AUTOMATIC SPRINKLER
LOCAL 281, U.A.
WELFARE FUND

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SUMMARY OF MATERIAL MODIFICATIONS #13 2021 PREVENTIVE SERVICES

Update to Your Plan of Benefits Effective January 1, 2021

November 2020

Dear Participant:

This notice provides an update regarding the types of preventive services covered by the Automatic Sprinkler Local 281, U.A. Welfare Fund (Fund). We encourage you to read this notice carefully and to keep it with your Plan Document and Summary Plan Description (SPD). Please note that this year's notice contains important information about covered coronavirus-related preventive services, including applicable COVID-19 vaccines.

The Fund Covers ACA-Mandated Preventive Services and Coronavirus-Related Preventive Services

The Affordable Care Act (ACA) requires non-grandfathered group health plans, like your Welfare Plan, to fully cover certain in-network preventive services. Additionally, the Coronavirus Aid, Relief, and Economic Security (CARES) Act requires group health plans, like your Welfare Plan, to fully cover certain in-network and out-of-network coronavirus-related preventive services.

When rendered out-of-network, non-coronavirus-related preventive services are subject to a 40% coinsurance rate after satisfaction of the applicable Major Medical Benefit Deductible. For coronavirus-related preventive services, the Fund will reimburse out-of-network providers the amount that would be paid under Medicare for the item or service.

The Fund Fully Covers In-Network ACA-Mandated Preventive Services 1 to 2 Years After Determination

The ACA delegates the task of determining which health services are "preventive services" to certain government agencies. In particular, the United States Preventive Services Task Force, the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention, and the Health Resources and Services Administration all decide on an ongoing basis which services qualify for preventive services status. A list of these preventive services, which incorporates the ongoing government agency changes, is located at www.healthcare.gov/preventive-care-benefits.

In terms of timing, the ACA requires the Fund to incorporate preventive services updates on the first day of the Plan Year beginning on or after one year following the date on which the update to the preventive services list occurs. In other words, for the January 1, 2021 Plan Year, the Fund will incorporate those preventive services updates made through 2019.

See Reverse Side

Some of the preventive services updates on the www.healthcare.gov/preventive-care-benefits list have been made after 2019. However, as noted above, the Fund is not required to cover these post-2019 preventive services. **Accordingly, enclosed is a complete list reflecting the preventive services completely covered when rendered in-network for the upcoming Plan Year.** For additional information about the Plan's coverage of these services, please refer to Section 12.06 of your SPD.

The Fund Will Fully Cover Coronavirus-Related Preventive Services, Including Applicable COVID-19 Vaccines, 15 Days After Determination by Federal Agencies

The CARES Act requires the Fund to fully cover in-network and out-of-network coronavirus-related preventive services within 15 days of their identification by the United States Preventive Services Task Force or the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention. These preventive services are expected to include FDA-approved COVID-19 vaccines currently being developed for widespread distribution through Operation Warp Speed as well as the private sector.

Therefore, upon designation by one of these federal agencies that a COVID-19 vaccine, and/or other items or services, are coronavirus-related preventive services, the Fund will provide full coverage within 15 days of the agency's announcement. This means there are no out-of-pocket costs for you or your family for such coronavirus-related preventive services when provided in-network. As mentioned above, for out-of-network coronavirus-related services, the Fund will reimburse the provider at the applicable Medicare rate.

Your Annual Summary of Benefits and Coverage Is Enclosed

In addition to the notice of preventive services relating to the Affordable Care Act, the Fund has also enclosed the annual Summary of Benefits and Coverage (SBC).

The Trustees will continue to monitor the Fund's resources to ensure it is able to provide high-quality health coverage to members and their families for many years to come. As always, if you have any questions about this notice, or the Fund in general, please feel free to contact the Fund Office.

