




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.bpajla.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 <u>deductible</u> ?	<u>In-Network Provider</u> : \$4,500 Individual / \$9,000 Family; <u>Out-of-Network Provider</u> : \$9,000 Individual / \$18,000 Family.	Generally, you must pay all of the costs from <u>providers</u> up to the <u>deductible</u> amount before this <u>plan</u> begins to pay. If you have other family members on this <u>plan</u> , each family member must meet their own individual <u>deductible</u> until the total amount of <u>deductible</u> expenses paid by all family members meets the overall family <u>deductible</u> .
Are there services covered before you meet your <u>deductible</u> ?	Yes. The following do not count towards the <u>deductible</u> : second surgical opinions, pre-admission testing, hospice care, well child care, and <u>preventive care</u> as required under the Affordable Care Act (ACA).	This <u>plan</u> covers some items and services even if you haven't yet met the <u>deductible</u> amount. But a <u>copay</u> or <u>coinsurance</u> may apply. For example, this <u>plan</u> covers certain <u>preventive services</u> without <u>cost sharing</u> and before you meet your <u>deductible</u> . See a list of covered <u>preventive services</u> at https://www.healthcare.gov/coverage/preventive-care-benefits .
Are there other <u>deductibles</u> for specific services?	Yes. \$250 for Preferred Provider Pharmacy Prescription Drug Benefits. There are no other specific <u>deductibles</u> .	You must pay all of the costs for these services up to the specific <u>deductible</u> amount before this <u>plan</u> begins to pay for these services.
What is the <u>out-of-pocket limit</u> for this <u>plan</u> ?	Medical: <u>In-Network Provider</u> : \$4,500 Individual / \$9,000 Family; <u>Out-of-Network Provider</u> : \$9,000 Individual / \$18,000 Family. PPRx: \$2,350 Individual / \$4,700 Family (including <u>deductible</u>).	The <u>out-of-pocket limit</u> ("OOP") is the most you could pay in a year for covered services. If you have other family members in this <u>plan</u> , they have to meet their own <u>out-of-pocket limits</u> until the overall family <u>out-of-pocket limit</u> has been met.

Important Questions	Answers	Why This Matters:
What is not included in the <u>out-of-pocket limit</u>?	<u>Coinsurance</u> for <u>preventive care</u> in excess of maximums, <u>premiums</u> , <u>balance billing charges</u> , and health care this <u>plan</u> does not cover.	Even though you pay these expenses, they don't count toward the <u>out-of-pocket-limit</u> .
Will you pay less if you use a <u>network provider</u>?	Yes. For a list of <u>network providers</u> , visit: www.welcometouhc.com/uhss or call the Fund Office at 1-800-253-5713.	This <u>plan</u> uses a <u>provider network</u> . You will pay less if you use a <u>provider</u> in the <u>plan's network</u> . You will pay the most if you use an <u>out-of-network provider</u> , and you might receive a bill from a <u>provider</u> for the difference between the <u>provider's charge</u> and what your <u>plan</u> pays (<u>balance billing</u>). Be aware your <u>network provider</u> might use an <u>out-of-network provider</u> for some services (such as lab work). Check with your <u>provider</u> before you get services.
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 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		Limitations, Exceptions* & 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	0% <u>coinsurance</u>	0% <u>coinsurance</u>	Plan pays 100% of charges after respective <u>In/Out-of-Network deductibles/out-of-pocket maximums</u> have been satisfied. Chiropractor visits limited to 24/year. Acupuncture limited to \$500/year.
	<u>Specialist visit</u>	0% <u>coinsurance</u>	0% <u>coinsurance</u>	
	<u>Preventive care/screening/immunization</u>	No charge	0% <u>coinsurance</u> for after <u>Out-of-Network deductibles/out-of-pocket maximums</u> have been satisfied	<u>Out-of-Network well child care</u> 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 60% <u>coinsurance</u> which does not apply to out-of-pocket limit). <u>Out-of-Network routine physical exams</u> for employee and dependent spouse limited to \$400/year (excess at 60% <u>coinsurance</u>), except <u>Preferred Provider Preventive Care Program</u> not limited. No limit for <u>In-Network well child care</u> or routine physical exams. No limit for routine immunizations. If the <u>Plan</u> does not have an <u>In-Network Provider</u> who can provide a particular covered preventive service, then it will cover the item or service without <u>cost sharing</u> when performed by an <u>Out-of-Network Provider</u> acting within the scope of his/her license or certification.
If you have a test	<u>Diagnostic test</u> (x-ray, blood work)	0% <u>coinsurance</u>	0% <u>coinsurance</u>	Plan pays 100% of charges after respective <u>In/Out-of-Network deductibles/out-of-pocket maximums</u> have been satisfied. Genetic testing limited to \$5,000/lifetime when medically necessary. <u>Out-of-Network lab charges</u> will be covered at <u>In-Network</u> level if you went to an <u>In-Network</u> physician and facility.
	Imaging (CT/PET scans, MRIs)	0% <u>coinsurance</u>	0% <u>coinsurance</u>	

