill and after: \$25 <u>copay</u>/script. Other Retail Pharmacy: 1<sup>st</sup> 3 fills \$10 <u>copay</u>/script for 30-day supply; 4<sup>th</sup> fill and after \$25 <u>copay</u>/script for 30-day supply. Mail order: \$10 <u>copay</u>/script for 30-day supply; \$17 <u>copay</u>/script for 60-day supply; \$25 <u>copay</u>/script for 90-day supply.</p>	<p>Retail only: \$10 <u>copay</u>/script plus the difference between <u>In-Network</u> and <u>Out-of-Network</u> costs. <u>Deductible</u> does not apply.</p>	<p>You cannot get an 84-90-day supply at a Non-CVS Pharmacy.</p> <p>No charge for generic contraceptives (or brand name if a generic is medically inappropriate) and certain other 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 <u>plan</u>.</p> <p>The <u>plan</u> only covers mail order and maintenance fills at <u>network</u> pharmacies.</p>
<p><b>If you need drugs to treat your illness or condition</b> More information about <b><u>prescription drug coverage</u></b> is available at <a href="http://www.caremark.com">www.caremark.com</a> or via phone at 1-800-824-6349.</p>	Preferred Brand Drugs	<p>CVS Retail Pharmacy: 1st 3 fills \$35 <u>copay</u>/script for 30-day supply; 4<sup>th</sup> fill and after \$55 <u>copay</u>/script for 30-day supply; 1<sup>st</sup> fill and after \$80 <u>copay</u>/script for 84-90-day supply. Other Retail Pharmacies: 1<sup>st</sup> 3 fills \$35 <u>copay</u>/script for 30-day supply; 4<sup>th</sup> fill and after \$55 <u>copay</u>/script for 30-day supply. Mail order: \$35 <u>copay</u>/script for 30-day supply; \$75 <u>copay</u>/script for 60-day supply; \$80 <u>copay</u>/script for 90-day supply.</p>	<p>Retail only: \$35 <u>copay</u>/script plus the difference between <u>In-Network</u> and <u>Out-of-Network</u> costs. <u>Deductible</u> does not apply.</p>	<p>You cannot get an 84-90-day supply at a Non-CVS Pharmacy.</p> <p>No charge for generic contraceptives (or brand name if generic is medically inappropriate) and certain other 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 <u>Plan</u>.</p>

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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)	
	Non-Preferred Brand Drugs	<p>CVS Retail Pharmacy: 1st 3 fills \$60 <u>copay</u>/script for 30-day supply; 4<sup>th</sup> fill and after \$80 <u>copay</u>/script for 30-day supply; 1<sup>st</sup> fill and after \$135 <u>copay</u>/script for 84-90-day supply.</p> <p>Other Retail Pharmacies: 1<sup>st</sup> 3 fills \$60 <u>copay</u>/script for 30-day supply; 4<sup>th</sup> fill and after \$80 <u>copay</u>/script for 30-day supply.</p> <p>Mail order: \$60 <u>copay</u>/script for 30-day supply; \$120 <u>copay</u>/script for 60-day supply; \$135 <u>copay</u>/script for 90-day supply.</p>	Retail only: \$60 <u>copay</u> /script plus the difference between <u>In-Network</u> and <u>Out-of-Network</u> costs. <u>Deductible</u> does not apply.	The <u>Plan</u> only covers mail order and maintenance fills at <u>network</u> pharmacies.
	<u>Specialty drugs</u>	<p>Retail: Not Covered</p> <p>Mail Order: Applicable <u>copay</u> above</p> <p>No charge for certain non-essential <u>specialty drugs</u> on the PrudentRx <u>Specialty Drug</u> List if you enroll in the program. You pay 30% <u>coinsurance</u> on the cost of these non-essential <u>specialty drugs</u> if you do not enroll in the program.</p>	Not covered	<p><u>Specialty drugs</u> are available from Caremark's SpecialtyRx Pharmacy. You can receive up to a 30-day supply of <u>specialty drugs</u> at a time. These drugs require preapproval from Caremark.</p> <p>Your <u>cost sharing</u> for certain non-essential <u>specialty drugs</u>, as well as any amount paid by the drug manufacturer through its <u>copay</u> assistance program, do not count toward your <u>out-of-pocket limit</u></p>
<b>If you have outpatient surgery</b>	Facility fee (e.g., ambulatory surgery center)	10% <u>coinsurance</u>	30% <u>coinsurance</u>	Benefits may be reduced by 50% up to \$2,500 if you do not obtain <u>preauthorization</u> for services.
	Physician/surgeon fees	10% <u>coinsurance</u>	30% <u>coinsurance</u>	
<b>If you need immediate medical attention</b>	<u>Emergency room care</u>	\$150 <u>copay</u> /visit	\$150 <u>copay</u> /visit	<u>Copay</u> waived if admitted to hospital within 24-hours. Professional/physician charges may be billed separately.
	<u>Emergency medical transportation</u>	10% <u>coinsurance</u>	30% <u>coinsurance</u>	Air ambulance limited to \$7,500 for airlift charges resulting from emergency