Very truly yours,

Tim Morrin, Administrator
On behalf of the Board of Trustees of the
Automatic Sprinkler Local 281, U.A. Welfare Fund

Automatic Sprinkler Local 281, U.A. Welfare Fund
List of Preventive Services Required by the Affordable Care Act
Effective January 1, 2021

Qualifying Coronavirus Preventive Services for All Participants and Dependents

a. Items, services, and/or immunizations that are intended to prevent or mitigate coronavirus disease 2019 (COVID–19), as identified by the United States Preventive Services Task Force or CDC

Covered Preventive Services for Adults

a. Abdominal aortic aneurysm one-time screening for men ages 65-75 who have ever smoked.
b. Alcohol misuse screening and counseling: screening and behavioral counseling interventions to reduce alcohol misuse by adults ages 18 and older, including pregnant women, in primary care settings.
c. Low-dose aspirin to prevent cardiovascular disease and colorectal cancer when prescribed by a health care provider, in adults ages 50 to 59 years who have a 10% or greater 10-year cardiovascular disease (CVD) risk, are not at increased risk for bleeding, have a life expectancy of at least 10 years, and are willing to take low-dose aspirin daily for at least 10 years. A prescription must be submitted in accordance with plan rules.
d. Blood pressure screening for all adults age 18 and older. Blood pressure screening is not payable as a separate claim, as it is included in the payment for a physician visit.
e. Cholesterol screening (Lipid Disorders Screening) for in adults aged 40 to 75 years.
f. Colorectal cancer screening using stool-based methods (such as fecal occult blood testing), sigmoidoscopy, or colonoscopy, in adults beginning at age 50 and continuing until age 75. The test methodology must be medically appropriate for the patient. The plan will not impose cost sharing with respect to a polyp removal during a colonoscopy performed as a screening procedure. The plan will not impose cost sharing with respect to the following services when these services are provided in connection with a screening colonoscopy and the attending provider determines the service is medically appropriate: anesthesia services, a pre-procedure specialist consultation, or a pathology exam on a polyp biopsy.
g. Depression screening for adults.
h. Screening for abnormal blood glucose as part of cardiovascular risk assessment in adults aged 40 to 70 years who are overweight or obese. Intensive behavioral counseling interventions to promote a healthful diet and physical activity or referral to such services for such adults aged 40 to 70 years with abnormal blood glucose. .
i. HIV screening for all adolescents and adults ages 15 to 65 and for younger and older individuals at increased risk.
j. Preexposure prophylaxis (PrEP) with effective antiretroviral therapy to persons who are at high risk of HIV acquisition.
k. Obesity screening and intensive counseling and behavioral interventions or referral to such interventions to promote sustained weight loss for adults with a body mass index of 30 kg/m2 or higher. Intensive behavioral counseling interventions to promote a healthful diet and physical activity for adults who are overweight or obese and have additional risk factors for cardiovascular disease.
l. Sexually transmitted infection (STI) prevention counseling for adults at higher risk.
m. Tobacco use screening for all adults and cessation interventions for tobacco users.
n. Syphilis screening for all adults at increased risk of infection.

o. Counseling for young adults to age 24 who have fair skin about minimizing their exposure to ultraviolet radiation to reduce risk for skin cancer.
p. Exercise or physical therapy to prevent falls in community-dwelling adults age 65 years and older who are at increased risk for falls.
q. Screening for hepatitis C virus (HCV) infection in persons at high risk for infection and a one-time screening for HCV infection in adults born between 1945 and 1965.
r. Annual screening for lung cancer with low-dose computed tomography in adults ages 55 to 80 years who have a 30 pack/year smoking history and currently smoke or have quit within the past 15 years.
s. Screening for hepatitis B virus infection in adults at high risk for infection.
t. Low-to-moderate-dose statin for the prevention of cardiovascular disease (CVD) events and mortality in adults ages 40-75 years with one or more CVD risk factors (i.e., dyslipidemia, diabetes, hypertension, or smoking), and a calculated 10-year risk of a cardiovascular event of 10% or greater, when identified as meeting these factors by their treating physician.
u. Screening for latent tuberculosis infection in populations at increased risk.

