



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.ufcwstringtrust.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:
<u>What is the overall deductible?</u>	PPO (Network) Providers: \$300/individual or \$600/family Non-PPO (Out-of-Network) Providers: \$2,000/individual or \$4,000/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.
<u>Are there services covered before you meet your deductible?</u>	Yes. <u>Home health care</u> , <u>prescription drugs</u> , <u>durable medical equipment</u> , vision services, and the following services when received from a PPO provider: <u>urgent care</u> , physician office visits, <u>preventive care</u> , 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/ .
<u>Are there other deductibles for specific services?</u>	No.	You don't have to meet deductibles for specific services.
<u>What is the out-of-pocket limit for this plan?</u>	Medical Out-of-Pocket Limit (including the Deductible) for PPO Providers: \$2,300/individual, \$6,600/family Prescription Drug Out-of-Pocket Limit (in-network): \$6,700/individual, \$11,400/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.
<u>What is not included in the out-of-pocket limit?</u>	Medical Out-of-Pocket Limit for PPO Providers: Premiums, <u>balance billing</u> charges, health care this plan doesn't cover, penalties for failure to obtain <u>preauthorization</u> or working spouse insurance coverage, <u>prescription drug</u> expenses, hearing aids, chiropractic care, acupuncture care, and expenses from non-PPO providers (i.e., <u>out-of-network</u>). Prescription Drug Out-of-Pocket Limit (applicable to prescription drugs from network pharmacies): premiums, deductibles, <u>balance billing</u> 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 <u>network provider</u>?	Yes. In California, see Anthem Blue Cross Prudent Buyer at www.anthem.com/ca or call 1-800-227-3641 for a list of medical care or behavioral health care PPO <u>providers</u> . Outside of California, see www.bluecross.com or call 1-800-810-2583.	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 charge</u> and what your <u>plan</u> pays (<u>balance billing</u>). Be aware your <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
		PPO Provider (You will pay the least)	Non-PPO Provider (You will pay the most)	
If you visit a health care <u>provider's office</u> or clinic	Primary care visit to treat an injury or illness	\$20 <u>copay</u> /visit. <u>Deductible</u> does not apply.	50% <u>coinsurance</u>	<u>Copay</u> does not count toward your <u>deductible</u> .
	<u>Specialist</u> visit	\$20 <u>copay</u> /visit. <u>Deductible</u> does not apply.	50% <u>coinsurance</u>	<u>Copay</u> does not count toward your <u>deductible</u> .
	<u>Preventive care</u> / <u>screening</u> / <u>immunization</u>	No charge. <u>Deductible</u> does not apply.	50% <u>coinsurance</u>	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	Diagnostic test (x-ray, blood work)	20% <u>coinsurance</u>	50% <u>coinsurance</u>	When required by law, non-PPO <u>diagnostic tests</u> will be treated like PPO.
	Imaging (CT/PET scans, MRIs)	20% <u>coinsurance</u>	50% <u>coinsurance</u>	When required by law, non-PPO imaging will be treated like 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)	
<p>If you need drugs to treat your illness or condition More information about <u>prescription drug coverage</u> is available at www.optumrx.com or by calling 1-800-788-7871.</p>	Generic drugs	\$12 <u>copay</u> /prescription. <u>Deductible</u> does not apply.	Not covered.	<ul style="list-style-type: none"> You must use a Participating Pharmacy listed in the UFCW Participating Pharmacy Directory of the Southern California Drug Benefit Fund or no coverage. Your <u>cost sharing</u> applies to the <u>prescription drug out-of-pocket limit</u>, not to the medical <u>out-of-pocket limit</u>. Limited to a 30-day supply (90-day supply for maintenance drugs in certain therapeutic classifications). If you purchase a brand drug when a generic drug is available, you pay the brand drug <u>copayment</u> plus the difference in cost between the brand drug and generic drug, unless your <u>provider</u> indicates "dispense as written." Mail order available only outside California. See the website listed or call 1-800-788-7891 for information on drugs covered by your <u>plan</u>. Not all drugs are covered.
	Formulary brand drugs (Preferred)	\$30 <u>copay</u> /prescription. <u>Deductible</u> does not apply.	Not covered.	
