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, visit www.pipetradesbenefits.org or call 1-877-811-4474. For 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 https://www.healthcare.gov/sbc-glossary or call 1-877-811-4474 to request a copy.

Important Questions	Answers	Why This Matters
What is the overall deductible?	For network providers $100/individual For out- of-network providers $200/individual	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 yet met the deductible amount. But a copayment or coinsurance may apply.
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 $500 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?	Out-of-network charges, premiums, balance-billing charges, and health care this plan doesn't 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. See www.blueshieldca.com or call 1-877-811-4474 for a list of network providers.	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 **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: Network Provider (You will pay the least)	What You Will Pay: Out-of-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	10% coinsurance	30% coinsurance	In some instances, services provided by an out-of-network provider at an in-network facility will be covered as in-network.
	Specialist visit	10% coinsurance	30% coinsurance	
	Preventive care/screening/immunization	Preventive care: 10% coinsurance Immunizations: 10% coinsurance	30% coinsurance	None
If you have a test	Diagnostic test (x-ray, blood work)	10% coinsurance	30% coinsurance	None
	Imaging (CT/PET scans, MRIs)	10% coinsurance	30% coinsurance	
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.WellDyne.com	Generic drugs (Tier 1)	20% coinsurance	Not Covered	Covers up to a 34-day supply (retail subscription); 90 day supply (mail order prescription). Certain drugs require preauthorization. See the Plan document for more information.
	Preferred brand drugs (Tier 2)	30% coinsurance	Not Covered	
	Non-preferred brand drugs (Tier 3)	50% coinsurance	Not Covered	
	Specialty drugs (Tier 4)	10% coinsurance	Not Covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	10% coinsurance	30% coinsurance	All inpatient non-emergency hospital stays require preauthorization. If you don't get preauthorization, no benefits will be paid. In some instances, services provided by an out-of-network provider at an in-network facility will be covered as in-network.
	Physician/surgeon fees	10% coinsurance	30% coinsurance	
If you need immediate medical attention	Emergency room care	10% coinsurance	10% coinsurance	Air ambulance covered as in-network.
	Emergency medical transportation	10% coinsurance	30% coinsurance	
	Urgent care	10% coinsurance	30% coinsurance	
If you have a hospital stay	Facility Fee (e.g., hospital room)	10% coinsurance	30% coinsurance	All inpatient non-emergency hospital stays require preauthorization. If you don't get preauthorization, no benefits will be paid.

* For more information about limitations and exceptions, see the plan or policy document at www.pipetradesbenefits.org.

Common Medical Event	Services You May Need	What You Will Pay: Network Provider (You will pay the least)	What You Will Pay: Out-of-Network Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information
If you have a hospital stay	Physician/surgeon fees	10% coinsurance	30% coinsurance	All inpatient non-emergency hospital stays require preauthorization. If you don't get preauthorization, no benefits will be paid. In some instances, services provided by an out-of-network provider at an in-network facility will be covered as in-network.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	10% coinsurance	30% coinsurance	
	Inpatient services	10% coinsurance	30% coinsurance	
If you are pregnant	Office visits	10% coinsurance	30% coinsurance	Cost sharing does not apply to certain preventive services. Depending on the type of services, coinsurance 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 needs	Home health care	10% coinsurance	30% coinsurance	Non-preferred home health care requires preauthorization. 100 visit maximum per year, must be within 14 days of hospital discharge.
	Rehabilitation services	10% coinsurance	30% coinsurance	None.
	Habilitation services	10% coinsurance	30% coinsurance	None.
	Skilled nursing care	10% coinsurance	30% coinsurance	Non-preferred home health care requires preauthorization. 100 visit maximum per year, must be within 14 days of hospital discharge.
	Durable medical equipment	10% coinsurance	30% coinsurance	Preauthorization is required.
	Hospice services	10% coinsurance	30% coinsurance	Preauthorization is required.
If your child needs dental or eye care	Children's eye exam	No Charge	$40 Allowance	One exam every 24 months.
	Children's glasses	No Charge	Allowance varies based on lens type; $40 allowance for frames	Every 24 months or at 12-month intervals if the prescription change indicates so.
	Children's dental checkups	10% coinsurance	30% coinsurance	$5,000 lifetime maximum for Orthodontics.

* For more information about limitations and exceptions, see the plan or policy document at www.pipetradesbenefits.org.

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 • Cosmetic Surgery	• Dependent Pregnancy • Infertility Treatment	• Routine Foot Care • Weight Loss Programs
Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)		
• Acupuncture (if prescribed for rehabilitation purposes) • Chiropractic Care • Dental care provided under the Dental Benefit Plan.	• Hearing Aids • Long Term Care • Routine Eye Care provided under the Vision Benefit Plan	• 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 those agencies is Department of Labor Employee Benefits Security Administration at 1-866-444-EBSA (3272) or 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 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 Administrator at 1-877-811-4474 or Department of Labor Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform

Does this plan provide Minimum Essential Coverage? Yes
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? 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 1-877-811-4474

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 plan's overall deductible $100
- Specialist coinsurance 10%
- Hospital (facility) coinsurance 10%
- Other coinsurance 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	**$12,700**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$100
Copayments	$0
Coinsurance	$500

What isn't covered	
Limits or exclusions	$0

The total Peg would pay is	**$600**

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

- The plan's overall deductible $100
- Specialist copayment 10%
- Hospital (facility) coinsurance 10%
- Other coinsurance 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	**$5,600**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$100
Copayments	$0
Coinsurance	$500

What isn't covered	
Limits or exclusions	$0

The total Joe would pay is	**$600**

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

- The plan's overall deductible $100
- Specialist coinsurance 10%
- Hospital (facility) coinsurance 10%
- Other coinsurance 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	**$2,800**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$100
Copayments	$0
Coinsurance	$270

What isn't covered	
Limits or exclusions	$0

The total Mia would pay is	**$370**

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