



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 1-800-397-3373. 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](http://www.healthcare.gov/sbc-glossary) or call 1-800-397-3373 to request a copy.

| Important Questions                                                 | Answers         | Why This Matters:                                                                                                     |
|---------------------------------------------------------------------|-----------------|-----------------------------------------------------------------------------------------------------------------------|
| What is the overall <u>deductible</u> ?                             | \$0             | See the Common Medical Events chart below for your costs for services this <u>plan</u> covers.                        |
| Are there services covered before you meet your <u>deductible</u> ? | Not Applicable. | This <u>plan</u> does not have a <u>deductible</u> .                                                                  |
| Are there other <u>deductibles</u> for specific services?           | No.             | You don't have to meet <u>deductibles</u> for specific services.                                                      |
| What is the <u>out-of-pocket limit</u> for this <u>plan</u> ?       | Not Applicable. | This <u>plan</u> does not have an <u>out-of-pocket limit</u> on your expenses.                                        |
| What is not included in the <u>out-of-pocket limit</u> ?            | Not Applicable. | This <u>plan</u> does not have an <u>out-of-pocket limit</u> on your expenses.                                        |
| Will you pay less if you use a <u>network provider</u> ?            | Not Applicable. | This <u>plan</u> does not use a <u>provider network</u> . You can receive covered services from any <u>provider</u> . |
| Do you need a <u>referral</u> to see a <u>specialist</u> ?          | No.             | You can see the <u>specialist</u> you choose without a <u>referral</u> .                                              |



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                                                                                                 |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------|-------------------------------------------------|----------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------|
|                                                                                                                                                                                                      |                                                  | PPO <u>Provider</u><br>(You will pay the least) | Non-PPO <u>Provider</u><br>(You will pay the most) |                                                                                                                                                        |
| <b>If you visit a health care provider's office or clinic</b>                                                                                                                                        | Primary care visit to treat an injury or illness | Not covered                                     | Not covered                                        | The <u>Plan</u> supplements your Medicare Advantage with <u>Prescription Drug</u> Benefit. See your Medicare Advantage documents for coverage details. |
|                                                                                                                                                                                                      | <u>Specialist</u> visit                          | Not covered                                     | Not covered                                        |                                                                                                                                                        |
|                                                                                                                                                                                                      | <u>Preventive care/screening/immunization</u>    | Not covered                                     | Not covered                                        |                                                                                                                                                        |
| <b>If you have a test</b>                                                                                                                                                                            | <u>Diagnostic test</u> (x-ray, blood work)       | Not covered                                     | Not covered                                        | The <u>Plan</u> supplements your Medicare Advantage with <u>Prescription Drug</u> Benefit. See your Medicare Advantage documents for coverage details. |
|                                                                                                                                                                                                      | Imaging (CT/PET scans, MRIs)                     | Not covered                                     | Not covered                                        |                                                                                                                                                        |
| <b>If you need drugs to treat your illness or condition</b><br>More information about <u>prescription drug coverage</u> is available at <a href="http://www.Uhcretiree.com">www.Uhcretiree.com</a> . | Generic drugs                                    | Not covered                                     | Not covered                                        | The <u>Plan</u> supplements your Medicare Advantage with <u>Prescription Drug</u> Benefit. See your Medicare Advantage documents for coverage details. |
|                                                                                                                                                                                                      | Formulary brand drugs                            | Not covered                                     | Not covered                                        |                                                                                                                                                        |
|                                                                                                                                                                                                      | Non-formulary brand drugs                        | Not covered                                     | Not covered                                        |                                                                                                                                                        |
| <b>If you have outpatient surgery</b>                                                                                                                                                                | Facility fee (e.g., ambulatory surgery center)   | Not covered                                     | Not covered                                        | The <u>Plan</u> supplements your Medicare Advantage with <u>Prescription Drug</u> Benefit. See your Medicare Advantage documents for coverage details. |
|                                                                                                                                                                                                      | Physician/surgeon fees                           | Not covered                                     | Not covered                                        |                                                                                                                                                        |
| <b>If you need immediate medical attention</b>                                                                                                                                                       | <u>Emergency room care</u>                       | Not covered                                     | Not covered                                        | The <u>Plan</u> supplements your Medicare Advantage with <u>Prescription Drug</u> Benefit. See your Medicare Advantage documents for coverage details. |
|                                                                                                                                                                                                      | <u>Emergency medical transportation</u>          | Not covered                                     | Not covered                                        |                                                                                                                                                        |
|                                                                                                                                                                                                      | <u>Urgent care</u>                               | Not covered                                     | Not covered                                        |                                                                                                                                                        |

