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.healthcare.gov/sbc-glossary or call 1-877-999-8329 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	***PPO (Network) Providers:*** $0 ***Non-PPO (Out-of-Network) Providers:*** $50/individual	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay.
Are there services covered before you meet your deductible?	Yes. For non-PPO providers, the deductible does not apply to: home health care, prescription drugs, durable medical equipment, urgent care, chiropractor and acupuncture, physician office visits, the special podiatry benefit, vision services, 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.
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?	Not applicable.	This plan does not have an out-of-pocket limit.
What is not included in the out-of-pocket limit?	Not applicable.	This plan does not have an out-of-pocket limit on your expenses.
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 network mental health and substance abuse providers, see Uprose Health (formerly known as HMC Healthworks) at 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	$10 copay/visit	No charge up to $25.50/visit. After Basic Medical limit has been reached and the deductible has been satisfied, you pay 20% coinsurance.	For non-PPO providers, Basic Medical pays up to $25.50/visit, not to exceed $300 per calendar year. Benefits begin on the first visit for each accident and second visit for each illness.
	Specialist visit	$10 copay/visit	No charge to allowed amount. Deductible does not apply.	Referral by attending physician required for non-PPO provider or no coverage. Allowed Amount for non-PPO provider is $60 per visit.
	Preventive care/screening/ immunization	No charge	15% 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)	No charge	15% coinsurance up to $750 per accident or per calendar year for all illnesses combined, then 25% coinsurance after deductible.	When required by law, non-PPO diagnostic tests will be treated as PPO.
	Imaging (CT/PET scans, MRIs)	No charge	15% coinsurance, up to $750 per accident or per calendar year for all illnesses combined, then 25% coinsurance after deductible.	When required by law, non-PPO imaging will be treated as PPO.

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	Generic drugs	$5 copay/prescription. Deductible does not apply.	Not covered.	• You must use a Participating Pharmacy listed in the UFCW Participating Pharmacy Directory of the Southern California Drug Benefit Fund or no coverage. • Limited to a 30-day supply (90-day supply for maintenance drugs in certain therapeutic classifications). • Mail order available only outside California. • 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." • See the website listed or call 1-800-788-7891 for information on drugs covered by your plan. Not all drugs are covered.
	Brand drugs	$5 copay/prescription if generic equivalent not available; $8 copay/ prescription if generic equivalent available and doctor orders "dispense as written." Deductible does not apply.	Not covered.	
	Generic Preventive Care Drugs (including FDA-approved contraceptives)	No charge. Deductible does not apply.	Not covered.	You must use a Participating Pharmacy listed in the UFCW Participating Pharmacy Directory of the Southern California Drug Benefit Fund or no coverage. You must have a prescription or no coverage. Brand name drugs will be covered if a generic drug is unavailable or 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 800-788-7871.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	No charge	*Outpatient Hospital facilities:* 15% coinsurance. *Outpatient Surgical Centers*: 100% coinsurance on any charges over the 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.

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	Physician/surgeon fees	No charge	*Basic Medical:* No charge up to scheduled allowance. *Major Medical:* Surgeon/Assistant Surgeon: After deductible, 20% coinsurance. Anesthesiologist: After deductible, 15% coinsurance.	When required by law, non-PPO physician/surgeon fees will be treated as PPO.
If you need immediate medical attention	Emergency room care	No charge	No charge	Physician/professional charges may be billed separately. When required by law, non-PPO emergency services will be treated as PPO.
	Emergency medical transportation	No charge	No charge. Deductible does not apply.	None.
	Urgent care	$10 copay/visit	Paid as physician office visit	Paid as office visit. For non-PPO providers, Basic Medical pays up to $25.50/visit, not to exceed $300 per calendar year. Benefits begin on the first visit for each accident and second visit for each illness.
If you have a hospital stay	Facility fee (e.g., hospital room)	No charge up to 120 days per disability. After 120 days, 20% coinsurance.	50% coinsurance, deductible does not apply, for first 120 days per disability. After 120 days, 20% coinsurance after deductible.	Preauthorization required to avoid penalty of non-payment. Only semi-private room covered unless private room is medically necessary.
	Physician/surgeon fees	No charge	*Physician hospital visits:* No charge, up to $25.50/day, then 20% coinsurance after deductible. *Surgeon:* Basic Medical benefits are paid by the Plan according to a schedule. After deductible, you pay 20% coinsurance on the remaining allowed amounts.	For physician hospital visits by non-PPO providers, Basic Medical benefits are limited to $300 per calendar year. When required by law, non-PPO physician/surgeon fees will be treated as PPO.

