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. This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, visit www.lumberfund.org or call 1-800-824-4427. 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 https://www.healthcare.gov/sbc-glossary/ or call 1-800-824-4427 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	$0 for PPO providers, $150/person or $450/family for non-PPO providers	Generally, you must pay all of the costs from non-PPO 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?	No.	You will have to meet the deductible before the plan pays for any 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?	$6,600/person or $13,200/family per calendar year for PPO providers and your cost-sharing for prescription drugs. There is no out-of-pocket limit for non-PPO providers.	The out-of-pocket limit is the most you could pay in a year for covered services for PPO providers. 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. This plan does not have an out-of-pocket limit on your expenses for non-PPO providers.
What is not included in the out-of-pocket limit?	Coinsurance and balance-billed charges for non-PPO providers, and health care that 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. For a list of PPO providers, visit www.bluecrossca.com or call 1-800-824-4427.	This plan uses a PPO provider network. You will pay less if you use a PPO provider in the plan's network. You will pay the most if you use a non-PPO/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 PPO network provider might use a non-PPO/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		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	20% coinsurance (of Contract Rate)	40% coinsurance (of Covered Charges[1])	——————none——————
	Specialist visit	20% coinsurance (of Contract Rate)	40% coinsurance (of Covered Charges[1])	——————none——————
	Preventive care/screening/ immunization	No Charge	40% coinsurance (of Covered Charges[1])	Covered to the extent recommended in guidelines by the U.S. Preventive Care Task Force, Centers for Disease Control and Prevention, and the Health Resources and Services Administration, as applicable. You may have to pay for services that are not preventive. Ask your provider if the services needed are preventive.
If you have a test	Diagnostic test (x-ray, blood work)	20% coinsurance (of Contract Rate)	40% coinsurance (of Covered Charges[1])	——————none——————
	Imaging (CT/PET scans, MRIs)	20% coinsurance (of Contract Rate)	40% coinsurance (of Covered Charges[1])	——————none——————
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.optumrx.com	Generic drugs	$10 copay / prescription (retail and mail order)	Not Covered	Covers up to a 30-day supply (retail prescription); 31-90 day supply (mail order prescription). Certain compound medications are excluded from coverage (i.e., non-FDA approved bulk chemicals, bulk chemicals for vitamins/supplements typically available over-the-counter, products for cosmetic uses, and ingredients used in compounding topical formulations not approved by the FDA for this route of administration). Any covered compound medications costing $50 or more require prior authorization from OptumRx.
	Preferred brand drugs	$20 copay / prescription (retail) $30 copay / prescription (mail order)	Not Covered	
	Non-preferred brand drugs	$40 copay / prescription (retail) $50 copay / prescription (mail order)	Not Covered	
	Specialty drugs	$30 copay / prescription (mail order only)	Not Covered	Covers up to a 30-day supply (mail order prescription only) Your doctor must obtain prior authorization from OptumRx or your

[1] For non-PPO services, "Covered Charges" are limited to the lesser of the services provider's charge or the 50th percentile allowed in the Context 4 Health UCR database.

				specialty drug will not be covered.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance (of Contract Rate)	40% coinsurance (of Covered Charges[1])	——————none——————
	Physician/surgeon fees	20% coinsurance (of Contract Rate)	40% coinsurance (of Covered Charges[1])	——————none——————
If you need immediate medical attention	Emergency room care	20% coinsurance (of Contract Rate)	20% coinsurance (of Covered Charges[1])	For non-PPO services, Covered Charges are limited to the lesser of the service provider's charge or the greater of: the median PPO rate, UCR charges, or the Medicare rate.
	Emergency medical transportation	20% coinsurance (of Contract Rate)	40% coinsurance (of Covered Charges[1])	For non-PPO services, Covered Charges are limited to 50% of the service provider's charge.
	Urgent care	20% coinsurance (of Contract Rate)	40% coinsurance (of Covered Charges[1])	——————none——————
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance (of Contract Rate)	40% coinsurance (of Covered Charges[1])	For non-PPO providers, coverage is limited to $1,000 per day for medical (including psychiatric/mental health and substance abuse), surgical, maternity, and immediate care; and $1,550 per day for intensive care unit (ICU).
	Physician/surgeon fees	20% coinsurance (of Contract Rate)	40% coinsurance (of Covered Charges[1])	——————none——————
If you need mental health, behavioral health, or substance abuse services	Outpatient services	20% coinsurance (of Contract Rate)	40% coinsurance (of Covered Charges[1])	——————none——————
	Inpatient services	20% coinsurance (of Contract Rate)	40% coinsurance (of Covered Charges[1])	For non-PPO providers, hospital/facility coverage is limited to $1,000 per day.
If you are pregnant	Office visits	20% coinsurance (of Contract Rate)	40% coinsurance (of Covered Charges[1])	Pregnancy benefits for dependent children are limited to complications of pregnancy.
	Childbirth/delivery professional services	20% coinsurance (of Contract Rate)	40% coinsurance (of Covered Charges[1])	Pregnancy benefits for dependent children are limited to complications of pregnancy.
	Childbirth/delivery facility services	20% coinsurance (of Contract Rate)	40% coinsurance (of Covered Charges[1])	Pregnancy benefits for dependent children are limited to complications of pregnancy. For non-PPO providers, maternity