Covered Preventive Services for Women, Including Pregnant Women

a. Well woman office visits for women beginning in adolescence and continuing across the lifespan, for the delivery of required preventive services.
b. Screening for anxiety in adolescent and adult women, including those who are pregnant or postpartum.
c. Bacteriuria urinary tract or other infection screening for pregnant women. Screening for asymptomatic bacteriuria with urine culture for pregnant women is payable at 12 to 16 weeks' gestation or at the first prenatal visit, if later.
d. Low-dose aspirin after 12 weeks of gestation for women who are at high risk for preeclampsia. A prescription must be submitted in accordance with plan rules.
e. Screening for preeclampsia in pregnant women with blood pressure measurements throughout pregnancy. Blood pressure screening is not payable as a separate claim, as it is included in the payment for a physician visit.
f. BRCA counseling about genetic testing for women at higher risk. Women whose family history is associated with an increased risk for deleterious mutations in BRCA 1 or BRCA 2 genes will receive referral for counseling. The plan will cover BRCA 1 or 2 genetic tests without cost sharing, if appropriate as determined by the woman's health care provider, including for a woman who has previously been diagnosed with cancer, as long as she is not currently symptomatic or receiving active treatment for breast, ovarian, tubal or peritoneal cancer.
g. Breast cancer screening mammography for women with or without clinical breast examination and with or without diagnosis, every 1 to 2 years for women aged 40 and older.
h. Breast cancer chemoprevention counseling for women at higher risk. The plan will pay for counseling by physicians with women at high risk for breast cancer and at low risk for adverse effects of chemoprevention, to discuss the risks and benefits of chemoprevention. The plan will also pay for risk-reducing medications (such as tamoxifene or raloxifene) for women at increased risk for breast cancer and at low risk for adverse medication effects.
i. Interventions during pregnancy and after birth to support breastfeeding. Comprehensive lactation support and counseling by a trained provider during pregnancy and for the duration of breastfeeding, and costs for renting breastfeeding equipment. The plan may pay for purchase of lactation equipment instead of rental, if deemed appropriate by the plan administrator.

j. Cervical cancer screening for women ages 21 to 29 with Pap smear every three years; for women ages 30-65, screening with Pap smear alone every three years or screening with Pap smear and human papillomavirus testing every five years.
k. Chlamydia infection screening for all sexually active non-pregnant young women aged 24 and younger, and for older non-pregnant women who are at increased risk, as part of a well woman visit. For all pregnant women aged 24 and younger, and for older pregnant women at increased risk, chlamydia infection screening is covered as part of the prenatal visit.
l. FDA-approved contraceptives methods, sterilization procedures, and patient education and counseling for women of reproductive capacity. FDA-approved contraceptive methods, include barrier methods, hormonal methods, and implanted devices, as well as patient education and counseling, as prescribed by a health care provider. The plan may cover a generic drug without cost sharing and charge cost sharing for an equivalent branded drug. The plan will accommodate any individual for whom the generic would be medically inappropriate, as determined by the individual's health care provider. Services related to follow-up and management of side effects, counseling for continued adherence, and device removal are also covered without cost sharing.
m. Daily folic acid supplements for women are planning or capable of pregnancy, containing 0.4 to 0.8 mg of folic acid. Over-the-counter supplements are covered only if the woman obtains a prescription.
n. Gonorrhea screening for sexually active women age 24 and younger and in older woman who are at increased risk for infection, provided as part of a well woman visit. The plan will pay for the most cost-effective test methodology only.
o. Counseling for sexually transmitted infections, once per year as part of a well woman visit.
p. Counseling and screening for HIV, once per year as part of a well woman visit, and for pregnant women, including those who present in labor who are untested and whose HIV status is not known.
q. Hepatitis B screening for pregnant women at their first prenatal visit.
r. Osteoporosis screening for women. Women younger than 65 will be eligible for osteoporosis screening with the most cost-effective test methodology if their risk of fracture is equal to or greater than that of a 65-year-old woman. Women aged 65 and older and postmenopausal women younger than 65 at increased risk of osteoporosis, as determined by a formal clinical risk assessment tool, will be eligible for screening for osteoporosis with bone measurement testing.
s. Rh(D) incompatibility screening for all pregnant women during their first visit for pregnancy related care, and follow-up testing for all unsensitized Rh(D)-negative women at 24-28 weeks' gestation, unless the biological father is known to be Rh(D)-negative.
t. Screening for gestational diabetes in asymptomatic pregnant women between 24 and 28 weeks' gestation and at the first prenatal visit for pregnant women identified to be at risk for diabetes.
u. Screening for diabetes for women with a history of gestational diabetes who are not currently pregnant and who have not previously been diagnosed with type 2 diabetes. Initial testing should occur within the first year postpartum, as early as 4 to 6 weeks postpartum. For women who test negative, rescreening every 3 years for 10 years after pregnancy.
v. Tobacco use screening and interventions for all women, as part of a well woman visit, and expanded counseling for pregnant tobacco users.
w. Early syphilis screening for all pregnant women. Syphilis screening for all other women at increased risk, as part of a well woman visit.