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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)	
				medical treatment. <u>Deductible</u> waived if admitted to hospital within 24 hours.
	<u>Urgent care</u>	\$25 <u>copay</u> /visit	30% <u>coinsurance</u>	None
<b>If you have a hospital stay</b>	Facility fee (e.g., hospital room)	10% <u>coinsurance</u>	30% <u>coinsurance</u>	Benefits may be reduced by 50% up to \$2,500 if you do not obtain <u>preauthorization</u> for services.
	Physician/surgeon fees	10% <u>coinsurance</u>	30% <u>coinsurance</u>	
<b>If you need mental health, behavioral health, or substance abuse services</b>	Outpatient services	Office visits: \$25 <u>copay</u> /visit; Other outpatient: 10% <u>coinsurance</u>	30% <u>coinsurance</u>	None
	Inpatient services	10% <u>coinsurance</u>	30% <u>coinsurance</u>	Benefits may be reduced by 50% up to \$2,500 if you do not obtain <u>preauthorization</u> for services.
<b>If you are pregnant</b>	Office visits	First visit: 10% <u>coinsurance</u> All other visits: No charge	30% <u>coinsurance</u>	<u>Cost sharing</u> does not apply for <u>preventive services</u> . Maternity care may include tests and services described elsewhere in the SBC (i.e., ultrasound). Depending on the type of services and <u>provider</u> , a <u>copayment</u> , <u>coinsurance</u> , or <u>deductible</u> may apply.
	Childbirth/delivery professional services	No charge	30% <u>coinsurance</u>	
	Childbirth/delivery facility services	No charge	30% <u>coinsurance</u>	

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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)	
<b>If you need help recovering or have other special health needs</b>	<u>Home health care</u>	10% <u>coinsurance</u>	30% <u>coinsurance</u> <u>Deductible</u> does not apply.	Limited to 200 visits/per calendar year.
	<u>Rehabilitation services</u>	Inpatient: 10% <u>coinsurance</u> Outpatient: \$25 <u>copay</u> /visit	30% <u>coinsurance</u>	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 <u>preauthorization</u> for services.
	<u>Habilitation services</u>	Not covered	Not covered	You must pay 100% of charges, even <u>In-Network</u> .
	<u>Skilled nursing care</u>	10% <u>coinsurance</u>	30% <u>coinsurance</u>	Limited to 60 days per calendar year in lieu of <u>hospitalization</u> . Benefits may be reduced by 50% up to \$2,500 if you do not obtain <u>preauthorization</u> for services.
	<u>Durable medical equipment</u>	10% <u>coinsurance</u>	30% <u>coinsurance</u>	Failure to obtain <u>preauthorization</u> may result in non-coverage or reduced coverage.
	<u>Hospice services</u>	10% <u>coinsurance</u>	30% <u>coinsurance</u>	Limited to 210 days/per lifetime.
<b>If your child needs dental or eye care</b>	Children's eye exam	No charge	Difference between <u>plan's</u> fee schedule and cost of service	Separately administered by Vision <u>Screening</u> , 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	Up to \$100; you pay charges that exceed \$100.		
	Children's dental check-up	Not covered	Not covered	You must pay 100% of these expenses, even <u>In-Network</u> .

\* For more information about limitations and exceptions, see the plan or policy document at [www.ualocal1funds.org](http://www.ualocal1funds.org).

## 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
- Dental care (Adult & Child)
- 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
- 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 of \$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](http://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](http://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](http://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](http://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.

————— *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 in-network pre-natal care and a hospital delivery)

- The plan's overall deductible \$0
- Specialist copayment \$35
- 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:

<i>Cost Sharing</i>	
<u>Deductibles</u>	\$0
<u>Copayments</u>	\$10
<u>Coinsurance</u>	\$80
<i>What isn't covered</i>	
Limits or exclusions	\$60
<b>The total Peg would pay is</b>	<b>\$150</b>

**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) 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:

<i>Cost Sharing</i>	
<u>Deductibles</u>	\$0
<u>Copayments</u>	\$720
<u>Coinsurance</u>	\$90
<i>What isn't covered</i>	
Limits or exclusions	\$230
<b>The total Joe would pay is</b>	<b>\$1040</b>

**Mia's Simple Fracture**

(in-network emergency room visit and follow up care)

- The plan's overall deductible \$0
- Specialist copayment \$35
- Hospital (facility) coinsurance 10%
- Other copayment (ER) \$150

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:

<i>Cost Sharing</i>	
<u>Deductibles</u>	\$0
<u>Copayments</u>	\$400
<u>Coinsurance</u>	\$90
<i>What isn't covered</i>	
Limits or exclusions	\$0
<b>The total Mia would pay is</b>	<b>\$490</b>