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, call the Trust Fund Office at 1-877-999-8329 or visit www.ufcwdrugtrust.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.dol.gov/ebsa/healthreform or call 1-877-999-8329 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	***PPO (Network) Providers*:** $300/individual or $600/family ***Non-PPO (Out-of-Network) Providers*:** $1,000/individual or $2,000/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. Home health care, prescription drugs, durable medical equipment, vision services, and the following services when received from a PPO provider: urgent care, physician office visits, preventive care, speech therapy, podiatry, and mental health/substance abuse office visits.	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?	***Medical Out-of-Pocket Limit for PPO Providers*:** $2,000/individual, $6,000/family ***Prescription Drug Out-of-Pocket Limit (in-network)*:** $6,050/individual, $10,100/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?	***Medical Out-of-Pocket Limit for PPO Providers:*** Premiums, balance billing charges, health care this plan doesn't cover, deductibles, penalties for failure to obtain preauthorization, prescription drug expenses, hearing aids, chiropractic care, acupuncture care, and expenses from non-PPO providers (i.e., out-of-network). ***Prescription Drug Out-of-Pocket Limit (applicable to prescription drugs from network pharmacies)*:** premiums, deductibles, balance billing charges, and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out-of-pocket limit.

Important Questions	Answers	Why This Matters:
Will you pay less if you use a network provider?	Yes. In California, see Anthem Blue Cross Prudent Buyer at www.anthem.com/ca or call 1-800-227-3641 for a list of PPO providers. Outside of California see www.bluecross.com or call 1-800-810-2583. For a list of podiatry providers, see www.podiatryplan.com or call 1-800-367-7762. For mental health and substance abuse providers, see hmc.personaladvantage.com (Access Code: SCDBF) or call 1-866-268-2510.	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.

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
		PPO Provider (You will pay the least)	Non-PPO 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.	50% coinsurance	Copay does not count toward your deductible.
	Specialist visit	$20 copay/visit. Deductible does not apply.	50% coinsurance	Copay does not count toward your deductible.
	Preventive care/screening/ immunization	No charge. Deductible does not apply.	50% coinsurance	You may have to pay for services that aren't 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	50% coinsurance	None.
	Imaging (CT/PET scans, MRIs)	20% coinsurance	50% coinsurance	None.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		PPO Provider (You will pay the least)	Non-PPO Provider (You will pay the most)	
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.optumrx.com or call 1-800-788-7871.	Generic drugs	$8 copayment/prescription. Deductible does not apply.	Not covered.	• You must use a Participating Pharmacy listed on the UFCW Participating Pharmacy Directory of the Southern California Drug Benefit Fund or no coverage. • Your cost sharing applies to the prescription drug out-of-pocket limit, not to the medical out-of-pocket limit. • Limited to a 30-day supply (90-day for maintenance drugs in certain therapeutic classifications). • If you purchase a brand drug when a generic drug is available, you pay the brand drug copayment plus the difference in cost between the brand drug and generic drug, unless your provider indicates "dispense as written." • Mail order available only outside California
	Formulary brand drugs (Preferred)	$25 copayment/prescription. Deductible does not apply.	Not covered.	
	Non-Formulary brand drugs (Non-preferred)	$45 copayment/prescription. Deductible does not apply.	Not covered.	
	Preventive care drugs	No charge. Deductible does not apply.	Not covered.	You must have a prescription or no coverage. Coverage is for generic drugs only (or brand name if generic is medically inappropriate). Preventive care drugs are limited to aspirin, fluoride supplementation, folic acid, colon cancer screening prep products, statin preventive medication, tobacco cessation medications, breast cancer preventive medication, FDA approved female contraceptives, and pre-exposure prophylaxis (PrEP) for persons at increased risk of HIV acquisition. Age and frequency limits apply.
	Injectable (Specialty) drugs	20% coinsurance. Deductible does not apply.	Not covered.	Preauthorization from OptumRx is required or no coverage. Call OptumRx at 1-800-788-7871.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		PPO Provider (You will pay the least)	Non-PPO Provider (You will pay the most)	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance	*Outpatient Hospital*: 50% coinsurance. *Outpatient Surgical Centers*: 50% coinsurance plus 100% of charges above the Plan's maximum benefit of $350/operative session.	Preauthorization required. For Non-PPO outpatient surgery centers, the Plan's maximum payment is limited to $350 per operative session. You are responsible for all charges over $350.
	Physician/surgeon fees	20% coinsurance	50% coinsurance	None.
If you need immediate medical attention	Emergency room care	20% coinsurance	20% coinsurance for emergency medical condition. 50% coinsurance if not an emergency medical condition.	None.
	Emergency medical transportation	20% coinsurance for emergency medical condition	20% coinsurance for emergency medical condition	You pay 50% coinsurance if the transportation is not emergency medical transportation.
	Urgent care	$20 copay/visit. Deductible does not apply.	50% coinsurance	Copay does not count toward your deductible.
If you have a hospital stay	Facility fee (e.g., hospital room)	$100 copay/admission, plus 20% coinsurance	$100 copay/admission, plus 50% coinsurance	Preauthorization required. Only semi-private room covered unless private room is medically necessary. Copay does not count toward your deductible.
	Physician/surgeon fees	20% coinsurance	50% coinsurance	None.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		PPO Provider (You will pay the least)	Non-PPO Provider (You will pay the most)	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$20 copay/office visit, not subject to the deductible. Other services at 20% coinsurance.	50% coinsurance	Preauthorization from HMC is required for all inpatient services, including inpatient detox, inpatient rehabilitation, and residential treatment programs. Preauthorization also required for intensive outpatient programs, ECT, psychological testing, and neuropsychological testing. For inpatient services, only semi-private room covered unless private room is medically necessary. Care may include tests and services described elsewhere in the SBC (i.e., diagnostic test).
	Inpatient services	20% coinsurance	50% coinsurance	
If you are pregnant	Office visits	$20 copay/visit. Deductible does not apply.	50% coinsurance	• Cost sharing does not apply for preventive services. • Maternity care may include tests and services described elsewhere in the SBC (i.e., ultrasound). • Depending on the type of services, a copay, coinsurance or the deductible may apply. • Prenatal care and pregnancy expenses (other than ACA-required preventive screenings) are not covered for Children (i.e., non-spouse Dependents). • Delivery expenses and complications of pregnancy are not covered for Children (i.e., non-spouse Dependents).
	Childbirth/delivery professional services	20% coinsurance	50% coinsurance	
	Childbirth/delivery facility services	$100 copay/ admission, plus 20% coinsurance	$100 copay/admission plus 50% coinsurance	

