Plumbers and Steamfitters
Local 166
Health and Welfare Fund

Summary of
Benefits and Coverage

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, 1-248-641-4966. 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.healthcare.gov/sbc-glossary or call 1-855 - 641 - 4966 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	In-Network: **$1,500**/individual; **$3,000**/family Out-of-Network: **$3,500**/individual; **$7,000**/family *Certain out-of-network claims are treated as in-network claims as required by No Surprises Act.*	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 unless 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**	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 www.healthcare.gov/coverage/preventive-care-benefits/.
Are there other deductibles for specific services?	**No**	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?	In-Network: **$4,000**/individual; **$8,000**/family Out-of-Network: No limit on Out-of-Network expenses *Certain out-of-network claims are treated as in-network claims as required by No Surprises Act.*	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. 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. By Law the Overall OOP for copayments, deductibles, and co-insurance on in-network essential benefits is: **2026:** $10,60000 Individual/ $21,200 Couple or Family
What is not included in the out-of-pocket limit?	Premiums, balance-billed charges, 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. *Out-of-network providers may be treated as In-Network providers as required by the No Surprises Act.*	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 permission from this plan.

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)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	20% coinsurance after deductible	40% coinsurance after deductible	——————none——————
	Specialist visit	20% coinsurance after deductible	40% coinsurance after deductible	If a network **provider** refers you to an out-of-network specialist who is the exclusive **provider** of the only medically necessary and appropriate treatment available, that service rendered by the out-of-network specialist will be charged at the network provider cost (i.e., 10% coinsurance after deductible).
	Preventive care/screening/ immunization	No charge, except see limitations and exceptions	40% coinsurance after deductible (50% coinsurance for colon/rectal screening)	Out-of-pocket maximum does not apply. In network: No coinsurance for immunizations recommended by the Advisory Committee on Immunization Practices. No charge for well-baby and childcare. Out-of-network: Annual physical not covered. You may have to pay for services that are not preventative. Ask your provider if the services you need are preventative. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	20% coinsurance after deductible	40% coinsurance after deductible	——————none——————
	Imaging (CT/PET scans, MRIs)	20% coinsurance after deductible	40% coinsurance after deductible	——————none——————

[For more information about limitations and exceptions, see the plan document at https://www.ourbenefitoffice.com/UALocal166/Benefits/.]

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)	
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at https://www.kpp-rx.com	Generic drugs	Retail: $30.00 Mail: $75.00	Not covered	Retail: Up to a 34-day supply Mail: 35-90 day supply. If prescription not written "dispense as written" (DAW), it will be filled generic. Maintenance Drugs must be through KPP, mail order, or, if available, at the Marathon Family Medical Center.
	Preferred brand drugs	Retail: $60.00 Mail: $150.00	Not covered	Retail: Up to a 34-day supply Mail: 35-90 day supply. If request brand drug and it's not DAW, must pay copay + difference between cost of generic and brand name drug. Step Therapy Program required for some brand name drugs. Contact Fund Office for list of drugs subject to Step Therapy. Once use of the brand name drug is approved under STP, only subject to copay. Maintenance Drugs must be through KPP Pharmacy, mail order, or, if available, at the Marathon Family Medical Center.
	Non-preferred brand drugs	Retail: $120.00 Mail: $300.00	Not covered	Retail: Up to a 34-day supply Mail Order: 35-90 day supply. If request brand drug and it's not DAW, must pay copay + difference between cost of generic and brand name drug. Maintenance Drugs must be through KPP Pharmacy, mail order, or, if available, at the Marathon Family Medical Center.
	Specialty drugs	Retail: 25% copayment, not to exceed $250.00 Mail: Only filled at retail	Not covered	Retail: Up to a 34-day supply Mail Order: 35-90 day supply. If request brand drug not DAW, pay copay + difference cost of generic and brand name drug. All Specialty medication must be filled at BioPlus Specialty Pharmacy, www.bioplus.com and require precertification from KPP. If drug is on "Select Drugs and Products List" through Paydhealth, Participant must enrolled in the Select Drugs and Product Program. Failure to enroll will result in Participant being responsible for 100% of cost of medication.

[For more information about limitations and exceptions, see the plan document at https://www.ourbenefitoffice.com/UALocal166/Benefits/.]

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)	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance after deductible	40% coinsurance after deductible unless otherwise required by the No Surprises Act	————————none————————
	Physician/surgeon fees	20% coinsurance after deductible	40% coinsurance after deductible unless otherwise required by the No Surprises Act	————————none————————
If you need immediate medical attention	Emergency room care	20% coinsurance after a $200 copayment	20% coinsurance of the Recognized Amount after a $200 copayment (in-network out-of-pocket maximums apply and this coinsurance and copayment counts toward in-network out-of-pocket maximums) unless otherwise required by the No Surprises Act	If admitted to the hospital for an Emergency Medical Condition: 20% coinsurance of Recognized Amount, no copayment. In other words, copayment waived if admitted.
	Emergency medical transportation	Ground ambulance: 20% coinsurance after deductible	Ground ambulance: Balance after Plans pay 150% of the applicable Medicare Rate. Air ambulance: 20% coinsurance of lesser of billed charges or the Qualified Payment Amount, after deductible (in-network deductible and in-network out-of-pocket maximums apply and this coinsurance counts toward in-network out-of-pocket maximums)	Trip must be to closest facility that can provide appropriate services for Emergency Medical Condition or to and from Hospital for a covered admission. Air ambulance service covered when Medically Necessary
	Urgent care	20% coinsurance after deductible	40% coinsurance after deductible unless otherwise required by the No Surprises Act	————————none————————
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance after deductible	40% coinsurance after deductible unless otherwise required by the No Surprises Act	Semi-private room

[For more information about limitations and exceptions, see the plan document at https://www.ourbenefitoffice.com/UALocal166/Benefits/.]

