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, visit 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?	$0	See the Common Medical Events chart below for your costs for services this plan covers.
Are there services covered before you meet your deductible?	Not applicable.	This plan does not have a deductible.
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; Prescription drugs (In-Network Only): $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, cost sharing for vision services under separate vision plan, and health care Medicare or this Plan does not 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.medicare.gov for a list of Medicare providers or www.ualocal1funds.org for a list of participating pharmacies or optical providers.	This plan uses a provider network. You will pay less if you use a Medicare provider or a pharmacy or optical provider in the plan's network. You will pay the full cost if you use a non-Medicare provider or an out-of-network pharmacy. 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 generally see the specialist you choose without a referral. Note, however, that Medicare may require you to get a referral for some types of care.

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

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
		Medicare Provider/Network Pharmacy (You will pay the least)	Non-Medicare Provider/Non-Network Pharmacy (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	Not covered	Plan pays secondary to Medicare based on the Medicare-approved amount. If you are not enrolled in Medicare, you are responsible for the amount Medicare would have paid. Plan does not cover services from providers who have opted out of Medicare. You pay 100% of charges associated with services from providers who have opted out of Medicare. Routine physical exams (except as required under the ACA preventive benefits) are not covered by Medicare or the Plan. You must pay 100%, even if In-Network.
	Specialist visit	No charge	Not covered	
	Preventive care/screening/ immunization	No charge	Not covered	
If you have a test	Diagnostic test (x-ray, blood work)	No charge	Not covered	
	Imaging (CT/PET scans, MRIs)	No charge	Not covered	
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.silverscript.com or 1-855-282-9586 and www.caremark.com or 1-866-831-4336.	Generic drugs	SilverScript Retail Pharmacy Network for Regular/ Maintenance Rx: $10 copay/script for 30-day supply; $20 copay/script for 60-day supply; $30 copay/script for 84-90-day supply. CVS Retail Pharmacy for Long-Term/Maintenance Rx: $10 copay/script for 30-day supply; $20 copay/script for 60-day supply; $25 copay/script for 90-day supply. CVS/Caremark Mail Order Pharmacy for Maintenance Rx:$10 copay/script for 30-day supply; $17 copay/script for 60-day supply; $25 copay/script for 90-day supply	Not covered	You do not have to enroll in Medicare Part D because this Plan's coverage is considered a Medicare Part D plan. If you are enrolled in another Medicare Part D plan, you will not have prescription drug coverage under the Plan. No charge for generic (or brand name if a generic is medically inappropriate) 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

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Medicare Provider/Network Pharmacy (You will pay the least)	Non-Medicare Provider/Non-Network Pharmacy (You will pay the most)	
				the Plan.
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.silverscript.com or 1-855-282-9586 and www.caremark.com or 1-866-831-4336.	Preferred Brand Drugs	SilverScript Retail Pharmacy Network for Regular/ Maintenance Rx: $35 copay/script for 30-day supply; $70 copay/script for 60-day supply; $105 copay/script for 84-90-day supply. CVS Retail Pharmacy for Long-Term/ Maintenance Rx: $35 copay/script for 30-day supply; $70 copay/script for 60-day supply; $80 copay/script for 90-day supply. CVS/Caremark Mail Order Pharmacy for Maintenance Rx:$35 copay/script for 30-day supply; $70 copay/script for 60-day supply; $80 copay/script for 90-day supply	Not covered	You do not have to enroll in Medicare Part D because this Plan's coverage is considered a Medicare Part D plan. If you are enrolled in another Medicare Part D plan, you will not have prescription drug coverage under the Plan. No charge for generic drugs (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.
	Non-Preferred Brand Drugs	SilverScript Retail Pharmacy Network for Regular/ Maintenance Rx: $60 copay/script for 30-day supply; $120 copay/script for 60-day supply; $180 copay/script for 84-90-day supply. CVS Retail Pharmacy for Long-Term/ Maintenance Rx: $60 copay/script for 30-day supply; $120 copay/script for 60-day supply; $135 copay/script for 90-day supply. CVS/Caremark Mail Order Pharmacy for Maintenance Rx: $60 copay/script for 30-day supply; $120 copay/script for 60-day supply; $135 copay/script for 90-day supply.	Not covered	

