



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: |
|--|---|---|
| <u>What is the overall deductible?</u> | For <u>network providers</u> \$3,000 individual/\$6,000 family; <u>out-of-network providers</u> \$6,000 individual/ \$12,000 family | Generally, you must pay all of the costs from <u>providers</u> up to the <u>deductible</u> amount before this plan begins to pay. If you have other family members on the <u>plan</u> , each family member must meet their own individual <u>deductible</u> until the total amount of <u>deductible</u> expenses paid by all family members meets the overall family <u>deductible</u> . |
| <u>Are there services covered before you meet your deductible?</u> | Yes. Preventive care is covered before you meet your deductible. | This <u>plan</u> covers some items and services even if you haven't yet met the deductible amount, but a <u>copayment</u> or <u>coinsurance</u> may apply. For example, this <u>plan</u> covers certain <u>preventive services</u> without <u>cost sharing</u> and before you meet your <u>deductible</u> . See a list of covered <u>preventive services</u> at https://www.healthcare.gov/coverage/preventive-care-benefits/ . |
| <u>Are there other deductibles for specific services?</u> | No. | You don't have to meet <u>deductibles</u> for specific services. |
| <u>What is the out-of-pocket limit for this plan?</u> | For <u>network providers</u> \$10,600 individual/\$21,200 family | The <u>out-of-pocket</u> 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 <u>out-of-pocket limits</u> until the overall family <u>out-of-pocket</u> limit has been met. |
| <u>What is not included in the out-of-pocket limit?</u> | Employee premiums, balance-billed charges and healthcare this plan doesn't cover. | Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u> . |

* 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 <u>network provider</u> ? | Yes. See www.UFCWS.com or call 201-569-8801 EST or 209-952-6533 PST for a list of <u>network providers</u> . | This <u>plan</u> uses a <u>provider network</u> . You will pay less if you use a <u>provider</u> in the <u>plan's network</u> . You will pay the most if you use an <u>out-of-network provider</u> , and you might receive a bill from a <u>provider</u> for the difference between the <u>provider's</u> charge and what your <u>plan</u> pays (balance billing). Be aware, you <u>network provider</u> might use an <u>out-of-network provider</u> for some services (such as lab work). Check with your <u>provider</u> before you get services. |
| Do you need a <u>referral</u> to see a <u>specialist</u> ? | No. | You can see the <u>specialist</u> you choose without a <u>referral</u> . |

 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, before deductible | 50% coinsurance | -----None----- |
| | <u>Specialist</u> visit | \$40 copay, before deductible | 50% coinsurance | -----None----- |
| | <u>Preventive care/screening/immunization</u> | No Charge | 50% coinsurance | You may have to pay for services that aren't preventive. Ask your <u>provider</u> if the services needed are preventive. Then check what your <u>plan</u> will pay for. |
| If you have a test | <u>Diagnostic test</u> (x-ray, blood work) | 30% coinsurance | 50% coinsurance | -----None----- |
| | Imaging (CT/PET scans, MRIs) | 30% coinsurance | 50% coinsurance | Requires prior authorization. |
| If you need drugs to treat your illness or condition More information about <u>prescription drug coverage</u> 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 (retail & mail order) | Not Covered | |
| | Non-preferred brand drugs | 35% coinsurance (retail & mail order) | Not Covered | |

