## Plumbers & Pipefitters Health and Welfare Plan

**And Health Reimbursement Arrangement (“HRA”)**  
**Coverage Period:** 1/1/2017-12/31/2017  
**Coverage for:** Individual/Family  
**Plan Type:** PPO

### Summary of Benefits and Coverage: What this Plan Covers & What it Costs

**Important Questions**

<table>
<thead>
<tr>
<th>Question</th>
<th>Answer</th>
<th>Why this Matters:</th>
</tr>
</thead>
<tbody>
<tr>
<td>What is the overall deductible?</td>
<td>$300 Individual/$900 Family</td>
<td>You must pay all the costs up to the deductible amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the deductible starts over (usually, but not always, January 1st). See the chart starting on page 2 for how much you pay for covered services after you meet the deductible.</td>
</tr>
<tr>
<td>Are there other deductibles for specific services?</td>
<td>Yes. $100 Prescription Drugs. There are no other specific deductibles.</td>
<td></td>
</tr>
<tr>
<td>Is there an out-of-pocket limit on my expenses?</td>
<td>Yes. In-network Medical $3,300 Individual/$6,600 Family; Prescription Drug $3,300 Individual/$6,600 Family. Out-of-Network Unlimited.</td>
<td>The out-of-pocket limit is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.</td>
</tr>
<tr>
<td>What is not included in the out-of-pocket limit?</td>
<td>Premiums, balance-bill charges, amounts exceeding reasonable &amp; appropriate, health care this plan doesn’t cover, preauthorization fee, out-of-network coinsurance.</td>
<td>Even though you pay these expenses, they don’t count toward the out-of-pocket limit.</td>
</tr>
<tr>
<td>Is there an overall annual limit on what the plan pays?</td>
<td>No.</td>
<td>The chart starting on page 2 describes any limits on what the plan will pay for specific covered services, such as office visits.</td>
</tr>
<tr>
<td>Does this plan use a network of providers?</td>
<td>Yes. For a list of In-network providers, see <a href="http://www.bcbsil.com">www.bcbsil.com</a> or call 1-800-810-2583.</td>
<td>If you use an in-network doctor or other health care provider, this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network provider for some services. Plans use the term in-network, preferred, or participating for providers in their network. See the chart starting on page 2 for how this plan pays different kinds of providers.</td>
</tr>
<tr>
<td>Do I need a referral to see a specialist?</td>
<td>No.</td>
<td>You can see the specialist you choose without permission from this plan.</td>
</tr>
<tr>
<td>Are there services this plan doesn’t cover?</td>
<td>Yes.</td>
<td>Some of the services this plan doesn’t cover are listed on page 5. See your policy or plan document for additional information about excluded services.</td>
</tr>
</tbody>
</table>

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**Plumbers & Pipefitters Health and Welfare Plan**  
And Health Reimbursement Arrangement (“HRA”)  
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- **Copayments** are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.
- **Coinsurance** is your share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan’s **allowed amount** for an overnight hospital stay is $1,000, your **coinsurance** payment of 20% would be $200. This may change if you haven’t met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges $1,500 for an overnight stay and the **allowed amount** is $1,000, you may have to pay the $500 difference. (This is called **balance billing**.)
- This plan may encourage you to use in-network **providers** by charging you lower **deductibles**, **copayments** and **coinsurance** amounts.
- If you are a participant in the company’s **Health Reimbursement Account (“HRA”)**, you may be reimbursed for eligible expenses (to the extent such expenses have not already been paid). The company will, in its discretion, make an annual contribution to your HRA. Any remaining balance after all reimbursement has been made for a calendar year will be carried over to reimburse your for eligible expenses during the next year, subject to certain limitations. For more information on eligible HRA expenses, please call 405-682-4581.

