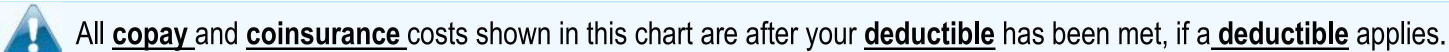
The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately.
This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, call 1-800-253-5713 or visit www.bpalja.com (login ID is: WPT; password is: steamwpt). For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copay, deductible, provider, or other underlined terms see the Glossary. You can view the Glossary at https://www.healthcare.gov/sbc-glossary or call 1-800-253-5713 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	In-Network Provider: **$4,500** Individual / **$9,000** Family; Out-of-Network Provider: **$9,000** Individual / **$18,000** 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 this 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. The following do not count towards the deductible: second surgical opinions, pre-admission testing, hospice care, well child care, and preventive care as required under the Affordable Care Act (ACA).	This plan covers some items and services even if you haven't yet met the deductible amount. But a copay or coinsurance may apply. For example, this plan covers certain preventive services without cost sharing and before you meet your deductible. See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits.
Are there other deductibles for specific services?	Yes. **$250** for Preferred Provider Pharmacy Prescription Drug Benefits. 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 Provider: **$4,500** Individual / **$9,000** Family; Out-of-Network Provider: **$9,000** Individual / **$18,000** Family. PPRx: **$2,350** Individual / **$4,700** Family (including deductible).	The out-of-pocket limit ("OOP") 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.

Important Questions	Answers	Why This Matters:
What is not included in the out-of-pocket limit?	Coinsurance for preventive care in excess of maximums, premiums, balance billing charges, and health care this plan does not cover.	Even though you pay these expenses, they don't count toward the out-of-pocket-limit.
Will you pay less if you use a network provider?	Yes. For a list of network providers, visit: www.welcometouhc.com/uhss or call the Fund Office at 1-800-253-5713.	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 copay 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: Network Provider (You will pay the least)	What You Will Pay: Non-Network Provider (You will pay the most)	Limitations, Exceptions* & Other Important Information
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	0% coinsurance	0% coinsurance	Plan pays 100% of charges after respective In/Out-of-Network deductibles/out-of-pocket maximums have been satisfied. Chiropractor visits limited to 24/year. Acupuncture limited to $500/year.
	Specialist visit	0% coinsurance	0% coinsurance	
	Preventive care/screening/ immunization	No charge	0% coinsurance for after Out-of-Network deductibles/out-of-pocket maximums have been satisfied	Out-of-Network well child care from birth to age 2 as recommended by the American Academy of Pediatrics; age 2 through 17 one routine exam and related lab and x-ray/year; age 18 to 26 up to $400/year (excess at 60% coinsurance which does not apply to out-of-pocket limit). Out-of-Network routine physical exams for employee and dependent spouse limited to $400/year (excess at 60% coinsurance), except Preferred Provider Preventive Care Program not limited. No limit for In-Network well child care or routine physical exams. No limit for routine immunizations. If the Plan does not have an In-Network Provider who can provide a particular covered preventive service, then it will cover the item or service without cost sharing when performed by an Out-of-Network Provider acting within the scope of his/her license or certification.
If you have a test	Diagnostic test (x-ray, blood work)	0% coinsurance	0% coinsurance	Play pays 100% of charges after respective In/Out-of-Network deductibles/out-of-pocket maximums have been satisfied. Genetic testing limited to $5,000/lifetime when medically necessary. Out-of-Network lab charges will be covered at In-Network level if you went to an In-Network physician and facility.
	Imaging (CT/PET scans, MRIs)	0% coinsurance	0% coinsurance	

[*For more information about limitations and exceptions, see the plan or policy document at www.bpalja.com (login ID: WPT; password: steamwpt).]