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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) | |
| | Specialty drugs | 20% coinsurance to a max. of \$300 | Not Covered | Mail Order covers 30-day supply only. Requires prior authorization. |
| If you have outpatient surgery | Facility fee (e.g., ambulatory surgery center) | 30% coinsurance | 50% coinsurance | -----None----- |
| | Physician/surgeon fees | 30% coinsurance | 50% coinsurance | -----None----- |
| If you need immediate medical attention | Emergency room care | \$200 copay | \$200 copay | Copay waived if admitted. |
| | Emergency medical transportation | 30% coinsurance | 30% coinsurance | -----None----- |
| | Urgent care | 30% coinsurance | 30% coinsurance | -----None----- |
| If you have a hospital stay | Facility fee (e.g., hospital room) | 30% coinsurance | 50% coinsurance | -----None----- |
| | Physician/surgeon fees | 30% coinsurance | 50% coinsurance | -----None----- |
| If you need mental health, behavioral health, or substance abuse services | Outpatient services | \$20 copay, before deductible | 50% coinsurance | -----None----- |
| | Inpatient services | 30% coinsurance | 50% coinsurance | -----None----- |
| If you are pregnant | Office visits | Prenatal: No Charge Postnatal: 30% coinsurance | 50% coinsurance | -----None----- |
| | Childbirth/delivery professional services | 30% coinsurance | 50% coinsurance | -----None----- |
| | Childbirth/delivery facility services | 30% coinsurance | 50% coinsurance | -----None----- |
| If you need help recovering or have other special health needs | Home health care | 30% coinsurance | 50% coinsurance | Limited to 40 visits per person, per calendar year. |
| | Rehabilitation services | \$40 copay, before deductible | 50% coinsurance | Depending on the type of therapy, the maximum amount of visits may vary. |
| | Habilitation services | Not Covered | Not Covered | -----None----- |
| | Skilled nursing care | 30% coinsurance | 50% coinsurance | Limited up to 120 days per person, per calendar year. |

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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) | |
| | <u>Durable medical equipment</u> | 30% coinsurance | 50% coinsurance | Total rental not to exceed purchase price. |
| | <u>Hospice services</u> | 30% coinsurance | 50% coinsurance | -----None----- |
| If your child needs dental or eye care | Children's eye exam | No Charge | 50% coinsurance | -----None----- |
| | Children's glasses | Not Covered | Not Covered | -----None----- |
| | Children's dental check-up | Not Covered | Not Covered | Benefits may be provided by dental plan. |

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
- Infertility treatment
- Long-term 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
- Bariatric surgery
- Chiropractic care
- Dental Care (may be provided by dental plan)
- Hearing aids (children only)
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing
- Routine eye care

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.ccio.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.

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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, kwiiijigo 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.

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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 | \$3,000 |
| ■ Specialist [cost sharing] | \$40 |
| ■ Hospital (facility) [cost sharing] | 30% |
| ■ Other [cost sharing] | 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*)

| | |
|--|-----------------|
| Total Example Cost | \$12,687 |
| In this example, Peg would pay: | |
| Cost Sharing | |
| Deductibles | \$3,000 |
| Copayments | \$11 |
| Coinsurance | \$2,888 |
| <i>What isn't covered</i> | |
| Limits or exclusions | \$0 |
| The total Peg would pay is | \$5,899 |

Managing Joe's Type 2 Diabetes

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

| | |
|---|---------|
| ■ The plan's overall deductible | \$3,000 |
| ■ Specialist [cost sharing] | \$40 |
| ■ Hospital (facility) [cost sharing] | 30% |
| ■ Other [cost sharing] | 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*)

| | |
|--|----------------|
| Total Example Cost | \$5,600 |
| In this example, Joe would pay: | |
| Cost Sharing | |
| Deductibles | \$912 |
| Copayments | \$955 |
| Coinsurance | \$22 |
| <i>What isn't covered</i> | |
| Limits or exclusions | \$0 |
| The total Joe would pay is | \$1,889 |

Mia's Simple Fracture

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

| | |
|---|---------|
| ■ The plan's overall deductible | \$3,000 |
| ■ Specialist [cost sharing] | \$40 |
| ■ Hospital (facility) [cost sharing] | 30% |
| ■ Other [cost sharing] | 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*)

| | |
|--|----------------|
| Total Example Cost | \$2,800 |
| In this example, Mia would pay: | |
| Cost Sharing | |
| Deductibles | \$944 |
| Copayments | \$445 |
| Coinsurance | \$0 |
| <i>What isn't covered</i> | |
| Limits or exclusions | \$0 |
| The total Mia would pay is | \$1,389 |

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

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