### Common Medical Event

<table>
<thead>
<tr>
<th>Services You May Need</th>
<th>Your Cost If You Use an In-network Provider</th>
<th>Your Cost If You Use an Out-of-network Provider</th>
<th>Limitations &amp; Exceptions</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>If you visit a health care provider’s office or clinic</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Primary care visit to treat an injury or illness</td>
<td>20% after deductible</td>
<td>50% after deductible</td>
<td>——none———</td>
</tr>
<tr>
<td>Specialist visit</td>
<td>20% after deductible</td>
<td>50% after deductible</td>
<td>——none———</td>
</tr>
<tr>
<td>Other practitioner office visit</td>
<td>Chiropractic: 20% after deductible</td>
<td>Chiropractic: 50% after deductible</td>
<td>Chiropractic/Spinal Manipulation: 24 visit per calendar year maximum</td>
</tr>
<tr>
<td>Preventive care/screening/immunization</td>
<td>No Charge Immunizations</td>
<td>50% after deductible</td>
<td>——none———</td>
</tr>
<tr>
<td><strong>If you have a test</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Diagnostic test (x-ray, blood work)</td>
<td>20% after deductible</td>
<td>50% after deductible</td>
<td>——none———</td>
</tr>
<tr>
<td>Imaging (CT/PET scans, MRIs)</td>
<td>20% after deductible</td>
<td>50% after deductible</td>
<td>——none———</td>
</tr>
</tbody>
</table>

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<th>Limitations &amp; Exceptions</th>
</tr>
</thead>
<tbody>
<tr>
<td>If you need drugs to treat your illness or condition</td>
<td>Generic drugs</td>
<td>Retail $10 copay</td>
<td></td>
<td>Amounts as indicated are after additional $100 prescription drug deductible.</td>
</tr>
<tr>
<td></td>
<td>Preferred brand drugs</td>
<td>Retail $20% after deductible</td>
<td>Mail Order: 20% after deductible</td>
<td>Preauthorization required for Compound Prescription benefits that exceed $300 for the year.</td>
</tr>
<tr>
<td></td>
<td>Non-preferred brand drugs</td>
<td>Retail 25% after deductible</td>
<td>Mail Order 25% after deductible</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Specialty drugs</td>
<td>Same rate as Preferred and Non-Preferred Brand Drugs</td>
<td></td>
<td></td>
</tr>
<tr>
<td>If you have outpatient surgery</td>
<td>Facility fee (e.g., ambulatory surgery center)</td>
<td>20% after deductible</td>
<td>50% after deductible</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Physician/surgeon fees</td>
<td>20% after deductible</td>
<td>50% after deductible</td>
<td>Bariatric Surgery not covered</td>
</tr>
<tr>
<td>If you need immediate medical attention</td>
<td>Emergency room services</td>
<td>20% after deductible</td>
<td>20% after deductible</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Emergency medical transportation</td>
<td>20% after deductible</td>
<td>50% after deductible</td>
<td>True Emergency Out-of-Network allowed at the In-Network level.</td>
</tr>
<tr>
<td></td>
<td>Urgent care</td>
<td>20% after deductible</td>
<td>50% after deductible</td>
<td>True Emergency Out-of-Network allowed at the In-Network level.</td>
</tr>
<tr>
<td>If you have a hospital stay</td>
<td>Facility fee (e.g., hospital room)</td>
<td>20% after deductible</td>
<td></td>
<td>Pre-authorization required. Failure to obtain preauthorization from the Plan will result in a $250 fee.</td>
</tr>
<tr>
<td></td>
<td>Physician/surgeon fee</td>
<td>20% after deductible</td>
<td>50% after deductible</td>
<td>Bariatric Surgery Not Covered</td>
</tr>
</tbody>
</table>

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# Summary of Benefits and Coverage: What this Plan Covers & What it Costs

