



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, you can view them at www.ufcwnationalfund.org. 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.healthcare.gov/sbc-glossary or call 201-569-8801 to request a copy.

Question: Call 201-569-8801 or visit us at www.ufcwnationalfund.org for more information, including a copy of your plan’s summary plan description.

Important Questions	Answers	Why This Matters:
What is the overall deductible ?	\$0	See the Common Medical Events chart below for your costs for services this plan covers.
Are there services covered before you meet your deductible ?	Yes. Preventive care, emergency transportation, and hospice are covered before you meet your deductible.	This plan covers some items and services even if you haven’t yet met the deductible amount, but a 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 <u>Network Providers</u> only: \$1,000 individual	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 ?	Copayments, employee premiums, balance-billed charges and healthcare 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.ufcwnationalfund.org or call 201-569-8801 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 .

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

 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 copay/visit	Not Covered	-----None-----
	Specialist visit	\$20 copay/visit	Not Covered	-----None-----
	Preventive care/screening/immunization	No Charge	Not Covered	You may have to pay for services that are preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	No Charge	Not Covered	-----None-----
	Imaging (CT/PET scans, MRIs)	\$100 copay/visit (doctor's office) 10% coinsurance (outpatient hospital)	Not Covered	Requires prior authorization.
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.ufcwnationalfund.org	Generic drugs	\$5 copay (retail) \$10 copay (mail order)	Not Covered	Retail: Covers 31-day supply. Mail Order: Covers 90-day supply.
	Preferred brand drugs	\$20 copay (retail) \$40 (mail order)	Not Covered	
	Non-preferred brand drugs	\$35 copay (retail) \$70 (mail order)	Not Covered	
	Specialty drugs	\$5 copay (generic) \$20 copay (preferred) \$35 copay (non-preferred)	Not Covered	Requires prior authorization,
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	10% coinsurance	Not Covered	-----None-----
	Physician/surgeon fees	No Charge	Not Covered	-----None-----
If you need immediate medical attention	Emergency room care	10% coinsurance	Not Covered	-----None-----
	Emergency medical transportation	No Charge	Not Covered	-----None-----
	Urgent care	\$10 copay/visit	Not Covered	-----None-----

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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 have a hospital stay	Facility fee (e.g., hospital room)	10% coinsurance	Not Covered	Requires prior authorization.
	Physician/surgeon fees	No Charge	Not Covered	-----None-----
If you need mental health, behavioral health, or substance abuse services	Outpatient services	10% coinsurance (partial hospitalization) \$20 copay/visit (professional)	Not Covered	-----None-----
	Inpatient services	10% coinsurance (facility) No Charge (professional)	Not Covered	Requires prior authorization.
If you are pregnant	Office visits	\$10 copay/visit	Not Covered	Depending on the type of services, a copayment, coinsurance or deductible may apply.
	Childbirth/delivery professional services	No Charge	Not Covered	-----None-----
	Childbirth/delivery facility services	\$200 copay	Not Covered	Requires prior authorization
If you need help recovering or have other special health needs	Home health care	No Charge	Not Covered	-----None-----
	Rehabilitation services	10% coinsurance (facility) \$20 copay/visit (professional)	Not Covered	Depending on the type of therapy, there is a limit of 30 visits per calendar year.
	Habilitation services	Not Covered	Not Covered	-----None-----
	Skilled nursing care	10% coinsurance	Not Covered	Limited up to 100 days per conditions.
	Durable medical equipment	No Charge	Not Covered	Total rental not to exceed purchase price.
	Hospice services	No Charge	Not Covered	-----None-----
If your child needs dental or eye care	Children's eye exam	Not Covered	Not Covered	-----None-----
	Children's glasses	Not Covered	Not Covered	-----None-----
	Children's dental check-up	Not Covered	Not Covered	-----None-----

* For more information about limitations and exceptions, see the plan or policy document at www.ufcwnationalfund.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](#).)

- | | | |
|-----------------------------|-------------------------|------------------------|
| • Acupuncture | • Hearing aids | • Private-duty nursing |
| • Cosmetic surgery | • Infertility treatment | • Routine foot care |
| • Dental Care (Adult/Child) | • Long-term care | • Weight loss programs |

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your [plan](#) document.)

- | | |
|---------------------|--|
| • Bariatric surgery | • Non-emergency care when traveling outside the U.S. |
| • Chiropractic care | • Hearing aids |

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 the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cciio.cms.gov or your state insurance department. 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: UFCW National Health and Welfare Fund, 66 Grand Avenue, Englewood, NJ 07631-3545, phone 201-569-8801.

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 201-569-8801.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 201-569-8801.

Chinese (中文): 如果需要中文的帮助, 请拨打这个号码201-569-8801.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijigo holne' 201-569-8801.

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](#) \$0
- [Specialist \[cost sharing\]](#) \$20
- 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	\$12,687
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In this example, Peg would pay:

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

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 \[cost sharing\]](#) \$20
- 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	\$5,600
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In this example, Joe would pay:

Cost Sharing	
Deductibles	\$0
Copayments	\$385
Coinsurance	\$34
What isn't covered	
Limits or exclusions	\$0
The total Joe would pay is	\$419

Mia's Simple Fracture

(in-network emergency room visit and follow up care)

- The [plan's](#) overall [deductible](#) \$0
- [Specialist \[cost sharing\]](#) \$20
- 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	\$2,800
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In this example, Mia would pay:

Cost Sharing	
Deductibles	\$0
Copayments	\$135
Coinsurance	\$39
What isn't covered	
Limits or exclusions	\$0
The total Mia would pay is	\$174

The [plan](#) would be responsible for the other costs of these EXAMPLE covered services.