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

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Medicare Provider/Network Pharmacy (You will pay the least)	Non-Medicare Provider/Non-Network Pharmacy (You will pay the most)	
	Specialty drugs	Applicable copay above for up to 30-day supply	Not covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	No charge	Not covered	Plan pays secondary to Medicare based on the Medicare-approved amount. If you are not enrolled in Medicare, you are responsible for the amount Medicare would have paid. Plan does not cover services from providers who have opted out of Medicare. You pay 100% of charges associated with services from providers who have opted out of Medicare.
	Physician/surgeon fees	No charge	Not covered	
If you need immediate medical attention	Emergency room care	No charge	Amount over Medicare allowance	Plan pays secondary to Medicare based on the Medicare-approved amount. If you are not enrolled in Medicare, you are responsible for the amount Medicare would have paid. Plan does not cover services from providers who have opted out of Medicare (except for emergency care in an emergency room). You pay 100% of charges associated with services from providers who have opted out of Medicare. Inpatient and outpatient care are not covered after you reach Medicare visit/day/lifetime limits.
	Emergency medical transportation	No charge	Not covered	
	Urgent care	No charge	Not covered	
If you have a hospital stay	Facility fee (e.g., hospital room)	No charge	Not covered	
	Physician/surgeon fees	No charge	Not covered	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	No charge	Not covered	
	Inpatient services	No charge	Not covered	
If you are pregnant	Office visits	No charge	Not covered	Plan pays secondary to Medicare based on the Medicare-approved amount. If you are not enrolled in Medicare, you

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Medicare Provider/Network Pharmacy (You will pay the least)	Non-Medicare Provider/Non-Network Pharmacy (You will pay the most)	
	Childbirth/delivery professional services	No charge	Not covered	are responsible for the amount Medicare would have paid. Plan does not cover services from providers who have opted out of Medicare. You pay 100% of charges associated with services from providers who have opted out of Medicare.
	Childbirth/delivery facility services	No charge	Not covered	
If you need help recovering or have other special health needs	Home health care	No charge	Not covered	Plan pays secondary to Medicare based on the Medicare-approved amount. If you are not enrolled in Medicare, you are responsible for the amount Medicare would have paid. Plan does not cover services from providers who have opted out of Medicare. You pay 100% of charges associated with services from providers who have opted out of Medicare. Home health care and skilled nursing care not covered after you reach Medicare day limits.
	Rehabilitation services	No charge	Not covered	
	Habilitation services	No charge	Not covered	
	Skilled nursing care	No charge	Not covered	
	Durable medical equipment	No charge	Not covered	
	Hospice services	No charge	Not covered	
If your child needs dental or eye care	Children's eye exam	Amounts over Plan allowance	Amounts over Plan allowance	Separately administered by Vision Screening, Inc. Limited to one eye exam and one pair of glasses once every 24 months.
	Children's glasses			
	Children's dental check-up	Not covered	Not covered	You must pay 100% of these expenses, even In-Network.

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

- Acupuncture
- Cosmetic surgery
- Dental care (Adult & Child)
- Infertility treatment
- 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 preventive benefits)

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

- Bariatric surgery Plan pays secondary to Medicare based on the Medicare-approved amount; not covered if provider opts out of Medicare).
- Chiropractic care Plan pays secondary to Medicare based on the Medicare-approved amount; not covered if provider opts out of Medicare).
- Hearing aids (Limit - $500 every 3 years)
- Routine eye care (Adult) (Eye exam and glasses limited to once every 24 months up to plan allowance under separately administered vision plan)

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 Medicare at www.medicare.gov for information about your Medicare benefits. 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.

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? **No**

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.

* 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
Specialist cost sharing	$0
Hospital (facility) cost sharing	$0
Generic drug copayment	$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	**$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 cost sharing	$0
Hospital (facility) cost sharing	$0
Generic drug copayment	$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	$0
Copayments	$550
Coinsurance	$0
What isn't covered	
Limits or exclusions	$230
The total Joe would pay is	**$780**

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

The plan's overall deductible	$0
Specialist cost sharing	$0
Hospital (facility) cost sharing	$0
Generic drug copayment	$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	$0
Copayments	$10
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$10**

Medicare and the **Plan** would be responsible for the other costs of these EXAMPLE covered services.