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 1-800-435-2388. 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 or call 1-800-435-2388 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	In-Network provider: **$600** Individual or **$1,200** Family; Non-Network provider: **$1,200** Individual or **$2,400** 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. In-Network provider preventive services 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?	No.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	Medical: In-Network provider **$3,000** Individual or **$6,000** Family; Non-Network provider **$6,000** Individual or **$12,000** Family. Prescription drugs: In-Network provider **$3,600** Individual or **$7,200** Family; Non-Network provider: No **limit** (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, and health care 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.supermednetwork.com or call 1-800-601-9208.	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)	Non-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% coinsurance	35% coinsurance	None
	Specialist visit	25% coinsurance	35% coinsurance	Chiropractic limit of 26 visits per calendar year, review required for additional visits.
	Preventive care/screening/ immunization	No charge. Deductible does not apply.	Not covered	Standard immunizations are subject to coinsurance and deductible if not preventive. You may have to pay for services that aren't preventive services. Ask your provider if the services needed are preventive services. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	25% coinsurance	35% coinsurance	None
	Imaging (CT/PET scans, MRIs)	25% coinsurance	35% coinsurance	None
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.caremark.com	Generic drugs	$15 copay/fill retail and $30 copay/fill mail order	Not covered	30-day supply or 100 units retail and 90-day supply mail order. No charge for FDA-approved generic contraceptives (or brand name contraceptives if a generic is medically inappropriate). If a brand medication is elected when a generic is available, the member will be charged the difference between the cost of the brand and generic plus the brand copay. Specialty drugs are limited to designated drugs and preauthorization is required (penalty?).
	Preferred brand drugs	20% coinsurance with $20 minimum retail and $40 minimum mail order	Not covered	
	Non-preferred brand drugs	40% coinsurance with $35 minimum retail and $70 minimum mail order	Not covered	
	Specialty drugs	40% coinsurance retail and mail order with $100 minimum and $150 maximum	Not covered	
If you have outpatient	Facility fee (e.g., ambulatory	25% coinsurance	35% coinsurance	None

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Non-Network Provider (You will pay the most)	
surgery	surgery center)			
	Physician/surgeon fees	25% coinsurance	35% coinsurance	None
If you need immediate medical attention	Emergency room care	25% coinsurance	25% coinsurance	None
	Emergency medical transportation	25% coinsurance	35% coinsurance	None
	Urgent care	25% coinsurance	35% coinsurance	None
If you have a hospital stay	Facility fee (e.g., hospital room)	25% coinsurance	35% coinsurance	Room and board in excess of the hospital's most common semi-private room rate is not covered.
	Physician/surgeon fees	25% coinsurance	35% coinsurance	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	25% coinsurance	35% coinsurance	None
	Inpatient services	25% coinsurance	35% coinsurance	Room and board in excess of the hospital's most common semi-private room rate is not covered.
If you are pregnant	Office visits	25% coinsurance	35% coinsurance	Maternity care may include tests and services described somewhere else in the SBC (i.e., ultrasound). Room and board in excess of the hospital's most common semi-private room rate is not covered. Prenatal care (other than ACA-required preventive screenings) is not covered for dependent children. Delivery expenses are not covered for dependent children.
	Childbirth/delivery professional services	25% coinsurance	35% coinsurance	
	Childbirth/delivery facility services	25% coinsurance	35% coinsurance	
If you need help recovering or have other special health needs	Home health care	25% coinsurance	35% coinsurance	None
	Rehabilitation services	25% coinsurance	35% coinsurance	None
	Habilitation services	25% coinsurance	35% coinsurance	None
	Skilled nursing care	25% coinsurance	35% coinsurance	None.
If you need help recovering or have other special health needs (Cont'd)	Durable medical equipment	25% coinsurance	35% coinsurance	Equipment rentals are limited to purchase price.
	Hospice services	Not covered	Not covered	You must pay 100% of these services, even in-network.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Non-Network Provider (You will pay the most)	
If your child needs dental or eye care	Children's eye exam	No charge	No cost sharing	Coverage for persons under age 19; one exam per year through medical benefits.
	Children's glasses	Not covered	Not covered	You must pay 100% of these services, even in-network.
	Children's dental check-up	No charge	No cost sharing	Dental coverage provided separately from medical benefits, one exam and cleaning every six months.

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
- Bariatric surgery
- Children's glasses
- Cosmetic surgery
- Dental care (Adult)
- Hearing aids
- Hospice services
- Infertility treatment
- Long-term care
- Routine eye care (Adult)
- Weight loss programs (except as required by health care law)

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

- Chiropractic care (limited to 26 visits)
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing
- Routine foot care

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 Department of Labor's 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 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 Administrative Manager, Plumbers & Pipefitters Local Union No. 396 Welfare Fund, BeneSys, Inc., 33 Fitch Boulevard, Austintown, OH 44515, 1-800-435-2388. 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.

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

This is not a cost estimator. Treatments shown are just examples of how this plan might cover medical care. Your

Peg is Having a

- The plan's overall deductible $600
- Specialist copayment $0
- Hospital (facility) coinsurance 25%
- 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	**$12,800**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$600
Copayments	$90
Coinsurance	$2,400
What isn't covered	
Limits or exclusions	$10
The total Peg would pay is	**$3,100**

Managing Joe's

- The plan's overall deductible $600
- Specialist copayment $0
- Hospital (facility) coinsurance 25%
- 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	**$7,400**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$600
Copayments	$570
Coinsurance	$1,040
What isn't covered	
Limits or exclusions	$420
The total Joe would pay is	**$2,630**

Mia's Simple

- The plan's overall deductible $600
- Specialist copayment $0
- Hospital (facility) coinsurance 25%
- 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	**$1,900**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$600
Copayments	$0
Coinsurance	$320
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$920**

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