| Common Medical Event                                                      | Services You May Need                     | What You Will Pay                                                                                                            |                                                                                                    | Limitations, Exceptions, & Other Important Information                                                                                                                                                 |
|---------------------------------------------------------------------------|-------------------------------------------|------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
|                                                                           |                                           | PPO <u>Provider</u><br>(You will pay the least)                                                                              | Non-PPO <u>Provider</u><br>(You will pay the most)                                                 |                                                                                                                                                                                                        |
| If you have a hospital stay                                               | Facility fee (e.g., hospital room)        | Not covered                                                                                                                  | Not covered                                                                                        | The <u>Plan</u> supplements your Medicare Advantage with <u>Prescription Drug Benefit</u> . See your Medicare Advantage documents for coverage details.                                                |
|                                                                           | Physician/surgeon fees                    | Not covered                                                                                                                  | Not covered                                                                                        |                                                                                                                                                                                                        |
| If you need mental health, behavioral health, or substance abuse services | Not covered                               | Not covered                                                                                                                  | Not covered                                                                                        | The <u>Plan</u> supplements your Medicare Advantage with <u>Prescription Drug Benefit</u> . See your Medicare Advantage documents for coverage details.                                                |
|                                                                           | Inpatient services                        | Not covered                                                                                                                  | Not covered                                                                                        |                                                                                                                                                                                                        |
| If you are pregnant                                                       | Office visits                             | Not covered                                                                                                                  | Not covered                                                                                        | The <u>Plan</u> supplements your Medicare Advantage with <u>Prescription Drug Benefit</u> . See your Medicare Advantage documents for coverage details.                                                |
|                                                                           | Childbirth/delivery professional services | Not covered                                                                                                                  | Not covered                                                                                        |                                                                                                                                                                                                        |
|                                                                           | Childbirth/delivery facility services     | Not covered                                                                                                                  | Not covered                                                                                        |                                                                                                                                                                                                        |
| If you need help recovering or have other special health needs            | <u>Home health care</u>                   | Not covered                                                                                                                  | Not covered                                                                                        | The <u>Plan</u> supplements your Medicare Advantage with <u>Prescription Drug Benefit</u> . See your Medicare Advantage documents for coverage details.                                                |
|                                                                           | <u>Rehabilitation services</u>            | Not covered                                                                                                                  | Not covered                                                                                        |                                                                                                                                                                                                        |
|                                                                           | <u>Habilitation services</u>              | Not covered                                                                                                                  | Not covered                                                                                        |                                                                                                                                                                                                        |
|                                                                           | <u>Skilled nursing care</u>               | Not covered                                                                                                                  | Not covered                                                                                        |                                                                                                                                                                                                        |
|                                                                           | <u>Durable medical equipment</u>          | Not covered                                                                                                                  | Not covered                                                                                        |                                                                                                                                                                                                        |
|                                                                           | <u>Hospice services</u>                   | Not covered                                                                                                                  | Not covered                                                                                        |                                                                                                                                                                                                        |
| If your child needs dental or eye care                                    | Children's eye exam                       | No charge                                                                                                                    | Reimbursed up to \$45                                                                              | Lenses and frames covered once every 24 months; separately administered by EyeMed (866-800-5457). Fund Office administers reimbursement of out-of-pocket vision costs up to \$250 per person per year. |
|                                                                           | Children's glasses                        | Frames: No charge up to \$130, 20% discount on balance over \$130; Lenses: No charge standard/polycarbonate non-progressive. | Frames: Reimbursed up to \$65; Lenses: Reimbursed up to \$25 single vision and \$24 polycarbonate. |                                                                                                                                                                                                        |
|                                                                           | Children's dental check-up                | Not covered                                                                                                                  | Not covered                                                                                        | You must pay 100% of this service, even <u>in-network</u> .                                                                                                                                            |

