



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.UFCWS.com](http://www.UFCWS.com). 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](http://www.healthcare.gov/sbc-glossary) or call 201-569-8801 EST or 209-952-6533 PST to request a copy.

**Question:** Call 201-569-8801 EST or 209-952-6533 PST or visit us at [www.UFCWS.com](http://www.UFCWS.com) for more information, including a copy of your plan's summary plan description or to utilize the Self-Service Price Comparison Tool located under the Members tab.

| Important Questions                                                             | Answers                                                                                                                                                  | Why This Matters:                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |
|---------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| What is the overall <a href="#">deductible</a> ?                                | \$1,000 Individual/ \$2,000 Family                                                                                                                       | Generally, you must pay all of the costs from <a href="#">providers</a> up to the <a href="#">deductible</a> amount before this plan begins to pay. If you have other family members on the <a href="#">plan</a> , each family member must meet their own individual <a href="#">deductible</a> until the total amount of <a href="#">deductible</a> expenses paid by all family members meets the overall family <a href="#">deductible</a> .                                                                                                                                                                                                          |
| Are there services covered before you meet your <a href="#">deductible</a> ?    | Yes. Preventive care is covered before you meet your deductible.                                                                                         | This <a href="#">plan</a> covers some items and services even if you haven't yet met the deductible amount, but a <a href="#">coinsurance</a> may apply. For example, this <a href="#">plan</a> covers certain <a href="#">preventive services</a> without <a href="#">cost sharing</a> and before you meet your <a href="#">deductible</a> . See a list of covered <a href="#">preventive services</a> at <a href="https://www.healthcare.gov/coverage/preventive-care-benefits/">https://www.healthcare.gov/coverage/preventive-care-benefits/</a> .                                                                                                  |
| Are there other <a href="#">deductibles</a> for specific services?              | No.                                                                                                                                                      | You don't have to meet <a href="#">deductibles</a> for specific services.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |
| What is the <a href="#">out-of-pocket limit</a> for this <a href="#">plan</a> ? | \$2,000 Individual/ \$4,000 Family                                                                                                                       | The <a href="#">out-of-pocket</a> limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own <a href="#">out-of-pocket limits</a> until the overall family <a href="#">out-of-pocket</a> limit has been met.                                                                                                                                                                                                                                                                                                                                                            |
| What is not included in the <a href="#">out-of-pocket limit</a> ?               | Employee premiums, balance-billed charges and healthcare this plan doesn't cover.                                                                        | Even though you pay these expenses, they don't count toward the <a href="#">out-of-pocket limit</a> .                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |
| Will you pay less if you use a <a href="#">network provider</a> ?               | Yes. See <a href="http://www.UFCWS.com">www.UFCWS.com</a> or call 201-569-8801 EST or 209-952-6533 PST for a list of <a href="#">network providers</a> . | This <a href="#">plan</a> uses a <a href="#">provider network</a> . You will pay less if you use a <a href="#">provider</a> in the <a href="#">plan's network</a> . You will pay the most if you use an <a href="#">out-of-network provider</a> , and you might receive a bill from a <a href="#">provider</a> for the difference between the <a href="#">provider's</a> charge and what your <a href="#">plan</a> pays (balance billing). Be aware, your <a href="#">network provider</a> might use an <a href="#">out-of-network provider</a> for some services (such as lab work). Check with your <a href="#">provider</a> before you get services. |

\* For more information about limitations and exceptions, see the plan or policy document at [www.UFCWS.com](http://www.UFCWS.com) or to utilize the Fund's Price Comparison Tool located under the Members tab.

| Important Questions                                                          | Answers | Why This Matters:                                                                          |
|------------------------------------------------------------------------------|---------|--------------------------------------------------------------------------------------------|
| Do you need a <a href="#">referral</a> to see a <a href="#">specialist</a> ? | No.     | You can see the <a href="#">specialist</a> you choose without a <a href="#">referral</a> . |