x. Screening and counseling for interpersonal and domestic violence, as part of a well woman visit.
y. Depression screening and counseling interventions for pregnant and postpartum women.
z. Screening women for urinary incontinence, as part of a well woman visit.

Covered Preventive Services for Children

a. Well baby and well child visits from ages newborn through 21 years as recommended for pediatric preventive health care by "Bright Futures/American Academy of Pediatrics." Visits will including the following age-appropriate screenings and assessments:
   - Physical examination
   - Developmental screening for children under age 3, and surveillance throughout childhood
   - Behavioral assessments for children of all ages
   - Medical history
   - Blood pressure screening
   - Depression screening for adolescents ages 11 and older
   - Vision screening
   - Hearing screening
   - Height, weight and body mass index measurements for children, including head circumference measurements for children 24 months and younger
   - Autism screening for children at 18 and 24 months
   - Tobacco, alcohol, and drug use assessments for adolescents
   - Maternal depression screening between 1 and 6 months
   - Newborn blood and bilirubin screenings
   - Critical congenital heart defect screening in newborns
   - Hematocrit or Hemoglobin screening for children
   - Lead screening for children at risk of exposure
   - Tuberculin testing for children at higher risk of tuberculosis
   - Dyslipidemia screening for children at higher risk of lipid disorders
   - Sexually transmitted infection (STI) screening and counseling for sexually active adolescents
   - Cervical dysplasia screening at age 21
   - Oral health risk assessment
b. Newborn screening tests recommended by the Advisory Committee on Heritable Disorders in Newborns and Children (such as hypothyroidism screening for newborns and sickle cell screening for newborns).
c. Prophylactic ocular topical medication for all newborns for the prevention of gonorrhea.
d. Oral fluoride supplementation at currently recommended doses (based on local water supplies) to preschool children older than 6 months of age whose primary water source is deficient in fluoride. Over-the-counter supplements are covered only with a prescription.
e. Obesity screening in children and adolescents 6 years and older, including offer of or referral for comprehensive, intensive behavioral interventions to promote improvements in weight status.
f. HIV screening for adolescents ages 15 and older and for younger adolescents at increased risk of infection.

g. Counseling for children, adolescents, and young adults ages 6 months to 24 years who have fair skin about minimizing their exposure to ultraviolet radiation to reduce risk for skin cancer.
h. Interventions, including education or brief counseling, to prevent initiation of tobacco use in school-aged children and adolescents.
i. Screening for hepatitis B virus infection in adolescents at high risk for infection.
j. Application of fluoride varnish to the primary teeth of all infants and children through to age 5 starting at the age of primary tooth eruption, in primary care practices.
k. Syphilis screening for adolescents who are at increased risk for infection.
l. For adolescents, screening and counseling for interpersonal and domestic violence.
m. Vision screening at least once in all children ages 3 to 5 years to detect amblyopia or its risk factors.

Immunizations

Routine adult immunizations are covered for participants and dependents who meet the age and gender requirements and who meet the CDC medical criteria for recommendation.

a. Immunization vaccines for adults—doses, recommended ages, and recommended populations must be satisfied:
   - DTaP/Tdap/Td (Diphtheria/tetanus/pertussis)
   - Hepatitis A
   - Hepatitis B
   - Hib *(Haemophilus Influenzae* type B)
   - HPV (Human papillomavirus)
   - Influenza
   - Measles/mumps/rubella (MMR)
   - Meningococcal
   - Pneumococcal (polysaccharide)
   - Varicella (Chickenpox)
   - Zoster (Shingles)

b. Immunization vaccines for children from birth to age 18—doses, recommended ages, and recommended populations must be satisfied:
   - DTaP/Tdap/Td (Diphtheria/tetanus/pertussis)
   - Hepatitis A
   - Hepatitis B
   - Hib *(Haemophilus Influenzae* type B)
   - HPV (Human papillomavirus)
   - Influenza
   - Measles/mumps/rubella (MMR)
   - Meningococcal
   - Pneumococcal (polysaccharide)
   - Polio
   - Rotavirus
   - Varicella (Chickenpox)

c. Other immunization vaccines—doses, recommended ages, and recommended populations

must be satisfied:

- Anthrax
- Cholera
- Japanese Encephalitis
- Rabies
- Smallpox (Vaccinia)
- Typhoid
- Yellow Fever

TRADES COUNCIL 458

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 (708) 597-1832. 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 https://www.healthcare.gov/sbc-glossary/ or call (708) 597-1832 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	In-Network: $500/individual or $1,500/family Out-of-Network: $660/individual or $1,980/family	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 Preventive Care and In-Network Prescriptions 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 in-network 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. Dental Benefit – $75/individual or $225/family. Ortho and periodontal - $75/individual or $225/family. 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?	Medical In-Network: $3,000/individual or $9,000/family Medical Out-of-Network: $5,760/individual Prescription In-Network: $3,850/ individual or $4,700/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 and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out-of-pocket limit.

Important Questions	Answers	Why This Matters:
Will you pay less if you use a network provider?	Yes. See www.bcbsil.com or call (800) 571-1043 for a list of network providers. You can also call the Fund Office at (708) 597-1832.	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
		In-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	15% coinsurance	40% coinsurance	MDLIVE Telemedicine - no copayment, deductible or coinsurance. MDLIVE Telemedicine is an In-Network benefit only – no coverage for a telemedicine program other than MDLIVE.
	Specialist visit			-------------------------none-------------------------
	Preventive care/screening/ immunization	No charge	40% coinsurance	In-Network providers not subject to the deductible. 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. For specific benefits and limitations, see Plan at Section 12.06*.
If you have a test	Diagnostic test (x-ray, blood work)	15% coinsurance	40% coinsurance	No deductible, copayment or coinsurance on tests provided by Absolute Solutions Network or on COVID-19 testing at any provider (in-network or out-of-network). See the Plan at Section 5.28*.
	Imaging (CT/PET scans, MRIs)			No deductible or coinsurance on tests provided by Absolute Solutions Network. See the Plan at Section 5.28*.

* For more information about limitations and exceptions, see the plan document.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-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 www.myoptumrx.com **For Medicare:** (708) 223-2239 **For Non-Medicare:** (855) 577-6319 **For Briova:** (855) 427-4682	Generic drugs	Retail – $8/prescription Mail Order – $11/prescription	Retail - 40% of actual charge after the Major Medical deductible and the applicable In-Network copayment. Mail Order – Not Covered	No deductible on In-Network Prescription Benefits. Present Prescription Drug Card at time of retail purchase. If card is not presented, it will be treated as an out-of-network purchase and you may submit receipt for reimbursement. Retail is up to 30-day supply. Specialty Mail Order is up to 30-day supply. Mail Order is 90-day supply. If generic equivalent is available; you will be required to pay the applicable copayment plus the price difference between the generic drug and the formulary brand name drug, unless the brand name is Medically Necessary as determined by your Physician and the PBM. Specialty drugs for which copay assistance is available through IPC/Evergreen are subject to 30% coinsurance so long as the assistance ensures that the participant pays $100 or less. See the Plan at Section 7.04 for Prescription Exclusions*.
	Preferred brand drugs	Retail – $30/prescription Mail Order – $50/prescription		
	Non-preferred brand drugs	Retail – $50/prescription Mail Order – $90/prescription		
	Specialty drugs	Retail - 20% up to $100 max Mail Order – 20% up to $100 max	Retail - 40% of actual charge after the Major Medical deductible and the applicable In-Network copayment. Mail Order – Not Covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	15% coinsurance	40% coinsurance	-------------------------none------------------------
	Physician/surgeon fees			