[1] For non-PPO services, "Covered Charges" are limited to the lesser of the services provider's charge or the 50th percentile allowed in the Context 4 Health UCR database.

				hospital/facility coverage is limited to $1,000 per day.
If you need help recovering or have other special health needs	Home health care	20% coinsurance (of Contract Rate)	40% coinsurance (of Covered Charges[1])	——————none——————
	Rehabilitation services	20% coinsurance (of Contract Rate)	40% coinsurance (of Covered Charges[1])	For non-PPO providers, physical therapy coverage is limited to 40 days per calendar year.
	Habilitation services	Not Covered	Not Covered	——————none——————
	Skilled nursing care	20% coinsurance (of Contract Rate)	40% coinsurance (of Covered Charges[1])	Coverage only after hospital inpatient admission for at least 3 consecutive days and confined in a skilled nursing, extended care, or convalescent facility within 7 days after discharge from hospital. Limited to 60 days per benefit period.
	Durable medical equipment	20% coinsurance (of Contract Rate)	40% coinsurance (of Covered Charges[1])	For non-PPO services, Covered Charges are limited to HCPCS allowance codes per Medicare fee schedule.
	Hospice services	20% coinsurance (of Contract Rate)	40% coinsurance (of Covered Charges[1])	——————none——————
If your child needs dental or eye care	Children's eye exam	Not covered under the Select Choice Indemnity Medical Plan, but dental and vision benefits may be available under the Select Choice Dental or Vision Plans, if eligible pursuant to the applicable collective bargaining agreement.		——————none——————
	Children's glasses			——————none——————
	Children's dental check-up			——————none——————

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
- Habilitation Services
- Hearing aids
- Infertility treatment
- Injuries/illnesses caused by third parties
- Long term care
- Non-emergency care when traveling outside the U.S.
- Non-medically necessary services/treatment
- Private-duty nursing
- 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, but non-PPO physical therapy,
- Dental care (Adult), if eligible for dental benefits
- Routine eye care (Adult), if eligible for vision

[1] For non-PPO services, "Covered Charges" are limited to the lesser of the services provider's charge or the 50th percentile allowed in the Context 4 Health UCR database.

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)		
acupuncture, and chiropractic care visits are limited to 40 visits/year total • Chiropractic care, but non-PPO physical therapy, acupuncture, and chiropractic care visits are limited to 40 visits/year total	through Select Choice Dental Plan, as determined by the applicable collective bargaining agreement (i.e., dental care is not available through the Select Choice Indemnity Medical Plan)	benefits through Select Choice Vision Plan, as determined by the applicable collective bargaining agreement (i.e., vision care is not available through the Select Choice Indemnity Medical Plan)

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: U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 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 Appeal 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 an 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 or an appeal for any reason to your plan. For more information about your rights, this notice, or assistance, contact: the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa/healthreform, or the plan at 1-800-824-4427 or at www.lumberfund.org.

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 1-800-824-4427.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-824-4427.

Chinese (中文): 如果需要中文的帮助，请拨打这个号码 1-800-824-4427.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-800-824-4427.

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

[1] For non-PPO services, "Covered Charges" are limited to the lesser of the services provider's charge or the 50th percentile allowed in the Context 4 Health UCR database.

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	$0
Specialist coinsurance	20%
Hospital (facility) coinsurance	20%
Other coinsurance	20%

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	$0
Copayments	$10
Coinsurance	$2,500
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	$2,570

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

The plan's overall deductible	$0
Specialist coinsurance	20%
Hospital (facility) coinsurance	20%
Other coinsurance	20%

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	$0
Copayments	$400
Coinsurance	$400
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	$820

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

The plan's overall deductible	$0
Specialist coinsurance	20%
Hospital (facility) coinsurance	20%
Other coinsurance	20%

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	$0
Copayments	$10
Coinsurance	$600
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	$610

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