 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<br>(You will pay the least)                                     | Out-of-Network Provider<br>(You will pay the most) |                                                                                                                                                        |
| If you visit a health care <a href="#">provider's</a> office or clinic                                                                                                                     | Primary care visit to treat an injury or illness       | \$30 copay                                                                       | 30% coinsurance                                    | -----None-----                                                                                                                                         |
|                                                                                                                                                                                            | <a href="#">Specialist</a> visit                       | 30% coinsurance                                                                  | 30% coinsurance                                    | -----None-----                                                                                                                                         |
|                                                                                                                                                                                            | <a href="#">Preventive care/screening/immunization</a> | No Charge                                                                        | 30% coinsurance                                    | 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                                                                                                                                                                         | <a href="#">Diagnostic test</a> (x-ray, blood work)    | 30% coinsurance                                                                  | 30% coinsurance                                    | -----None-----                                                                                                                                         |
|                                                                                                                                                                                            | Imaging (CT/PET scans, MRIs)                           | 30% coinsurance                                                                  | 30% coinsurance                                    | Requires prior authorization.                                                                                                                          |
| If you need drugs to treat your illness or condition<br>More information about <a href="#">prescription drug coverage</a> is available at <a href="http://www.UFCWS.com">www.UFCWS.com</a> | Generic drugs                                          | \$7 copay (retail)<br>\$0 copay (mail order)                                     | Not Covered                                        | Retail: Covers 30-day supply.<br>Mail Order Covers 90-day supply.                                                                                      |
|                                                                                                                                                                                            | Preferred brand drugs                                  | \$30 copay (retail)<br>\$60 copay (mail order)                                   | Not Covered                                        |                                                                                                                                                        |
|                                                                                                                                                                                            | Non-preferred brand drugs                              | 30% coinsurance                                                                  | Not Covered                                        |                                                                                                                                                        |
|                                                                                                                                                                                            | <a href="#">Specialty drugs</a>                        | \$7 copay (generic)<br>\$30 copay (preferred)<br>30% coinsurance (non-preferred) | Not Covered                                        | Mail Order Covers 30-day supply.<br>Requires prior authorization.                                                                                      |
| If you have outpatient surgery                                                                                                                                                             | Facility fee (e.g., ambulatory surgery center)         | 30% coinsurance                                                                  | 30% coinsurance                                    | -----None-----                                                                                                                                         |
|                                                                                                                                                                                            | Physician/surgeon fees                                 | 30% coinsurance                                                                  | 30% coinsurance                                    | -----None-----                                                                                                                                         |

\* For more information about limitations and exceptions, see the plan or policy document at [www.UFCWS.com](http://www.UFCWS.com) or to utilize the Fund's Price Comparison Tool located under the Members tab.

| Common Medical Event                                                      | Services You May Need                            | What You Will Pay                            |                                                    | Limitations, Exceptions, & Other Important Information                                      |
|---------------------------------------------------------------------------|--------------------------------------------------|----------------------------------------------|----------------------------------------------------|---------------------------------------------------------------------------------------------|
|                                                                           |                                                  | Network Provider<br>(You will pay the least) | Out-of-Network Provider<br>(You will pay the most) |                                                                                             |
| If you need immediate medical attention                                   | <a href="#">Emergency room care</a>              | 30% coinsurance                              | 30% coinsurance                                    | -----None-----                                                                              |
|                                                                           | <a href="#">Emergency medical transportation</a> | 30% coinsurance                              | 30% coinsurance                                    | -----None-----                                                                              |
|                                                                           | <a href="#">Urgent care</a>                      | 30% coinsurance                              | 30% coinsurance                                    | -----None-----                                                                              |
| If you have a hospital stay                                               | Facility fee (e.g., hospital room)               | 30% coinsurance                              | 30% coinsurance                                    | -----None-----                                                                              |
|                                                                           | Physician/surgeon fees                           | 30% coinsurance                              | 30% coinsurance                                    | -----None-----                                                                              |
| If you need mental health, behavioral health, or substance abuse services | Outpatient services                              | 30% coinsurance                              | 30% coinsurance                                    | -----None-----                                                                              |
|                                                                           | Inpatient services                               | 30% coinsurance                              | 30% coinsurance                                    | -----None-----                                                                              |
| If you are pregnant                                                       | Office visits                                    | 30% coinsurance                              | 30% coinsurance                                    | -----None-----                                                                              |
|                                                                           | Childbirth/delivery professional services        | 30% coinsurance                              | 30% coinsurance                                    | -----None-----                                                                              |
|                                                                           | Childbirth/delivery facility services            | 30% coinsurance                              | 30% coinsurance                                    | -----None-----                                                                              |
| If you need help recovering or have other special health needs            | <a href="#">Home health care</a>                 | 30% coinsurance                              | 30% coinsurance                                    | Limited up to 40 visits per calendar year.                                                  |
|                                                                           | <a href="#">Rehabilitation services</a>          | 30% coinsurance                              | 30% coinsurance                                    | Depending on the type of therapy, there is a limit of 30 combined visits per calendar year. |
|                                                                           | <a href="#">Habilitation services</a>            | Not Covered                                  | Not Covered                                        | -----None-----                                                                              |
|                                                                           | <a href="#">Skilled nursing care</a>             | 30% coinsurance                              | 30% coinsurance                                    | -----None-----                                                                              |
|                                                                           | <a href="#">Durable medical equipment</a>        | 30% coinsurance                              | 30% coinsurance                                    | Total rental not to exceed purchase price.                                                  |
|                                                                           | <a href="#">Hospice services</a>                 | Not Covered                                  | Not Covered                                        | -----None-----                                                                              |
| If your child needs dental or eye care                                    | Children's eye exam                              | Not Covered                                  | Not Covered                                        | Benefits may be provided by optical plan.                                                   |
|                                                                           | Children's glasses                               | Not Covered                                  | Not Covered                                        | Benefits may be provided by optical plan.                                                   |
|                                                                           | Children's dental check-up                       | Not Covered                                  | Not Covered                                        | Benefits may be provided by dental plan.                                                    |

\* For more information about limitations and exceptions, see the plan or policy document at [www.UFCWS.com](http://www.UFCWS.com) or to utilize the Fund's Price Comparison Tool located under the Members tab.