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</tr>
</thead>
<tbody>
<tr>
<td>If you have mental health, behavioral health, or substance abuse needs</td>
<td>Mental/Behavioral health outpatient services</td>
<td>20% after deductible</td>
<td>50% after deductible</td>
<td>none</td>
</tr>
<tr>
<td></td>
<td>Mental/Behavioral health inpatient services</td>
<td>20% after deductible</td>
<td>50% after deductible</td>
<td>none</td>
</tr>
<tr>
<td></td>
<td>Substance use disorder outpatient services</td>
<td>Not Covered</td>
<td>Not Covered</td>
<td>Not Covered</td>
</tr>
<tr>
<td></td>
<td>Substance use disorder inpatient services</td>
<td>Not Covered</td>
<td>Not Covered</td>
<td>Not Covered</td>
</tr>
<tr>
<td>If you are pregnant</td>
<td>Prenatal and postnatal care</td>
<td>20% after deductible</td>
<td>50% after deductible</td>
<td>Dependent child pregnancy Not Covered.</td>
</tr>
<tr>
<td></td>
<td>Delivery and all inpatient services</td>
<td>20% after deductible</td>
<td>$250 copay; then 50% after deductible</td>
<td>Inpatient maternity admission which exceeds the 48 hour vaginal delivery or 96 hour cesarean delivery requires pre-authorization. Failure to obtain preauthorization from the Plan will result in a $250 fee.</td>
</tr>
<tr>
<td>If you need help recovering or have other special health needs</td>
<td>Home health care</td>
<td>20% after deductible</td>
<td>50% after deductible</td>
<td>Limited to 50 visits every 24 months</td>
</tr>
<tr>
<td></td>
<td>Rehabilitation services</td>
<td>20% after deductible</td>
<td>50% after deductible</td>
<td>Occupational and Physical Therapy Limited to 26 visits per calendar year</td>
</tr>
<tr>
<td></td>
<td>Habilitation services</td>
<td>Not Covered</td>
<td>Not Covered</td>
<td>Not Covered</td>
</tr>
<tr>
<td></td>
<td>Skilled nursing care</td>
<td>20% after deductible</td>
<td>50% after deductible</td>
<td>Not to exceed 50% of the hospital room rate</td>
</tr>
<tr>
<td></td>
<td>Durable medical equipment</td>
<td>20% after deductible</td>
<td>Not Covered</td>
<td>The Plan will pay 85% per 12 months not to exceed the purchase price. The Plan will pay 100% for replacement parts, with a maximum allowance of 1 replacement part every 5 years.</td>
</tr>
<tr>
<td>If your child needs</td>
<td>Hospice service</td>
<td>20% after deductible</td>
<td>50% after deductible</td>
<td>Limited to 90 days of care every 24 months</td>
</tr>
<tr>
<td></td>
<td>Eye exam</td>
<td>Not Covered</td>
<td>Not Covered</td>
<td>Not Covered. Refer to Vision Plan.</td>
</tr>
</tbody>
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</thead>
<tbody>
<tr>
<td>dental or eye care</td>
<td>Glasses</td>
<td>No charge</td>
<td>Not Covered</td>
<td>Limited to one pair of conventional glasses or one pair of contacts every 12 months</td>
</tr>
<tr>
<td></td>
<td>Dental check-up</td>
<td>Not Covered</td>
<td>Not Covered</td>
<td>Refer to the Dental Plan</td>
</tr>
<tr>
<td>If you need eye care</td>
<td>Eye Exam</td>
<td>No charge up to $100 per individual</td>
<td>N/A</td>
<td>Limited to one exam every 12 months</td>
</tr>
<tr>
<td></td>
<td>Glasses</td>
<td>No charge up to: Frames: $200; Single vision: $185; Bifocals: $200; Contacts: $180</td>
<td>N/A</td>
<td>Limited to one pair of glasses or contacts up to the allowable charge every 12 months</td>
</tr>
</tbody>
</table>

Excluded Services & Other Covered Services:

<table>
<thead>
<tr>
<th>Services Your Plan Does NOT Cover</th>
<th>Services Your Plan Does NOT Cover</th>
<th>Services Your Plan Does NOT Cover</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acupuncture</td>
<td>Habilitation services</td>
<td>Substance use and disorder treatment</td>
</tr>
<tr>
<td>Bariatric Surgery</td>
<td>Infertility Treatment</td>
<td>Routine foot care</td>
</tr>
<tr>
<td>Cosmetic Surgery</td>
<td>Non-emergency care when traveling outside the U.S.</td>
<td>Weight loss programs</td>
</tr>
<tr>
<td>Dental Care (Adult &amp; Child)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dependent Child Pregnancy</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Other Covered Services</th>
<th>Other Covered Services</th>
<th>Other Covered Services</th>
</tr>
</thead>
<tbody>
<tr>
<td>Chiropractic care</td>
<td>Long-term care</td>
<td>Private-duty nursing limited to 30 days per</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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- Hearing aids – one per ear every 48 consecutive months for dependents up to age 18 calendar year (subject to deductible and coinsurance)

Your Rights to Continue Coverage: If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a premium, which may be significantly higher than the premium you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply.