	Non- <u>Formulary</u> brand drugs (Non-Preferred)	\$50 <u>copay</u> /prescription. <u>Deductible</u> does not apply.	Not covered.	
	Preventive care drugs	No charge. <u>Deductible</u> 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. Coverage is for generic drugs only (or brand name if a generic drug is unavailable or medically inappropriate). <u>Preventive care drugs</u> are limited to aspirin, fluoride supplementation, folic acid, colon cancer <u>screening</u> 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 limitations apply.
	Injectable (Specialty) drugs	20% <u>coinsurance</u> . <u>Deductible</u> does not apply.	Not covered.	<u>Preauthorization</u> from OptumRx is required or no coverage. Call OptumRx at 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% <u>coinsurance</u>	<i>Outpatient Hospital: 50% coinsurance.</i> <i>Outpatient Surgical Centers: 50% coinsurance plus 100% of charges above the plan's maximum benefit of \$350 per operative session.</i>	<u>Preauthorization</u> required. For non-PPO outpatient surgery centers, the <u>plan's</u> maximum payment is limited to \$350 per operative session. You are responsible for all charges over \$350.
	Physician/surgeon fees	20% <u>coinsurance</u>	50% <u>coinsurance</u>	When required by law, non-PPO physician/surgeon fees will be treated like PPO.
If you need immediate medical attention	<u>Emergency room care</u>	20% <u>coinsurance</u>	20% <u>coinsurance</u> for <u>emergency medical condition</u> . 50% <u>coinsurance</u> if not an <u>emergency medical condition</u> .	When required by law, non-PPO <u>emergency services</u> will be treated like PPO.
	<u>Emergency medical transportation</u>	20% <u>coinsurance</u> for <u>emergency medical condition</u>	20% <u>coinsurance</u> for <u>emergency medical condition</u>	You pay 50% <u>coinsurance</u> if the transportation is not <u>emergency medical transportation</u> .
	<u>Urgent care</u>	\$20 <u>copay/visit</u> . <u>Deductible</u> does not apply.	50% <u>coinsurance</u>	<u>Copay</u> does not count toward your <u>deductible</u> .
If you have a hospital stay	Facility fee (e.g., hospital room)	\$100 <u>copay/admission</u> , plus 20% <u>coinsurance</u>	\$100 <u>copay/admission</u> , plus 50% <u>coinsurance</u>	<u>Preauthorization</u> required. Only semi-private room covered unless private room is <u>medically necessary</u> . <u>Copay</u> does not count toward your deductible.
	Physician/surgeon fees	20% <u>coinsurance</u>	50% <u>coinsurance</u>	When required by law, non-PPO physician/surgeon fees will be treated like 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	\$20 <u>copay</u> /office visit, not subject to the <u>deductible</u> . Other services at 20% <u>coinsurance</u> .	50% <u>coinsurance</u>	To find Anthem Blue Cross Prudent Buyer PPO providers, see www.anthem.com/ca or call 1-800-227-3641 for a list. <u>Preauthorization</u> from Anthem is required for all inpatient services (except <u>emergency services</u>), including inpatient detox, inpatient rehabilitation, and residential treatment programs. <u>Preauthorization</u> is also required for intensive outpatient programs, partial day <u>hospitalization</u> , ECT, psychological testing, and neuropsychological testing. For inpatient services, only semi-private room covered unless private room is <u>medically necessary</u> . Care may include tests and services described elsewhere in the SBC (i.e., <u>diagnostic test</u>). When required by law, non-PPO <u>mental health/substance abuse services</u> will be treated like PPO.
	Inpatient services	20% <u>coinsurance</u>	50% <u>coinsurance</u>	
If you are pregnant	Office visits	\$20 <u>copay</u> /visit. <u>Deductible</u> does not apply.	50% <u>coinsurance</u>	<ul style="list-style-type: none"> • <u>Cost sharing</u> does not apply for <u>preventive services</u>. • Maternity care may include tests and services described elsewhere in the SBC (i.e., ultrasound). • Depending on the type of services, a <u>copayment</u>, <u>coinsurance</u>, or the <u>deductible</u> may apply. • Prenatal care and pregnancy expenses (other than ACA-required preventive <u>screenings</u>) are not covered for Children (i.e., non-spouse Dependents). • Delivery expenses and <u>complications of pregnancy</u> are not covered for Children (i.e., non-spouse Dependents).
	Childbirth/delivery professional services	20% <u>coinsurance</u>	50% <u>coinsurance</u>	
	Childbirth/delivery facility services	\$100 <u>copay</u> /admission, plus 20% <u>coinsurance</u>	\$100 <u>copay</u> /admission plus 50% <u>coinsurance</u>	

