



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, visit the Fund's website at www.ufcw1189benefits.com or call the Fund Office at 1-800-535-6373. 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 <https://www.healthcare.gov/sbc-glossary>, call 1-800-318-2596, or call the Fund Office at 1-800-535-6373 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall <u>deductible</u> ?	\$300 per person	Generally, you must pay all of the costs from <u>providers</u> up to the <u>deductible</u> amount before this <u>plan</u> begins to pay. If you have other family members on this <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> .
Are there services covered before you meet your <u>deductible</u> ?	Yes. The following do not count toward the <u>deductible</u> : pre-admission testing, hospice care, home health care, Doctor On Demand, and ACIP recommended immunizations.	This <u>plan</u> covers some items and services even if you haven't yet met the <u>deductible</u> amount. But a <u>copayment</u> or <u>coinsurance</u> may apply.
Are there other <u>deductibles</u> for specific services?	Yes. \$100 per lifetime for infertility treatment. There are no other specific <u>deductibles</u> .	You must pay all of the costs for these services up to the specific <u>deductible</u> amount before this <u>plan</u> begins to pay for these services.
What is the <u>out-of-pocket limit</u> for this <u>plan</u> ?	\$2,500 per person	The <u>out-of-pocket limit</u> is the most you could pay in a year for covered services. If you have other family members in this <u>plan</u> , they have to meet their own <u>out-of-pocket limits</u> until the overall family <u>out-of-pocket limit</u> has been met.
What is not included in the <u>out-of-pocket limit</u> ?	Services for infertility treatment; penalties, <u>premiums</u> , <u>balance billing</u> charges, and health care this <u>plan</u> does not cover.	Even though you pay these expenses, they don't count toward the <u>out-of-pocket-limit</u> .
Will you pay less if you use a <u>network provider</u> ?	Yes. *See www.umr.com for a list of <u>network providers</u> . * <i>Out-of-network providers are treated as in-network providers for cost sharing purposes in certain circumstances: emergency treatment by an out-of-network provider, services from an out-of-network provider at an in-network facility, and out-of-network air ambulance costs for emergencies.</i>	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 (a <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.

Important Questions	Answers	Why This Matters:
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
		In-network (You will pay the least)	Out-of-network (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% <u>coinsurance</u>	20% <u>coinsurance</u>	Doctor On Demand Visits covered at 100% with no <u>deductible</u> requirement.
	<u>Specialist</u> visit	20% <u>coinsurance</u>	20% <u>coinsurance</u>	None
	<u>Preventive care/screening/immunization</u>	20% <u>coinsurance</u>	20% <u>coinsurance</u>	No charge for routine/preventive immunizations.
If you have a test	<u>Diagnostic test</u> (x-ray, blood work)	20% <u>coinsurance</u>	20% <u>coinsurance</u>	No charge for pre-admission testing.
	Imaging (CT/PET scans, MRIs)	20% <u>coinsurance</u>	20% <u>coinsurance</u>	No charge for pre-admission testing.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-network (You will pay the least)	Out-of-network (You will pay the most)	
<p>If you need drugs to treat your illness or condition</p> <p>More information about <u>prescription drug coverage</u> is available at www.savrx.com.</p>	Generic drugs (Tier 1)	20% <u>coinsurance</u>	You must pay 100% up front and submit claim for reimbursement at 20% <u>coinsurance</u>	<p>You also must pay the difference between cost of generic and brand name if generic is available and pharmacy dispenses brand name for any reason other than physician's "Dispense as written." Covers up to a 31-day supply (standard retail) unless filled at a maintenance retail pharmacy which covers a 90-day supply. Specialty drugs limited to a 31-day supply (through Sav-Rx only).</p>
	Preferred brand drugs (Tier 2)	20% <u>coinsurance</u>	You must pay 100% up front and submit claim for reimbursement at 20% <u>coinsurance</u>	
	Non-preferred brand drugs (Tier 3)	20% <u>coinsurance</u>	You must pay 100% up front and submit claim for reimbursement at 20% <u>coinsurance</u>	
	<u>Specialty drugs</u> (Tier 4)	20% <u>coinsurance</u>	Not covered	
<p>If you have outpatient surgery</p>	Facility fee (e.g., ambulatory surgery center)	20% <u>coinsurance</u>	20% <u>coinsurance</u>	None
	Physician/surgeon fees	20% <u>coinsurance</u>	20% <u>coinsurance</u>	None