For more information on your rights to continue coverage, contact the plan at 405-682-4581. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cciio.cms.gov.

Your Grievance and Appeals Rights:
If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to appeal or file a grievance. For questions about your rights, this notice, or assistance, you can contact: The plan at 405-682-4581 or the Department of Labor’s Employee Benefits Security Administration at 1-866-444-EBSA (3272).

Does this Coverage Provide Minimum Essential Coverage?
The Affordable Care Act requires most people to have health care coverage that qualifies as “minimum essential coverage.” This plan or policy does provide minimum essential coverage.

Does this Coverage Meet the Minimum Value Standard?
The Affordable Care Act establishes a minimum value standard of benefits of a health plan. The minimum value standard is 60% (actuarial value). This health coverage does meet the minimum value standard for the benefits it provides.

Language Access Services: Para obtener asistencia en Español, llame al 405-682-4581.

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About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.

<table>
<thead>
<tr>
<th>Having a baby (normal delivery)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Amount owed to providers:</strong> $7,540</td>
</tr>
<tr>
<td><strong>Plan pays:</strong> $5,800</td>
</tr>
<tr>
<td><strong>Patient pays:</strong> $1,740</td>
</tr>
</tbody>
</table>

**Sample care costs:**
- Hospital charges (mother) $2,700
- Routine obstetric care $2,100
- Hospital charges (baby) $900
- Anesthesia $900
- Laboratory tests $500
- Prescriptions $200
- Radiology $200
- Vaccines, other preventive $40
- **Total** $7,540

**Patient pays:**
- Deductibles $300
- Copays $0
- Coinsurance $1,440
- **Total** $1,740

These numbers assume the patient has given notice of her pregnancy to the plan. If you are pregnant and have not given notice of your pregnancy, your costs may be higher. For more information please contact 405-682-4581.

<table>
<thead>
<tr>
<th>Managing type 2 diabetes (routine maintenance of a well-controlled condition)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Amount owed to providers:</strong> $5,400</td>
</tr>
<tr>
<td><strong>Plan pays:</strong> $4,100</td>
</tr>
<tr>
<td><strong>Patient pays:</strong> $1,300</td>
</tr>
</tbody>
</table>

**Sample care costs:**
- Prescriptions $2,900
- Medical Equipment and Supplies $1,300
- Office Visits and Procedures $700
- Education $300
- Laboratory tests $100
- Vaccines, other preventive $100
- **Total** $5,400

**Patient pays:**
- Deductibles $300
- Copays $0
- Coinsurance $1,000
- **Total** $1,300

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Questions and answers about the Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

- Costs don’t include **premiums**.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren’t specific to a particular geographic area or health plan.
- The patient’s condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network **providers**. If the patient had received care from out-of-network **providers**, costs would have been higher.

What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how **deductibles**, **copayments**, and **coinsurance** can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn’t covered or payment is limited.

Does the Coverage Example predict my own care needs?

**No.** Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor’s advice, your age, how serious your condition is, and many other factors.

Does the Coverage Example predict my future expenses?

**No.** Coverage Examples are not cost estimators. You can’t use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your **providers** charge, and the reimbursement your health plan allows.

Can I use Coverage Examples to compare plans?

**Yes.** When you look at the Summary of Benefits and Coverage for other plans, you’ll find the same Coverage Examples. When you compare plans, check the “Patient Pays” box in each example. The smaller that number, the more coverage the plan provides.

Are there other costs I should consider when comparing plans?

**Yes.** An important cost is the **premium** you pay. Generally, the lower your **premium**, the more you’ll pay in out-of-pocket costs, such as **copayments**, **deductibles**, and **coinsurance**. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.