PLUMBERS' WELFARE FUND
LOCAL 130, U.A.

UNION TRUSTEES

JAMES F. COYNE
Co-Chairman

1340 W. WASHINGTON BLVD., SUITE 303
CHICAGO, ILLINOIS 60607-1986
Phone (312) 226-4200
Fax (312) 226-7285

Joseph F. Ohm
Fund Administrator

Anthony M. Rottman
Field Representative

CONTRACTOR TRUSTEES

DAVID ARIANO
Co-Chairman

May 18, 2020

Summary of Benefits and Coverage

Dear Active Participant:

On behalf of the Board of Trustees of the Plumbers' Welfare Fund, Local 130 U.A. ("Fund"), we are pleased to provide you with the enclosed Summary of Benefits and Coverage (SBC) effective June 1, 2020. This document includes a summary of benefits and cost-sharing requirements under the Fund's Preferred Provider Option (PPO) Plan. It reflects the latest benefit improvements to the PPO Plan approved by the Board of Trustees.

The Fund developed the SBC in accordance with the requirements set forth in the Patient Protection and Affordable Care Act, also known as the Health Care Reform law. In the event there is a discrepancy between the SBC and the governing Plan documents, the Plan document will control.

You may request additional copies of the SBC at any time. As indicated in the SBC, if you have any questions about your coverage under the PPO Plan, please feel free to contact the Fund Office at 312-226-5000.

In addition to the benefits described in the SBC, the Plumbers' Local 130 Welfare Fund provides health care and vision benefits through the Plumbers' Local 130 Wellness and Vision Centers which opened in August 2019. We hope that you and your family will utilize the Wellness Center since it provides office visits, various wellness services, physical therapy treatments, and the most frequently prescribed generic drugs at no cost to you. By going to the Wellness Center, you may obtain many basic and wellness services under one roof. The Wellness Center is available to individuals covered by the Fund.

Sincerely,

Plumbers' Welfare Fund
Local 130 U.A.

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 Wellness Center services or routine oral exams). 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	PPO Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information
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% coinsurance for expenses exceeding $1,000	30% coinsurance	Telemedicine office visits paid same as PPO Provider. Pre-certification is required for all out-of-network services.
	Specialist visit	No charge for the first $1,000 per individual calendar year and 20% coinsurance for expenses exceeding $1,000	30% coinsurance	Pre-certification is required for all out-of-network services.
	Preventive care/screening/ immunization	No charge. Deductible does not apply.	30% 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. Pre-certification is required for all out-of-network services except services related to COVID-19 testing.
If you have a test	Diagnostic test (x-ray, blood work)	No charge for the first $1,000 per individual per calendar year and 20% coinsurance for expenses exceeding $1,000	30% coinsurance	Pre-admission testing is covered at 100% if accepted by the Hospital and is not subject to the deductible. Pre-certification is required for all out-of-network services.
	Imaging (CT/PET scans, MRIs)	No charge for the first $1,000 per individual per calendar year and 20% coinsurance for expenses exceeding $1,000	30% coinsurance	

Common Medical Event	Services You May Need	PPO Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information
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)	$10 copay/prescription (retail); no charge (mail order). Deductible does not apply.	Not covered	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 contraceptives (or brand name contraceptives if a generic is medically inappropriate).
	Preferred brand drugs (Tier 2)	$20 copay/prescription (retail); $10 copay/prescription (mail order). Deductible does not apply.	Not covered	
	Non-preferred brand drugs (Tier 3)	$40 copay/prescription (retail); $20 copay/prescription (mail order). Deductible does not apply.	Not covered	
	Specialty drugs (Tier 4)	$20 copay/prescription. Deductible does not apply.	Not covered	Prescribed specialty and self-administered injectable drugs (except insulin) must be acquired from Accredo.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	No charge for the first $2,000 per individual per calendar year and 10% coinsurance for expenses exceeding $2,000	30% coinsurance	Pre-certification is required for all out-of-network services.
	Physician/surgeon fees	No charge	30% coinsurance	
If you need immediate medical attention	Emergency room care	$150 copay/visit plus 20% coinsurance for covered expenses exceeding $1,000	$150 copay/visit plus 30% coinsurance	Pre-certification is required for all out-of-network services.
	Emergency medical transportation	No charge for the first $1,000 per individual per calendar year and 20% coinsurance for covered expenses exceeding $1,000	30% coinsurance	
	Urgent care	No charge for the first $1,000 per individual per calendar year and 20% coinsurance for covered expenses exceeding $1,000	30% coinsurance	Pre-certification is required for all out-of-network services.