* For more information about limitations and exceptions, see the plan document.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need immediate medical attention	Emergency room care	15% coinsurance	40% coinsurance	$200 copayment per person per visit unless moderate to severe conditions as reported by the ER or inpatient admission.
	Emergency medical transportation			-------------------------none------------------------
	Urgent care			MDLIVE Telemedicine - no copayment, deductible or coinsurance. MDLIVE Telemedicine is an In-Network benefit only – no coverage for a telemedicine program other than MDLIVE.
If you have a hospital stay	Facility fee (e.g., hospital room)	15% coinsurance	40% coinsurance	Limited to semi-private room rate.
	Physician/surgeon fees			-------------------------none------------------------
If you need mental health, behavioral health, or substance abuse services	Outpatient services	15% coinsurance	40% coinsurance	Consider MAP program for assistance first.
	Inpatient services			-------------------------none------------------------
If you are pregnant	Office visits	15% coinsurance	40% coinsurance	Maternity care may include tests and services described elsewhere in this document (i.e. ultrasound). Pregnancy of a dependent child not covered except under very limited circumstances. Cost-sharing does not apply to preventive services.
	Childbirth/delivery professional services			
	Childbirth/delivery facility services			In-patient stay of at least 48 hours for the mother and newborn child following a vaginal delivery or at least 96 hours for the mother and newborn child following a cesarean section delivery. Pregnancy of a dependent child not covered except under very limited circumstances.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need help recovering or have other special health needs	Home health care	15% coinsurance	40% coinsurance	Treatment must be within 90 days following a Hospital stay or Convalescent Facility stay of at least five days.
	Rehabilitation services			Limited to 20 visits per illness before review required for Medically Necessity. Physical Therapy received through ATI Physical Therapy's ATI First program is covered at 100% with no copayment, deductible or coinsurance.
	Habilitation services	15% coinsurance	40% coinsurance	Limited to certain illness and conditions. Refer to Plan at Section 5.19, 5.23 and 5.26*. Physical Therapy received through ATI Physical Therapy's ATI First program is covered at 100% with no copayment, deductible or coinsurance.
	Skilled nursing care			Limited to lesser of semi-private room rate or 50% of prior hospital semi-private room rate.
	Durable medical equipment			It is recommended to contact the Fund Office at (708) 597-1832 prior to purchase.
	Hospice services			-------------------------none------------------------
If your child needs dental or eye care	Children's eye exam	No charge	Reimbursement up to $35	Exam limited to once each calendar year. Out-of-Network charges are reimbursed after claim form submitted.
	Children's glasses	Frames: No charge up to $300 Lenses: No charge	Frames: Reimbursement up to $75 Lenses: Reimbursement up to: Single - $25 Bifocal - $40 Trifocal - $55	Lenses & Frames **or** Contact Lenses once every per calendar year. Additional benefits available for contacts, bifocals, etc. Out-of-Network charges are reimbursed after claim is submitted.
	Children's dental check-up	20% coinsurance after dental deductible		Limit two dental check-ups per person per Calendar Year. Subject to $2,500 per year individual maximum.

* For more information about limitations and exceptions, see the plan document.

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 • Cosmetic surgery (unless medically necessary)	• Long-term care • Non-emergency care when traveling outside the U.S.	• Private-duty nursing • Routine foot care • Weight loss programs (except those covered under ACA preventive care guidelines)

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)		
• Chiropractic care • Dental care (Adult)	• Hearing aids • Infertility treatment	• Routine eye care (adult)

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: 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 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 Fund Office at (708) 597-1832 or 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
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? 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 (708) 597-1832.

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.

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** — **$500**
- **Specialist coinsurance** — **15%**
- **Hospital (facility) coinsurance** — **15%**
- **Other coinsurance** — **15%**

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	$500
Copayments	$10
Coinsurance	$1,800
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$2,370**

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

- **The plan's overall deductible** — **$500**
- **Specialist coinsurance** — **15%**
- **Hospital (facility) coinsurance** — **15%**
- **Other coinsurance** — **15%**

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	$500
Copayments	$200
Coinsurance	$200
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$920**

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

- **The plan's overall deductible** — **$500**
- **Specialist coinsurance** — **15%**
- **Hospital (facility) coinsurance** — **$200**
- **Other coinsurance** — **15%**

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	$500
Copayments	$200
Coinsurance	$300
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,000**

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