[*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)	
<p>If you need drugs to treat your illness or condition¹</p> <p>More information about prescription drug coverage is available at www.serve-you-rx.com.</p>	Generic drugs	\$20 <u>copay</u> / prescription (retail and mail-order)	Not covered	<p><u>In-Network</u>: 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.</p> <p>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.</p>
	Brand name drugs	Retail: 20% <u>coinsurance</u> , \$30 minimum, \$60 maximum Mail-order: \$50 <u>copay</u> /prescription	Not covered	
	Specialty drugs	\$100 <u>copay</u> / 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 <u>deductible</u>	Not covered	
<p>If you have outpatient surgery</p>	Facility fee (e.g., ambulatory surgery center)	0% <u>coinsurance</u>	0% <u>coinsurance</u>	<p>Plan pays 100% of charges after respective <u>In/Out-of-Network deductibles/out-of-pocket maximums</u> have been satisfied.</p>
	Physician/surgeon fees	0% <u>coinsurance</u>	0% <u>coinsurance</u>	
<p>If you need immediate medical attention</p>	<u>Emergency room care</u>	0% <u>coinsurance</u>	0% <u>coinsurance</u>	<p>Plan pays 100% of charges after respective <u>In/Out-of-Network deductibles/out-of-pocket maximums</u> have been satisfied. Benefits payable at <u>In-Network</u> level for <u>Out-of-Network</u> hospital (including resulting hospital charges if admitted and if had been transported by ambulance).</p> <p>Subject to <u>In-Network deductible</u></p>
	<u>Emergency medical transportation</u>	0% <u>coinsurance</u>	0% <u>coinsurance</u>	

¹ 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.

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)	<u>Urgent care</u>	0% <u>coinsurance</u>	0% <u>coinsurance</u>	Plan pays 100% of charges after respective <u>In/Out-of-Network deductibles/out-of-pocket maximums</u> have been satisfied.
If you have a hospital stay	Facility fee (e.g., hospital room)	0% <u>coinsurance</u>	Not covered	Limited to hospital's semi-private room rate. Plan pays 100% of charges after respective <u>In-Network deductible</u> and out-of-pocket maximum have been satisfied.
	Physician/surgeon fees	0% <u>coinsurance</u>	Not covered	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	0% <u>coinsurance</u>	0% <u>coinsurance</u>	Plan pays 100% of charges after respective <u>In-Network deductible</u> and out-of-pocket maximum have been satisfied.
	Inpatient services	0% <u>coinsurance</u>	Not covered	
If you are pregnant	Office visits	0% <u>coinsurance</u>	0% <u>coinsurance</u>	Prenatal care is covered under the <u>preventive care</u> benefits provisions. Plan pays 100% of charges after respective <u>In-Network deductible</u> and out-of-pocket maximum have been satisfied.
	Childbirth/delivery professional services	0% <u>coinsurance</u>	0% <u>coinsurance</u>	
	Childbirth/delivery facility services	0% <u>coinsurance</u>	Not covered	
If you need help recovering or have other special health needs	<u>Home health care</u>	0% <u>coinsurance</u>	0% <u>coinsurance</u>	Limited to 10 visits per period of disability. Plan pays 100% of charges after respective <u>In/Out-of-Network deductibles/out-of-pocket maximums</u> have been satisfied.
	<u>Rehabilitation services</u>	0% <u>coinsurance</u>	0% <u>coinsurance</u>	Treatment plans are reviewed for ongoing medical appropriateness after 20 visits. Plan pays 100% of charges after respective <u>In/Out-of-Network deductibles/out-of-pocket maximums</u> have been satisfied.
	<u>Habilitation services</u>	Not covered	Not covered	Not covered
	<u>Skilled nursing care</u>	0% <u>coinsurance</u>	0% <u>coinsurance</u>	Limited to 30 days per period of disability. Plan pays 100% of charges after respective <u>In/Out-of-Network deductibles/out-of-pocket maximums</u> have been satisfied.

[*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 help recovering or have other special health needs (continued)	<u>Durable medical equipment</u>	0% <u>coinsurance</u>	0% <u>coinsurance</u>	Plan pays 100% of charges after respective In/Out-of-Network deductibles/out-of-pocket maximums have been satisfied.
	<u>Hospice services</u>	0% <u>coinsurance</u>	0% <u>coinsurance</u>	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.

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

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, 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.—————

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
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In this example, Peg would pay:

<i>Cost Sharing</i>	
Deductibles	\$4,540
Copays	\$0
Coinsurance	\$0
<i>What isn't covered</i>	
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
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In this example, Joe would pay:

<i>Cost Sharing</i>	
Deductibles	\$1,450
Copays	\$1,620
Coinsurance	\$0
<i>What isn't covered</i>	
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
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In this example, Mia would pay:

<i>Cost Sharing</i>	
Deductibles	\$1,900
Copays	\$0
Coinsurance	\$0
<i>What isn't covered</i>	
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.