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	<u>Home health care</u>	20% <u>coinsurance</u> . <u>Deductible</u> does not apply.	20% <u>coinsurance</u> . <u>Deductible</u> does not apply.	<u>Preauthorization</u> required. Must be prescribed by a health care <u>provider</u> . Homemaker services not covered.
	<u>Rehabilitation services</u>	Speech therapy: \$20 <u>copay/visit</u> (<u>deductible</u> does not apply). Physical therapy and other services: 20% <u>coinsurance</u> .	Speech therapy: Not covered. Physical therapy and other services: 50% <u>coinsurance</u> .	<u>Preauthorization</u> 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.
	<u>Habilitation services</u>			
	<u>Skilled nursing care</u>	20% <u>coinsurance</u>	50% <u>coinsurance</u>	Limited to 240 days per disability. <u>Preauthorization</u> required. <u>Skilled nursing care</u> in the home will be paid as <u>Home Health Care</u> .
	<u>Durable medical equipment</u>	20% <u>coinsurance</u> . <u>Deductible</u> does not apply.	20% <u>coinsurance</u> . <u>Deductible</u> does not apply.	None.
	<u>Hospice services</u>	20% <u>coinsurance</u>	50% <u>coinsurance</u>	None.
If your child needs dental or eye care	Children's eye exam	No charge. <u>Deductible</u> does not apply.	No charge. <u>Deductible</u> does not apply.	Maximum benefit of \$135 per exam.
	Children's glasses	You pay all charges over the Fund's allowance. <u>Deductible</u> does not apply.	You pay all charges over the Fund's allowance. <u>Deductible</u> does not apply.	<u>Allowed amount</u> of \$135 per year is reduced by the cost of eye exam(s) paid by the Fund. Pediatric vision benefits are for individuals up to 19 years. Unused vision benefits from 2025 roll over for use in 2026.
	Children's dental check-up	You may elect dental coverage from the Indemnity Dental <u>Plan</u> or the United Concordia Dental HMO <u>Plan</u> .		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 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 Anthem Blue Cross PPO provider; coverage for non-PPO provider benefit 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, kwijjigo 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 <u>plan's overall deductible</u>	\$300
■ <u>Specialist copayment</u>	\$20
■ Hospital (facility) <u>copayment</u>	\$100
■ <u>Other coinsurance</u>	+ 20% 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
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In this example, Peg would pay:

Cost Sharing	
<u>Deductibles</u>	\$300
<u>Copayments</u>	\$110
<u>Coinsurance</u>	\$1,600
What isn't covered	
Limits or exclusions	\$20
The total Peg would pay is	\$2,030

Managing Joe's Type 2 Diabetes

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

■ The <u>plan's overall deductible</u>	\$300
■ <u>Specialist copayment</u>	\$20
■ Hospital (facility) <u>copayment</u>	\$100
■ <u>Other coinsurance</u>	+ 20% 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
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In this example, Joe would pay:

Cost Sharing	
<u>Deductibles</u>	\$120
<u>Copayments</u>	\$960
<u>Coinsurance</u>	\$0
What isn't covered	
Limits or exclusions	\$120
The total Joe would pay is	\$1,200

Mia's Simple Fracture

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

■ The <u>plan's overall deductible</u>	\$300
■ <u>Specialist copayment</u>	\$20
■ Hospital (facility) <u>coinsurance</u>	20%
■ <u>Other coinsurance</u>	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
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In this example, Mia would pay:

Cost Sharing	
<u>Deductibles</u>	\$300
<u>Copayments</u>	\$90
<u>Coinsurance</u>	\$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.