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		PPO Provider (You will pay the least)	Non-PPO Provider (You will pay the most)	
If you need help recovering or have other special health needs	Home health care	20% coinsurance. Deductible does not apply.	20% coinsurance. Deductible does not apply.	Preauthorization required. Must be prescribed by a health care provider. Homemaker services not covered.
	Rehabilitation services	Speech therapy: $20 copay/visit (deductible does not apply). Physical therapy and other services: 20% coinsurance.	Speech therapy: Not covered. Physical therapy and other services: 50% coinsurance.	Preauthorization required. Speech therapy limited to 24 visits per calendar year. Physical therapy and occupational therapy have a combined limit of 25 visits per calendar year.
	Habilitation services			
	Skilled nursing care	20% coinsurance	50% coinsurance	Limited to 240 days per disability. Preauthorization required. Skilled nursing care in the home will be paid as Home Health Care.
	Durable medical equipment	20% coinsurance. Deductible does not apply.	20% coinsurance. Deductible does not apply.	None.
	Hospice services	20% coinsurance	50% coinsurance	None.
If your child needs dental or eye care	Children's eye exam	No charge. Deductible does not apply.	No charge. Deductible does not apply.	Maximum benefit of $135 per exam.
	Children's glasses	You pay all charges over the Fund's allowance. Deductible does not apply.	You pay all charges over the Fund's allowance. Deductible does not apply.	Allowed amount of $135 is reduced by the cost of eye exam(s). Pediatric vision benefits are for children up to 19 years.
	Children's dental check-up	You may elect dental coverage from the Indemnity Dental Plan or the United Concordia Dental HMO Plan.		Your dental coverage is not subject to health care reform.

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 (Adult) (available under separate Indemnity Dental Plan or United Concordia Dental HMO)
- Infertility treatment
- Long-term care
- Private-duty nursing
- Weight loss programs (except as required by Health Reform)

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)		
• Acupuncture (plan pays $25.50 per visit to a maximum of $500/year, combined with chiropractic) • Bariatric surgery • Chiropractic care (plan pays $25.50 per visit to a maximum benefit of $500/year combined with acupuncture)	• Hearing aids (maximum benefit of $750 for each ear in a 12-month period) • Non-emergency care when traveling outside the U.S.	• Routine eye care (Adult) (maximum benefit of $135/year for exam, frames and lenses) • Routine foot care (maximum of 8 visits per year; must use Podiatry Plan, Inc. provider; coverage for non-Podiatry Plan, Inc. provider limited to $120 per year)

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 Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (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. For more information about your rights, this notice, or assistance, contact the Trust Fund Office at 1-877-999-8329.

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 the Trust Fund Office at 1-877-999-8329. You may also contact the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform.

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 1-877-999-8329.
Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-877-999-8329.
Chinese (中文): 如果需要中文的帮助，**请拨打这个号码** 1-877-999-8329.
Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-877-999-8329.

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** **$300**
- **Specialist copayment** **$20**
- **Hospital (facility)** **$100 copayment + 20% coinsurance**
- **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	$300
Copayments	$140
Coinsurance	$2,100
What isn't covered	
Limits or exclusions	$20
The total Peg would pay is	**$2,560**

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

- **The plan's overall deductible** **$300**
- **Specialist copayment** **$20**
- **Hospital (facility)** **$100 copayment + 20% coinsurance**
- **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	$120
Copayments	$1,020
Coinsurance	$10
What isn't covered	
Limits or exclusions	$0
The total Joe would pay is	**$1,150**

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

- **The plan's overall deductible** **$300**
- **Specialist copayment** **$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	$300
Copayments	$90
Coinsurance	$420
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$810**

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