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-network (You will pay the least)	Out-of-network (You will pay the most)	
If you need immediate medical attention	<u>Emergency room care</u>	20% <u>coinsurance</u>	20% <u>coinsurance</u>	\$250 <u>copayment</u> after 3 rd visit/calendar year, then subject to <u>deductible</u> and <u>coinsurance</u> (waived if admitted to hospital).
	<u>Emergency medical transportation</u>	20% <u>coinsurance</u>	20% <u>coinsurance</u>	None
	<u>Urgent care</u>	20% <u>coinsurance</u>	20% <u>coinsurance</u>	None
If you have a hospital stay	Facility fee (e.g., hospital room)	20% <u>coinsurance</u>	20% <u>coinsurance</u>	Preauthorization is required. Limited to admitting hospital's semi-private room rate for general and acute care and twice semi-private room rate for intensive or coronary care.
	Physician/surgeon fee	20% <u>coinsurance</u>	20% <u>coinsurance</u>	None
If you have mental health, behavioral health, or substance abuse needs	Outpatient services	20% <u>coinsurance</u>	20% <u>coinsurance</u>	None
	Inpatient services	20% <u>coinsurance</u>	20% <u>coinsurance</u>	Preauthorization is required.
If you are pregnant	Office visits	20% <u>coinsurance</u>	20% <u>coinsurance</u>	<u>Coinsurance</u> decreased to 10% if enrolled in and complete Plan's Maternity Program. Cost sharing does not apply to certain preventive services. Depending on the type of services, <u>deductible</u> , <u>copayment</u> , or <u>coinsurance</u> may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e., ultrasound).
	Childbirth/delivery professional services	20% <u>coinsurance</u>	20% <u>coinsurance</u>	
	Childbirth/delivery facility services	20% <u>coinsurance</u>	20% <u>coinsurance</u>	

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-network (You will pay the least)	Out-of-network (You will pay the most)	
If you need help recovering or have other special health needs	<u>Home health care</u>	No charge	No charge	40 maximum visits per calendar year (without additional approval from the <u>plan</u>).
	<u>Rehabilitation services</u>	20% <u>coinsurance</u>	20% <u>coinsurance</u>	None
	<u>Habilitation services</u>	Not covered	Not covered	None
	<u>Skilled nursing care</u>	20% <u>coinsurance</u>	20% <u>coinsurance</u>	30 maximum days per disability.
	<u>Durable medical equipment</u>	20% <u>coinsurance</u>	20% <u>coinsurance</u>	None
	<u>Hospice service</u>	No charge	No charge	None
If your child needs dental or eye care	Children's eye exam	Not covered	Not covered	Not covered
	Children's glasses	Not covered	Not covered	Not covered
	Children's dental check-up	Not covered	Not covered	Not covered

Excluded Services & Other Covered Services:

Services Your <u>Plan</u> Does NOT Cover (Check your policy or <u>plan</u> document for more information and a list of any other <u>excluded services</u> .)		
• Cosmetic surgery	• Long-term care	• Routine eye care (Adult)
• Habilitation services	• Non-emergency care when traveling outside the U.S.	• Routine foot care
• Hearing aids	• Private-duty nursing	• Weight loss programs
Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your <u>plan</u> document.)		
• Acupuncture (Covered if performed by a medical doctor or a licensed acupuncturist under the supervision of a medical doctor)	• Chiropractic care (up to \$35/visit and \$900/year)	
• Bariatric surgery when medically necessary for treatment of morbid obesity	• Dental care (Adult)	
	• Infertility treatment, up to \$10,000 per lifetime	

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: U.S. Department of Labor's Employee Benefits Security Administration is 1-866-444-EBSA (3272) or www.HealthCare.gov. 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 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 Plan at 1-800-535-6373 locally, or contact: U.S. Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.HealthCare.gov.

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.

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</u> overall <u>deductible</u>	\$300
■ <u>Specialist</u> <u>coinsurance</u>	20%
■ <u>Hospital (facility)</u> <u>coinsurance</u>	20%
■ <u>Other</u> <u>coinsurance</u>	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 **\$12,800**

In this example, Peg would pay:

<u>Cost Sharing</u>	
<u>Deductibles</u>	\$300
<u>Copayments</u>	\$0
<u>Coinsurance</u>	\$2,300
<i>What isn't covered</i>	
Limits or exclusions	\$0
The total Peg would pay is	\$2,600

Managing Joe's type 2 Diabetes

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

■ The <u>plan's</u> overall <u>deductible</u>	\$300
■ <u>Specialist</u> <u>coinsurance</u>	20%
■ <u>Hospital (facility)</u> <u>coinsurance</u>	20%
■ <u>Other</u> <u>coinsurance</u>	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 **\$7,400**

In this example, Joe would pay:

<u>Cost Sharing</u>	
<u>Deductibles</u>	\$300
<u>Copayments</u>	\$0
<u>Coinsurance</u>	\$1,400
<i>What isn't covered</i>	
Limits or exclusions	\$0
The total Joe would pay is	\$1,700

Mia's Simple Fracture

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

■ The <u>plan's</u> overall <u>deductible</u>	\$300
■ <u>Specialist</u> <u>coinsurance</u>	20%
■ <u>Hospital (facility)</u> <u>coinsurance</u>	20%
■ <u>Other</u> <u>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 **\$1,900**

In this example, Mia would pay:

<u>Cost Sharing</u>	
<u>Deductibles</u>	\$300
<u>Copayments</u>	\$0
<u>Coinsurance</u>	\$300
<i>What isn't covered</i>	
Limits or exclusions	\$0
The total Mia would pay is	\$600

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