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, www.pipetradesbenefits.org or by calling 1-877-811-4474. 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.pipetradesbenefits.org or call 1-877-811-4474 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	$200.00 Annually for preferred providers, $200 for non-preferred providers	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. This Plan covers some items and services even if you haven't met the deductible amount. But a coinsurance may apply.	You don't have to meet deductibles for specific services.
Are there other deductibles for specific services?	No	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	For network providers $1000 individual/No cap for out-of-network providers	The out-of-pocket limit is the most you could pay in a year for covered services.
What is not included in the out-of-pocket limit?	Charges incurred out-of-network will not be included in the out-of-pocket limit.	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 preferred providers, see www.blueshieldca.com or call 1-877-811-4474	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).
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
		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	10% coinsurance	30% coinsurance	No limitations
	Specialist visit	10% coinsurance	30% coinsurance	No limitations
	Preventive care/screening/ immunization	10% coinsurance	30% coinsurance	Well Baby Care from birth to 2nd birthday. Routine Exam: One exam per year 2-19 and over 65. One exam every two years 20-64.
If you have a test	Diagnostic test (x-ray, blood work)	10% coinsurance	30% coinsurance	No limitations
	Imaging (CT/PET scans, MRIs)	10% coinsurance	30% coinsurance	No limitations
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at https://www.welldynerx.com/	Generic drugs	20% of cost	Not applicable	No limitations
	Preferred brand drugs	30% of Cost	Not applicable	No limitations
	Non-preferred brand drugs	50% of Cost	Not applicable	No limitations
	Specialty drugs	10% of contract rate, after deductible	Not covered	No limitations
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	10% coinsurance	30% coinsurance	Some services must be pre-certified. See the Plan document for more information.
	Physician/surgeon fees	10% coinsurance	30% coinsurance	Some services must be pre-certified. See the Plan document for more information.
If you need immediate medical attention	Emergency room care	10% coinsurance	30% coinsurance	No limitations
	Emergency medical transportation	10% coinsurance	30% coinsurance	No limitations
	Urgent care	10% coinsurance	30% coinsurance	No limitations
If you have a hospital stay	Facility fee (e.g., hospital room)	10% coinsurance	30% coinsurance	All inpatient non-emergency hospital stays must be pre-certified.
	Physician/surgeon fees	10% coinsurance	30% coinsurance	All inpatient non-emergency hospital stays must be pre-certified.

[* For more information about limitations and exceptions, see the plan or policy document at www.ualocal447.org/benefits.]

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	10% coinsurance	30% coinsurance	No limitations
	Inpatient services	10% coinsurance	30% coinsurance	Not covered unless pre-certified.
If you are pregnant	Office visits	10% coinsurance	30% coinsurance	Depending on the type of services, a coinsurance or deductible may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound)
	Childbirth/delivery professional services	10% coinsurance	30% coinsurance	
	Childbirth/delivery facility services	10% coinsurance	30% coinsurance	
If you need help recovering or have other special health needs	Home health care	10% coinsurance	30% coinsurance	No coverage for Non-preferred home health care unless Pre-Certified. 100 visit maximum per year, must be within 14 days of hospital discharge.
	Rehabilitation services	10% coinsurance	30% coinsurance	No limitation, no exceptions for physical therapy and acupuncture combined.
	Habilitation services	10% coinsurance	30% coinsurance	No limitation, no exceptions for physical therapy and acupuncture combined.
	Skilled nursing care	10% coinsurance	30% coinsurance	No coverage for Non-preferred home health care unless Pre-Certified. 100 visit maximum per year, must be within 14 days of hospital discharge.
	Durable medical equipment	10% coinsurance	30% coinsurance	Durable Medical Equipment, not covered unless Pre-Certified by the Plan.
	Hospice services	10% coinsurance	30% coinsurance	Not covered unless Pre-Certified by the Plan.
If your child needs dental or eye care	Children's eye exam	No Charge	$40 allowance	Once every 24 months
	Children's glasses	No Charge for standard frames and lenses	Allowance varies based on lens type and $40 allowance for frames.	Every 24 months OR at 12-month intervals and if the prescription change so indicates
	Children's dental check-up	10% coinsurance	30% coinsurance	$0 calendar year dental maximum for children under the age of 18. $3,000 calendar year maximum. $5,000 lifetime maximum for Orthodontics (children under the age of 19 ONLY)

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 – unless Pre-Certified by the Plan	• Cosmetic Surgery	• Infertility Treatment
• Dependent pregnancy	• Weight Loss Programs	•

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)		
• Acupuncture	• Audiology and Hearing Aids	• Chiropractic care
• Dental care (Adult)	• Long Term Care	• Non-emergency care when traveling outside the U.S.
• Private-duty nursing	• Routine eye care (Adult)	• Routine foot care

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 Services, Center for Consumer Information and Insurance Oversight, at 1-877-267-2323 x61565 or www.cciio.cms.gov. 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 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: 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

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.

Language Access Services:

[Spanish (Español): Para obtener asistencia en Español, llame al [insert telephone number].]

[Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa [insert telephone number].]

[Chinese (中文): 如果需要中文的帮助， **请拨打这个号码** [insert telephone number].]

[Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' [insert telephone number].]

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.ualocal447.org/benefits.]

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	$200
Specialist coinsurance	%10
Hospital (facility) *[cost sharing]*	%10
Other *[cost sharing]*	%10

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

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

The plan's overall deductible	$200
Specialist *[cost sharing]*	%10
Hospital (facility) *[cost sharing]*	%10
Other *[cost sharing]*	%10

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	$5400

In this example, Joe would pay:

Cost Sharing	
Deductibles	$200
Copayments	$0
Coinsurance	$1,000
What isn't covered	
Limits or exclusions	$0
The total Joe would pay is	$1,200

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

The plan's overall deductible	$200
Specialist *[cost sharing]*	%10
Hospital (facility) *[cost sharing]*	%10
Other *[cost sharing]*	%10

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	$13500

In this example, Mia would pay:

Cost Sharing	
Deductibles	$200
Copayments	$0
Coinsurance	$1,000
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	$1,200

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