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. 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 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 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 deductible?	For network providers $500 individual/$1,000 employee +1/ $1,500 family; out-of-network providers $1,500 individual/ $3,000 employee +1/ $4,500 family	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, Preventative care, ambulance, 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 copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost sharing and before you meet your deductible. See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/.
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 $2,000 individual/$4,000 employee + 1/ $6,000 family; out-of-network providers $4,500 individual/ $9,000 employee +1/ $13,500 family	The out-of-pocket 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 out-of-pocket limits until the overall family out-of-pocket limit has been met.
What is not included in the out-of-pocket limit?	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.

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

Important Questions	Answers	Why This Matters:
Will you pay less if you use a network provider?	Yes. See www.UFCWS.com or call 201-569-8801 EST or 209-952-6533 PST 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, you 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		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 copay/visit Deductible does not apply	40% coinsurance	----------None----------
	Specialist visit	$30 copay/visit Deductible does not apply	40% coinsurance	----------None----------
	Preventive care/screening/ immunization	No Charge	40% 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	Diagnostic test (x-ray, blood work)	20% coinsurance	40% coinsurance	----------None----------
	Imaging (CT/PET scans, MRIs)	20% coinsurance	40% coinsurance	Requires prior authorization.
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.UFCWS.com	Generic drugs	$15 copay (retail) $30 copay (mail order)	Not Covered	Retail: Covers 30-day supply. Mail Order: Covers 90-day supply.
	Preferred brand drugs	20% coinsurance; $30 Min, $60 Max (retail) 20% coinsurance; $60 Min, $120 Max (mail order)	Not Covered	

* For more information about limitations and exceptions, see the plan or policy document at 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 (You will pay the least)	Out-of-Network Provider (You will pay the most)	
	Non-preferred brand drugs	30% coinsurance; $50 Min, $100 Max (retail) 30% coinsurance; $100 Min, $200 Max (mail order)	Not Covered	
	Specialty drugs	30% coinsurance, $50 Min, $100 Max	Not Covered	Mail order covers 30-day supply only. Requires prior authorization.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance	40% coinsurance	----------None----------
	Physician/surgeon fees	20% coinsurance	40% coinsurance	----------None----------
If you need immediate medical attention	Emergency room care	$100 copay	$100 copay	Copay waived if admitted.
	Emergency medical transportation	No Charge	No Charge	----------None----------
	Urgent care	$100 copay	$100 copay	----------None----------
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance	40% coinsurance	----------None----------
	Physician/surgeon fees	20% coinsurance	40% coinsurance	----------None----------
If you need mental health, behavioral health, or substance abuse services	Outpatient services	No Charge Deductible does not apply	40% coinsurance	Applies to Partial Hospitalization and Intensive Outpatient Services.
	Inpatient services	No Charge Deductible does not apply	40% coinsurance	----------None----------
If you are pregnant	Office visits	$20 copay for 1st visit	40% coinsurance	----------None----------
	Childbirth/delivery professional services	20% coinsurance	40% coinsurance	----------None----------
	Childbirth/delivery facility services	20% coinsurance	40% coinsurance	----------None----------
If you need help recovering or have other special health needs	Home health care	20% coinsurance	40% coinsurance	30 visits for out-of-network providers.
	Rehabilitation services	$20 copay	40% coinsurance	Limited up to 60 combined visits per calendar year.
	Habilitation services	20% coinsurance	Not Covered	----------None----------
	Skilled nursing care	20% coinsurance	40% coinsurance	Limited up to 100 days.

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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)	
	Durable medical equipment	20% coinsurance	40% coinsurance	Total rental not to exceed purchase price.
	Hospice services	No Charge	No Charge	----------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----------

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.)

- Cosmetic surgery
- Dental Care
- Infertility treatment
- Long-term care
- Routine eye care
- 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 (12 visits each annually)
- Bariatric surgery
- Chiropractic care (12 visits each annually)
- Hearing aids (1 pair every 24 mos., for children ages 12 or younger)
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing

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 or 1212 West Robinhood Drive, Suite 3-E, Stockton, CA 95207-5505, phone 209-952-6533.

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

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 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, kwiijigo 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 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 plan's overall deductible	$500
Specialist *[cost sharing]*	$30
Hospital (facility) *[cost sharing]*	20%
Other *[cost sharing]*	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	**$12,687**
In this example, Peg would pay:	
Cost Sharing	
Deductibles	$500
Copayments	$11
Coinsurance	$1,489
What isn't covered	
Limits or exclusions	$0
The total Peg would pay is	**$2,000**

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

The plan's overall deductible	$500
Specialist *[cost sharing]*	$30
Hospital (facility) *[cost sharing]*	20%
Other *[cost sharing]*	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	$500
Copayments	$935
Coinsurance	$87
What isn't covered	
Limits or exclusions	$0
The total Joe would pay is	**$1,522**

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

The plan's overall deductible	$500
Specialist *[cost sharing]*	$30
Hospital (facility) *[cost sharing]*	20%
Other *[cost sharing]*	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	$500
Copayments	$265
Coinsurance	$49
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$814**

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

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