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions* & Other Important Information
		Network Provider (You will pay the least)	Non-Network Provider (You will pay the most)	
If you need drugs to treat your illness or condition[1] More information about **prescription drug coverage** is available at www.serve-you-rx.com.	Generic drugs	$20 copay/ prescription (retail and mail-order)	Not covered	In-Network: Retail: covers up to a 30-day supply Mail-order: 90-day supply Specialty: 30-day supply Benefits payable at 50% for non-generic prescription PPIs and non-sedating antihistamines. Maintenance medications must be purchased through mail-order. Step Therapy Program applies to medications for asthma, diabetes, ADHD, and cholesterol. Drugs not on the formulary list are not covered.
	Brand name drugs	Retail: 20% coinsurance, $30 minimum, $60 maximum Mail-order: $50 copay/prescription	Not covered	
	Specialty drugs	$100 copay/ prescription	Not covered	
	Generic OTC medications in the following categories: non-sedating antihistamines, proton pump inhibitors, and proton pump inhibitor-antacid combinations, upon a physician's written prescription	No charge (retail and mail-order), no deductible	Not covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	0% coinsurance	0% coinsurance	Play pays 100% of charges after respective In/Out-of-Network deductibles/out-of-pocket maximums have been satisfied.
	Physician/surgeon fees	0% coinsurance	0% coinsurance	
If you need immediate medical attention	Emergency room care	0% coinsurance	0% coinsurance	Plan pays 100% of charges after respective In/Out-of-Network deductibles/out-of-pocket maximums have been satisfied. Benefits payable at In-Network level for Out-of-Network hospital (including resulting hospital charges if admitted and if had been transported by ambulance).
	Emergency medical transportation	0% coinsurance	0% coinsurance	Subject to In-Network deductible

[1] Upon a physician's written prescription, the following will be covered at a $0 copayment: generic contraceptives and contraceptives for which there is no generic alternative; OTC generic aspirin up to 325mg once per day for age 45 and older; federal legend generic sodium fluoride for five and younger; OTC generic folic acid for doses of 0.4mg-0.8mg once per day for women age 55 and younger; OTC iron supplements up to age one; and FDA-approved tobacco cessation medications (including both prescription and OTC medications) for a 90-day treatment regimen when prescribed by a health care provider, with no requirement for prior authorization.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions* & Other Important Information
		Network Provider (You will pay the least)	Non-Network Provider (You will pay the most)	
If you need immediate medical attention (continued)	Urgent care	0% coinsurance	0% coinsurance	Plan pays 100% of charges after respective In/Out-of-Network deductibles/out-of-pocket maximums have been satisfied.
If you have a hospital stay	Facility fee (e.g., hospital room)	0% coinsurance	0% coinsurance	Limited to hospital's semi-private room rate. Plan pays 100% of charges after respective In/Out-of-Network deductibles/out-of-pocket maximums have been satisfied.
	Physician/surgeon fees	0% coinsurance	0% coinsurance	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	0% coinsurance	0% coinsurance	Plan pays 100% of charges after respective In/Out-of-Network deductibles/out-of-pocket maximums have been satisfied.
	Inpatient services	0% coinsurance	0% coinsurance	
If you are pregnant	Office visits	0% coinsurance	0% coinsurance	Prenatal care is covered under the preventive care benefits provisions. Plan pays 100% of charges after respective In/Out-of-Network deductibles/out-of-pocket maximums have been satisfied.
	Childbirth/delivery professional services	0% coinsurance	0% coinsurance	
	Childbirth/delivery facility services	0% coinsurance	0% coinsurance	
If you need help recovering or have other special health needs	Home health care	0% coinsurance	0% coinsurance	Limited to 10 visits per period of disability. Plan pays 100% of charges after respective In/Out-of-Network deductibles/out-of-pocket maximums have been satisfied.
	Rehabilitation services	0% coinsurance	0% coinsurance	Treatment plans are reviewed for ongoing medical appropriateness after 20 visits. Plan pays 100% of charges after respective In/Out-of-Network deductibles/out-of-pocket maximums have been satisfied.
	Habilitation services	Not covered	Not covered	Not covered
	Skilled nursing care	0% coinsurance	0% coinsurance	Limited to 30 days per period of disability. Plan pays 100% of charges after respective In/Out-of-Network deductibles/out-of-pocket maximums have been satisfied.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions* & Other Important Information
		Network Provider (You will pay the least)	Non-Network Provider (You will pay the most)	
If you need help recovering or have other special health needs (continued)	Durable medical equipment	0% coinsurance	0% coinsurance	Plan pays 100% of charges after respective In/Out-of-Network deductibles/out-of-pocket maximums have been satisfied.
	Hospice services	0% coinsurance	0% coinsurance	Plan pays 100% of charges after respective In/Out-of-Network deductibles/out-of-pocket maximums have been satisfied.
If your child needs dental or eye care	Children's eye exam	No charge	Not covered	Limited to 1 exam per year, up to age 19
	Children's glasses	No charge	Not covered	Limited to 1 pair of glasses/2years, up to $300 for lenses and frames.
	Children's dental check-up	No charge	No charge	Limited to 2 check-ups per year, up to age 19.