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	Mental health office visits: No charge for first through fifth visit, then $10 copay/visit. Substance abuse office visits: no charge.	No charge, up to $25.50/office visit, then 20% coinsurance after deductible.	To find Uprise Health (formerly known as HMC Healthworks) providers, see hmc.personaladvantage.com (Access Code: SCDBF) or call 1-866-268-2510. The Fund's payment for non-PPO office visits will not be less than the lower of $60/visit or billed charges. Preauthorization from Uprise Health is required for all inpatient services (except emergency hospitalization), including inpatient detox, inpatient rehabilitation, and residential treatment programs. Preauthorization is also required for ECT, psychological testing, and neuropsychological testing. Intensive outpatient programs and partial day hospitalization are paid as inpatient services. 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 testing). When required by law, non-PPO mental health/substance abuse services will be treated as PPO.
	Inpatient services	No charge	50% coinsurance for first 120 days per disability. After 120 days, 20% coinsurance after deductible.	
If you are pregnant	Office visits	$10 copay/visit	No charge, up to $25.50/visit, then 20% coinsurance after deductible.	• Cost sharing does not apply to certain preventive services. • Maternity care may include tests and services described elsewhere in the SBC (i.e., ultrasound). • Depending on the type of services, a copayment, coinsurance, or the deductible may apply. • Prenatal care and pregnancy expenses (other than certain 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). • For non-PPO provider office visits, Basic Medical pays up to $25.50/visit, not to exceed $300 per calendar year.
	Childbirth/delivery professional services	No charge	*Physician:* No charge, up to $25.50/day, then 20% coinsurance after deductible. *Surgeon: Basic Medical:* No charge up to scheduled allowance. *Major Medical:* After deductible, 20% coinsurance.	
	Childbirth/delivery facility services	No charge up to 120 days per disability. After 120 days, 20% coinsurance.	50% coinsurance, deductible does not apply, for first 120 days per disability. After 120 days, 20% coinsurance after deductible.	

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	20% coinsurance. Deductible does not apply.	Preauthorization required. Must be prescribed by a health care provider. Homemaker services not covered.
	Rehabilitation services	Speech therapy: $10 copay/visit. Physical therapy and other services: No charge	Speech therapy: Not covered. Physical therapy and other services: No charge, up to $25.50/visit, then 20% coinsurance after deductible.	Preauthorization required for speech therapy. After 24 visits, preauthorization required for physical therapy, occupational therapy, and other covered services. *For physical therapy from non-PPO providers:* Basic Medical pays up to $25.50/visit, not to exceed $300 per calendar year.
	Habilitation services			
	Skilled nursing care	57.5% coinsurance	57.5% coinsurance	Preauthorization required. Limited to twice the unused number of allowed days per disability (the number of allowed days is 120 days minus the number of days spent in the hospital). Patient must be transferred to the Skilled Nursing Facility within 14 days of inpatient hospitalization lasting at least 3 days. Skilled nursing care in the home will be paid as Home Health Care.
	Durable medical equipment	20% coinsurance	20% coinsurance. Deductible does not apply.	None.
	Hospice services	*Facility:* 20% coinsurance *In home:* paid as home health care	*Facility:* 50% coinsurance for first 120 days per disability. After 120 days, 20% coinsurance after deductible. *In home:* paid as home health care	Preauthorization required.
If your child needs dental or eye care	Children's eye exam	No charge.	No charge. Deductible does not apply.	Maximum benefit of $135 per exam.
	Children's glasses	You pay all charges over the Fund's allowance.	You pay all charges over the Fund's allowance. Deductible does not apply.	Allowed amount of $135 per year is reduced by the cost of eye exam(s) paid by the Fund. Pediatric vision benefits are for children up to 19 years. Unused vision benefits from 2023 roll over for use in 2024.
	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

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 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 combined)
- Routine foot care (maximum of 8 visits per year with Anthem Blue Cross PPO provider; coverage for non-PPO provider limited to $120/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	**$0**
Specialist copayment	**$10**
Hospital (facility) coinsurance	**0%**
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	$0
Copayments	$20
Coinsurance	$0
What isn't covered	
Limits or exclusions	$20
The total Peg would pay is	**$40**

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 copayment	**$10**
Hospital (facility) coinsurance	**0%**
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	$0
Copayments	$360
Coinsurance	$0
What isn't covered	
Limits or exclusions	$140
The total Joe would pay is	**$500**

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

The plan's overall deductible	**$0**
Specialist copayment	**$10**
Hospital (facility) coinsurance	**0%**
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	$0
Copayments	$50
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$50**

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