Common Medical Event	Services You May Need	PPO Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information
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% coinsurance	Eligible costs for Surgical Assistants will be covered at 16% of the cost of the Surgeon's charge. Pre-certification is required for all out-of-network services.
	Physician/surgeon fees	No charge for the first $2,000 per individual per calendar year and 10% coinsurance for covered expenses exceeding $2,000	30% coinsurance	
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% coinsurance	Pre-certification is required for all out-of-network services.
	Inpatient services	No charge for the first $2,000 per individual per calendar year and 10% coinsurance for covered expenses exceeding $2,000	30% coinsurance	
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% coinsurance	Other than ACA-required preventive screenings for pregnant women, the plan does not cover maternity and obstetrical care for dependent children. 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 services.
	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% coinsurance	
	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% coinsurance	

Common Medical Event	Services You May Need	PPO Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information
If you need help recovering or have other special health needs	Home health care	No charge for the first $1,000 per individual per calendar year and 20% coinsurance for covered expenses exceeding $1,000	30% 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 services.
	Rehabilitation services	No charge for the first $1,000 per individual per calendar year and 20% coinsurance for covered expenses exceeding $1,000	30% coinsurance	Pre-certification is required for all out-of-network services.
	Habilitation services	No charge for the first $1,000 per individual per calendar year and 20% coinsurance for covered expenses exceeding $1,000	30% coinsurance	
	Skilled nursing care	No charge for the first $2,000 per individual per calendar year and 10% coinsurance for covered expenses exceeding $2,000	30% coinsurance	Pre-certification is required for all out-of-network services.
	Durable medical equipment	No charge for the first $1,000 per individual per calendar year and 20% coinsurance for covered expenses exceeding $1,000	30% coinsurance	Prior approval required for amounts exceeding $1,500 or not covered. Pre-certification is required for all out-of-network services.
	Hospice services	20% coinsurance. Deductible does not apply.	30% coinsurance. Deductible does not apply.	Limited to 180 days per three-year period. Pre-certification is required for all out-of-network services.

Common Medical Event	Services You May Need	PPO Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information
If your child needs dental or eye care	Children's eye exam	No charge up to $40 per exam. Deductible does not apply.	No charge up to $40 per exam. Deductible does not apply.	Limited to one examination in any 12-month period. Dollar limit not applicable to individuals under age 19.
	Children's glasses	No charge up to $350 per individual. Deductible does not apply.	No charge up to $350 per individual. Deductible does not apply.	Limited to one pair of glasses and corrective contact lenses in any 12-month period. Dollar limit not applicable to individuals under age 19.
	Children's dental check-up	No charge. Dental and medical deductibles do not apply.	No charge. Dental and medical deductibles 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, or licensed Chiropractor)
- 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)

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 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**

If you don't have Minimum Essential Coverage for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

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	**$12,800**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$200
Copayments	$30
Coinsurance	$710
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$1,000**

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	**$7,400**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$200
Copayments	$710
Coinsurance	$590
What isn't covered	
Limits or exclusions	$380
The total Joe would pay is	**$1,880**

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	**$1,900**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$200
Copayments	$150
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$350**

The **plan** would be responsible for the other costs of these EXAMPLE covered services.