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.)		
• Bariatric surgery • Cosmetic surgery, except if medically appropriate as specified in your Summary Plan Description • Dental care (Adult)	• Habilitation services • Long-term care • Private-duty nursing	• Routine eye care (Adult) • Routine foot care • Weight loss programs, except medically appropriate physician visits for treatment of morbid obesity are covered

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)		
• Acupuncture, up to $500/year • Chiropractic care, up to 24 visits/year • Hearing aids, up to $1,000 per aid/two years	• Infertility treatment, except invitro fertilization and artificial insemination are excluded	• Non-emergency care when traveling outside the U.S.

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 the Department of Labor's Employee Benefits Security Administration is 1-866-444-EBSA (3272) or https://www.dol.gov/agencies/ebsa. 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 1-800-253-5713.

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 Plan Administrator at 1-800-253-5713, or the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or https://www.dol.gov/agencies/ebsa.

Does this plan provide Minimum Essential Coverage? Yes

If you don't have Minimum Essential Coverage for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

Does this plan meet the Minimum Value Standards? Yes

If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

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

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, copays 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** — **$4,500**
- **Specialist copay** — **$0**
- **Hospital (facility) coinsurance** — **0%**
- **Other coinsurance** — **0%**

This EXAMPLE event includes services like:
Specialist office visits (*prenatal care)*
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic tests (*ultrasounds and blood work)*
Specialist visit *(anesthesia)*

Total Example Cost	**$12,800**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$4,540
Copays	$0
Coinsurance	$0
What isn't covered	
Limits or exclusions	$250
The total Peg would pay is	**$4,790**

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

- **The plan's overall deductible** — **$4,500**
- **Specialist copay** — **$0**
- **Hospital (facility) coinsurance** — **0%**
- **Other coinsurance** — **0%**

This EXAMPLE event includes services like:
Primary care physician office visits (*including disease education)*
Diagnostic tests *(blood work)*
Prescription drugs
Durable medical equipment *(glucose meter)*

Total Example Cost	**$7,400**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$1,450
Copays	$1,620
Coinsurance	$0
What isn't covered	
Limits or exclusions	$30
The total Joe would pay is	**$3,100**

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

- **The plan's overall deductible** — **$4,500**
- **Specialist copay** — **$0**
- **Hospital (facility) coinsurance** — **0%**
- **Other coinsurance** — **0%**

This EXAMPLE event includes services like:
Emergency room care *(including medical supplies)*
Diagnostic test *(x-ray)*
Durable medical equipment *(crutches)*
Rehabilitation services *(physical therapy)*

Total Example Cost	**$1,900**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$1,900
Copays	$0
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,900**

* The Plan has other deductibles for services included in this coverage example.

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