## Excluded Services & Other Covered Services:

| Services Your <u>Plan</u> Generally Does NOT Cover (Check your policy or <u>plan</u> document for more information and a list of any other <u>excluded services</u> .) |                                                                                                                                                                                                                                             |                                                                                                                                                                                                |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <ul style="list-style-type: none"><li>• Acupuncture</li><li>• Bariatric surgery</li><li>• Chiropractic care</li><li>• Cosmetic surgery</li></ul>                       | <ul style="list-style-type: none"><li>• Dental care (Adult and Child) (Covered only through insured <u>plan</u> and only if Retiree elects and pays for dental benefits)</li><li>• Infertility treatment</li><li>• Long-term care</li></ul> | <ul style="list-style-type: none"><li>• Non-emergency care when traveling outside the U.S.</li><li>• Private-duty nursing</li><li>• Routine foot care</li><li>• Weight loss programs</li></ul> |
| Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your <u>plan</u> document.)                                    |                                                                                                                                                                                                                                             |                                                                                                                                                                                                |
| <ul style="list-style-type: none"><li>• Hearing aids (\$4,000 per person every 3 years)</li></ul>                                                                      | <ul style="list-style-type: none"><li>• Routine eye care (Adult) (up to \$250 per person per year)</li></ul>                                                                                                                                |                                                                                                                                                                                                |

**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](http://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](http://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 Plan Administrator, Wisconsin Laborers' Health Fund, Benefit Plan Administrators, 4633 LIUNA Way, Suite 201, DeForest, WI 53532-2514, Telephone 1-800-397-3373. 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](http://www.dol.gov/ebsa/healthreform).

## Does this plan provide Minimum Essential Coverage? No

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? No

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 1-800-397-3373.

Navajo (Dine): Dinekehgo shika at'ohwol ninisingo, kwijigo holne' 1-800-397-3373.

*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 in-network pre-natal care and a hospital delivery)

|                                               |     |
|-----------------------------------------------|-----|
| ■ The <u>plan's</u> overall <u>deductible</u> | N/A |
| ■ <u>Specialist</u> copayment                 | N/A |
| ■ Hospital (facility) <u>coinsurance</u>      | N/A |
| ■ Other <u>coinsurance</u>                    | N/A |

#### 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*)

|                           |                 |
|---------------------------|-----------------|
| <b>Total Example Cost</b> | <b>\$12,700</b> |
|---------------------------|-----------------|

#### In this example, Peg would pay:

| Cost Sharing                      |                 |
|-----------------------------------|-----------------|
| <u>Deductibles</u>                | \$0             |
| <u>Copayments</u>                 | \$0             |
| <u>Coinsurance</u>                | \$0             |
| What isn't covered                |                 |
| Limits or exclusions              | \$12,700        |
| <b>The total Peg would pay is</b> | <b>\$12,700</b> |

### Managing Joe's Type 2 Diabetes

(a year of routine in-network care of a well-controlled condition)

|                                               |     |
|-----------------------------------------------|-----|
| ■ The <u>plan's</u> overall <u>deductible</u> | N/A |
| ■ <u>Specialist</u> copayment                 | N/A |
| ■ Hospital (facility) <u>coinsurance</u>      | N/A |
| ■ Other <u>coinsurance</u>                    | N/A |

#### 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*)

|                           |                |
|---------------------------|----------------|
| <b>Total Example Cost</b> | <b>\$5,600</b> |
|---------------------------|----------------|

#### In this example, Joe would pay:

| Cost Sharing                      |                |
|-----------------------------------|----------------|
| <u>Deductibles</u>                | \$0            |
| <u>Copayments</u>                 | \$0            |
| <u>Coinsurance</u>                | \$0            |
| What isn't covered                |                |
| Limits or exclusions              | \$5,600        |
| <b>The total Joe would pay is</b> | <b>\$5,600</b> |

### Mia's Simple Fracture

(in-network emergency room visit and follow up care)

|                                               |     |
|-----------------------------------------------|-----|
| ■ The <u>plan's</u> overall <u>deductible</u> | N/A |
| ■ <u>Specialist</u> copayment                 | N/A |
| ■ Hospital (facility) <u>coinsurance</u>      | N/A |
| ■ Other <u>coinsurance</u>                    | N/A |

#### This EXAMPLE event includes services like:

Emergency room care (*including medical supplies*)  
Diagnostic test (*x-ray*)  
Durable medical equipment (*crutches*)  
Rehabilitation services (*physical therapy*)

|                           |                |
|---------------------------|----------------|
| <b>Total Example Cost</b> | <b>\$2,800</b> |
|---------------------------|----------------|

#### In this example, Mia would pay:

| Cost Sharing                      |                |
|-----------------------------------|----------------|
| <u>Deductibles</u>                | \$0            |
| <u>Copayments</u>                 | \$0            |
| <u>Coinsurance</u>                | \$0            |
| What isn't covered                |                |
| Limits or exclusions              | \$2,800        |
| <b>The total Mia would pay is</b> | <b>\$2,800</b> |

\*NOTE: You may be eligible to file for reimbursement of some of these expenses, as permitted by the Plan's Health Reimbursement Arrangement.