## 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      | • Infertility treatment | • Routine foot care    |
| • Cosmetic surgery | • Long-term care        | • Weight loss programs |
| • Hearing aids     |                         |                        |

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

- |                     |                                                      |                                                      |
|---------------------|------------------------------------------------------|------------------------------------------------------|
| • Bariatric surgery | • Dental Care (may be provided by dental plan)       | • Private-duty nursing                               |
| • Chiropractic care | • Non-emergency care when traveling outside the U.S. | • Routine eye care (may be provided by optical 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 the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or [www.dol.gov/ebsa](http://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](http://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](http://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 or 1212 West Robinhood Drive, Suite 3-E, Stockton, CA 95207-5505, phone 209-952-6533.

### 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](#).

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### Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al 201-569-8801 EST or 209-952-6533 PST.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 201-569-8801 EST or 209-952-6533 PST.

Chinese (中文): 如果需要中文的帮助, 请拨打这个号码 201-569-8801 EST or 209-952-6533 PST.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijigo holne' 201-569-8801 EST or 209-952-6533 PST.

*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.UFCWS.com](http://www.UFCWS.com) or to utilize the Fund's Price Comparison Tool located under the Members tab.

## 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 <a href="#">plan's</a> overall <a href="#">deductible</a> | \$1,000 |
| ■ <a href="#">Specialist</a> [ <a href="#">cost sharing</a> ]   | 30%     |
| ■ Hospital (facility) [ <a href="#">cost sharing</a> ]          | 30%     |
| ■ Other [ <a href="#">cost sharing</a> ]                        | 30%     |

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*)

|                           |                 |
|---------------------------|-----------------|
| <b>Total Example Cost</b> | <b>\$12,687</b> |
|---------------------------|-----------------|

In this example, Peg would pay:

| <i>Cost Sharing</i>               |                |
|-----------------------------------|----------------|
| <a href="#">Deductibles</a>       | \$1,000        |
| <a href="#">Copayments</a>        | \$0            |
| <a href="#">Coinsurance</a>       | \$1,000        |
| <i>What isn't covered</i>         |                |
| Limits or exclusions              | \$0            |
| <b>The total Peg would pay is</b> | <b>\$2,000</b> |

### Managing Joe's Type 2 Diabetes

(a year of routine in-network care of a well-controlled condition)

|                                                                 |         |
|-----------------------------------------------------------------|---------|
| ■ The <a href="#">plan's</a> overall <a href="#">deductible</a> | \$1,000 |
| ■ <a href="#">Specialist</a> [ <a href="#">cost sharing</a> ]   | 30%     |
| ■ Hospital (facility) [ <a href="#">cost sharing</a> ]          | 30%     |
| ■ Other [ <a href="#">cost sharing</a> ]                        | 30%     |

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*)

|                           |                |
|---------------------------|----------------|
| <b>Total Example Cost</b> | <b>\$5,600</b> |
|---------------------------|----------------|

In this example, Joe would pay:

| <i>Cost Sharing</i>               |                |
|-----------------------------------|----------------|
| <a href="#">Deductibles</a>       | \$613          |
| <a href="#">Copayments</a>        | \$1,387        |
| <a href="#">Coinsurance</a>       | \$0            |
| <i>What isn't covered</i>         |                |
| Limits or exclusions              | \$0            |
| <b>The total Joe would pay is</b> | <b>\$2,000</b> |

### Mia's Simple Fracture

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

|                                                                 |         |
|-----------------------------------------------------------------|---------|
| ■ The <a href="#">plan's</a> overall <a href="#">deductible</a> | \$1,000 |
| ■ <a href="#">Specialist</a> [ <a href="#">cost sharing</a> ]   | 30%     |
| ■ Hospital (facility) [ <a href="#">cost sharing</a> ]          | 30%     |
| ■ Other [ <a href="#">cost sharing</a> ]                        | 30%     |

This EXAMPLE event includes services like:

[Emergency room care](#) (*including medical supplies*)  
[Diagnostic test](#) (*x-ray*)  
[Durable medical equipment](#) (*crutches*)  
[Rehabilitation services](#) (*physical therapy*)

|                           |                |
|---------------------------|----------------|
| <b>Total Example Cost</b> | <b>\$2,800</b> |
|---------------------------|----------------|

In this example, Mia would pay:

| <i>Cost Sharing</i>               |                |
|-----------------------------------|----------------|
| <a href="#">Deductibles</a>       | \$1,000        |
| <a href="#">Copayments</a>        | \$65           |
| <a href="#">Coinsurance</a>       | \$436          |
| <i>What isn't covered</i>         |                |
| Limits or exclusions              | \$0            |
| <b>The total Mia would pay is</b> | <b>\$1,501</b> |

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

\* For more information about limitations and exceptions, see the plan or policy document at [www.UFCWS.com](http://www.UFCWS.com) or to utilize the Fund's Price Comparison Tool located under the Members tab.