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)	
	Physician/surgeon fees	20% coinsurance after deductible	40% coinsurance after deductible unless otherwise required by the No Surprises Act	In-Network: Surgical expense may differ for multiple surgical procedures. No charge for second surgical opinion.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	20% coinsurance after deductible	40% coinsurance after deductible unless otherwise required by the No Surprises Act	——————none——————
	Inpatient services			
If you are pregnant	Office visits	20% coinsurance after deductible	40% coinsurance after deductible unless otherwise required by the No Surprises Act	Cost sharing does not apply for preventive services.
	Childbirth/delivery professional services			
	Childbirth/delivery facility services			
If you need help recovering or have other special health needs	Home health care	20% coinsurance after deductible	40% coinsurance after deductible	Maximum 100 visits per calendar year. Each 4 hours shall be considered 1 visit.
	Rehabilitation services	20% coinsurance after deductible	40% coinsurance after deductible	Must be non-maintenance to be covered. Includes cardiac, pulmonary, chemotherapy, outpatient dialysis, radiation, respiratory, speech, physical and occupational therapy
	Habilitation services	20% coinsurance after deductible	40% coinsurance after deductible	Covered to treat mental health conditions and substance use disorders, only.
	Skilled nursing care	20% coinsurance after deductible	40% coinsurance after deductible	Must begin within 2 days after confinement in hospital (with hospital stay lasting at least 3 consecutive days) and must be seen by doctor at least once every 30 days
	Durable medical equipment	20% coinsurance after deductible	40% coinsurance after deductible	Expenses not included in out-of-pocket maximum. Wheelchair or motorized scooter subject to $2,000 lifetime maximum.
	Hospice services	20% coinsurance	20% coinsurance	Treatment plan must be approved by Plan. Benefits may exceed 6 months should patient live beyond prognosis for life expectancy.
If your child needs dental or eye care	Children's eye exam	Not Covered	Not Covered	This plan covers certain preventive services without cost-sharing and before you meet your deductible, including vision screening for all children. See a list of covered preventive services at www.healthcare.gov/coverage/preventive-care-benefits

[For more information about limitations and exceptions, see the plan document at https://www.ourbenefitoffice.com/UALocal166/Benefits/.]

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)	
	Children's glasses	Not Covered	Not Covered	This plan covers certain preventive services without cost-sharing and before you meet your deductible. See a list of covered preventive services at www.healthcare.gov/coverage/preventive-care-benefits
	Children's dental check-up	Not Covered	Not Covered	This plan covers certain preventive services without cost-sharing and before you meet your deductible, including, for some children, fluoride supplements and fluoride varnish. See a list of covered preventive services at www.healthcare.gov/coverage/preventive-care-benefits

[For more information about limitations and exceptions, see the plan document at https://www.ourbenefitoffice.com/UALocal166/Benefits/.]

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 • Dental care (Adult) • Gene Therapy • Infertility Treatment	• Long-term care • Non-emergency care when traveling outside the U.S.	• Routine eye care (Adult) • Routine foot care
Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)		
• Enteral/Parental Nutrition Therapy	• Private duty Nursing Services (Contact Fund Office for more information re: requirements)	• Transplants

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: [insert State, HHS, DOL, and/or other applicable agency contact information]. 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 Fund Office by calling the number on the back of your ID card. Or, you can contact Michigan Office of Financial and Insurance Regulation at **www.michigan.gov/ofir** or 1-877-999-6442. For group health coverage subject to ERISA, you may also contact Employee Benefits Security Administration at 1-866-444-EBSA (3272).

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, certain Medicare and Medicaid coverage, 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 216-267-3344 or 888-424-7488.]

[Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 216-267-3344 or 888-424-7488.]

[Chinese (中文): 如果需要中文的帮助， **请拨打这个号码** 216-267-3344 or 888-424-7488.]

[Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 216-267-3344 or 888-424-7488.]

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 document at https://www.ourbenefitoffice.com/UALocal166/Benefits/.]

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	$1,500
Specialist coinsurance	20%
Hospital (facility) *coinsurance*	20%
Other coinsurance	20%

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	**$8,640**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$1,500
Copayments	$0
Coinsurance	$2,500
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$4,060**

Managing Joe's type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

The plan's overall deductible	$1,500
Specialist coinsurance	20%
Hospital (facility) coinsurance	20%
Other coinsurance	20%

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	**$3,280**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$1,500
Copayments	$500
Coinsurance	$300
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$2,320**

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

The plan's overall deductible	$1,500
Specialist coinsurance	20%
Hospital (facility) coinsurance	20%
Other coinsurance	20%

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	**$2,190**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$1,500
Copayments	$200
Coinsurance	$98
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,798**

Questions: Call the Fund Office at 1-248-641-4966, toll free 1-855-641-4966. For in-network providers you may also call Anthem (1-800-810-BLUE). Call Caremark for Rx questions at 1-866-885-4944. If you aren't clear about any of the terms used in this form, call the Fund Office or see the Glossary at http://www.dol.gov/ebsa/healthreform.

PLUMBERS & STEAMFITTERS LOCAL 166
BENEFIT FUNDS
P.O. BOX 99485
TROY, MI 48099-9485

Important Plan Information