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, call 1-800-318-2596, or contact the Fund Office at 1-800-253-5713 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	In-Network Provider: **$1,000** Individual / **$3,000** Family; Out-of-Network Provider: **$2,000** Individual / **$6,000** 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, home health care, skilled nursing home 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. **$100** for Classes A and J 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: **$3,600** Individual / **$7,200** Family; Out-of-Network Provider: **$7,200** Individual / **$14,400** 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.

[1] Class C Claims are paid at the in-network level of benefits.

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.

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

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		Limitations, Exceptions*,[1] & Other Important Information
		Network Provider (You will pay the least)	Non-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	$25 copay/visit	$25 copay/visit	CareATC visits/services covered at 100%.
	Specialist visit	$25 copay/visit	$25 copay/visit	Chiropractor and acupuncture In-Network: 20% coinsurance Out-of-Network: 40% coinsurance Chiropractor visits limited to 24/year. Acupuncture limited to $500/year.
	Preventive care/screening/ immunization	No charge	No charge for routine immunizations. 40% coinsurance for routine physical exams for employee and dependent spouse (unless through Preferred Provider Preventive Care Program) and 40% coinsurance for well child care from birth through age 26	Out-of-Network well child care from birth to age 2 as recommended by the American Academy of Pediatrics; age 2 through 26 one routine exam and related lab and x-ray/year up to $400/year (excess at 80% 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 80% 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.

[1] Class C claims are paid at the in-network level of benefits.

[*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*,[1] & Other Important Information
		Network Provider (You will pay the least)	Non-Network Provider (You will pay the most)	
If you have a test	Diagnostic test (x-ray, blood work)	20% coinsurance except no charge for pre-admission testing	40% coinsurance except no charge for pre-admission testing	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)	20% coinsurance	40% coinsurance	None
If you need drugs to treat your illness or condition[2] More information about **prescription drug coverage** is available at www.serve-you-rx.com.	Generic drugs	$13 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	20% coinsurance, minimum $26, maximum $52 (retail); $32.50 copay/prescription (mail-order)	Not covered	
	Specialty drugs	$13 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)	20% coinsurance	40% coinsurance	None
	Physician/surgeon fees	20% coinsurance	40% coinsurance	None

[1] Class C claims are paid at the in-network level of benefits.

[2] Upon a physician's written prescription, certain generic OTC medications will be covered at a $0 copayment subject to recommendations provided by the United States Preventive Services Task Force (USPSTF) as described in your Summary Plan Description/Plan Document. For information on the USPSTF recommendations, you can visit their website at: www.uspreventiveservicestaskforce.org.

[*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*,[1], & Other Important Information
		Network Provider (You will pay the least)	Non-Network Provider (You will pay the most)	
If you need immediate medical attention	Emergency room care	$100 copay/visit, then 20% coinsurance	$100 copay/visit, then 20% coinsurance	Benefits payable at In-Network level for Out-of-Network hospital (including resulting hospital charges if admitted and if had been transported by ambulance). Copay waived if admitted.
	Emergency medical transportation	20% coinsurance	20% coinsurance	Subject to In-Network deductible
	Urgent care	20% coinsurance	40% coinsurance	None
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance	Not covered	Limited to hospital's semi-private room rate.
	Physician/surgeon fees	20% coinsurance	Not covered	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$25 copay/visit	$25 copay/visit	None
	Inpatient services	20% coinsurance	Not covered	None
If you are pregnant	Office visits	$25 copay/visit	$25 copay/visit	Prenatal care is covered under the preventive care benefits provisions.
	Childbirth/delivery professional services	20% coinsurance	40% coinsurance	
	Childbirth/delivery facility services	20% coinsurance	Not covered	None
If you need help recovering or have other special health needs	Home health care	No charge	No charge	Limited to 10 visits per period of disability.
	Rehabilitation services	20% coinsurance	40% coinsurance	Treatment plans are reviewed for ongoing medical appropriateness after 20 visits.
	Habilitation services	Not covered	Not covered	Not covered
	Skilled nursing care	No charge	No charge	Limited to 30 days per period of disability.
	Durable medical equipment	20% coinsurance	40% coinsurance	None
	Hospice services	No charge	No charge	None
If your child needs dental or eye care	Children's eye exam	No charge	No charge	Limited to 1 exam per year, up to age 19.
	Children's glasses	No charge	No charge	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.

[1] Class C claims are paid at the in-network level of benefits.

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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
- Habilitation services
- Long-term care
- Private-duty nursing
- 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
- Dental care (Adult) (Available as an option for retirees at additional self-payment amount)
- 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.
- Routine eye care (Adult) (Available as an option for retirees at additional self-payment amount)

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, call 1-800-318-2596, or contact the Fund Office at 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.

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

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	**$1,000**
Specialist copay	**$25**
Hospital (facility) coinsurance	**80%**
Other coinsurance	**80%**

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	$1,040
Copays	$0
Coinsurance	$2,100
What isn't covered	
Limits or exclusions	$250
The total Peg would pay is	**$3,390**

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

The plan's overall deductible	**$1,000**
Specialist copay	**$25**
Hospital (facility) coinsurance	**80%**
Other coinsurance	**80%**

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	$600
Copays	$1,540
Coinsurance	$0
What isn't covered	
Limits or exclusions	$30
The total Joe would pay is	**$2,170**

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

The plan's overall deductible	**$1,000**
Specialist copay	**$25**
Hospital (facility) coinsurance	**80%**
Other coinsurance	**80%**

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	$1,000
Copays	$150
Coinsurance	$120
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,270**

* 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.