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 Fund Office at 877-284-2320 or see www.scufcwfunds.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.dol.gov/ebsa/healthreform or call 877-284-2320 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	**Network (PPO) Providers:** $1,000 per person or $2,000 per family. **Out-of-network (Non-PPO) Providers:** $1,200 per person or $2,400 per family. Plan deductibles, coinsurance, and prescription drug copayments are payable from your Health Reimbursement Account (HRA).	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, certain preventive care services and most prescription drugs are covered before you meet the deductible.	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 services from network providers)*: $3,000 person / $6,000 family. ***Prescription drug out-of-pocket limit*** *(applicable to network prescription drug copayments)*: $5,700 person / $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.
What is not included in the out-of-pocket limit?	***For the medical out-of-pocket limit*** *(applicable to network providers):* premiums, balance billing charges, health care this plan doesn't cover, out-of-network coinsurance, penalties for failure to obtain precertification or to participate in the disease management program, and prescription drugs (except certain injectables). ***For the prescription drug out-of-pocket limit*** *(applicable to prescription drugs obtained from network pharmacies):* expenses for non-formulary drugs without a PBM-approved medical exception, most injectable drugs, premiums, balance billing charges, expenses for drugs obtained from out-of-network pharmacies, and health care this plan doesn't cover.	Even though you pay these expenses, they do not count toward the out–of–pocket limit.

Important Questions	Answers	Why This Matters:
Will you pay less if you use a network provider?	Yes. For network providers, contact Anthem: 855-686-5613 or www.anthem.com/ca; outside of California call 800-810-2583. For podiatry providers, call Podiatry Plan of California at 800-367-7762 or www.podiatryplan.com. For mental health/substance abuse providers, contact HMC HealthWorks EMAP: 800-461-9179 or https://hmc.personaladvantage.com.	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
		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	25% coinsurance	50% coinsurance	None
	Specialist visit	25% coinsurance	50% coinsurance	None
	Preventive Care/screening/ immunization	No charge, deductible does not apply.	50% coinsurance	You may have to pay for services that are not preventive. Ask your provider if the services you need are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	25% coinsurance	50% coinsurance	None
	Imaging (CT/PET scans, MRIs)	25% coinsurance	50% coinsurance	None

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 need drugs to treat your illness or condition More information about **prescription drug coverage** is available at **www.caremark.com**	Formulary generic drugs	$10 copay per prescription ($7 for certain maintenance drugs).	Not covered	• Deductible does not apply. • Covers a 30-day or 31-90-day supply. • Copays shown are for a 30-day supply. Up to 90-day supply can be obtained for 2 copays. • Prescription drug copays are payable from your Health Reimbursement Account (HRA) if you opt in. • Certain maintenance medications used to treat hypertension, high cholesterol, diabetes, osteoporosis, glaucoma, and asthma are eligible for reduced copays. • Emergency benefits for out-of-network pharmacies: you pay applicable copay plus $25 and any balance billing. • No charge for ACA-required preventive care drugs (usually generic, with some exceptions if a generic is medically inappropriate) purchased at a network pharmacy with a prescription from a physician.
	Formulary brand drugs	$25 copay per prescription ($15 for certain maintenance drugs).	Not covered	
	Non-formulary generic or brand drugs	$40 copay per prescription ($25 for certain maintenance drugs).	Not covered	
	Specialty drugs (including injectable drugs)	25% coinsurance	50% coinsurance	Deductible does not apply (except for injectable drugs). Coverage for injectable drugs is generally provided through the Indemnity Medical Plan rather than Caremark. Coinsurance for injectable drugs counts towards medical out-of-pocket limit.

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 have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	25% coinsurance	50% coinsurance plus any amount over the $1,000 benefit maximum	For out-of-network Ambulatory Surgery Facilities (outpatient surgery centers), the Plan's maximum payment is limited to $1,000. You are responsible for all charges over $1,000.
	Physician/surgeon fees	25% coinsurance	50% coinsurance	Coverage for out-of-network TMJ surgery is limited to $2,100 per period of disability.
If you need immediate medical attention	Emergency room care	25% coinsurance	25% coinsurance	Professional/physician charges may be billed separately.
	Emergency medical transportation	25% coinsurance	25% coinsurance	None
	Urgent care	25% coinsurance	25% coinsurance	None
If you have a hospital stay	Facility fee (e.g., hospital room)	25% coinsurance	50% coinsurance	Must be precertified to avoid a 20% penalty. The allowed amount for knee and hip joint replacement surgeries is $35,000. Unless you use a designated hospital, you will be responsible for any charges above the allowed amount, even if you use a network hospital. Use a designated hospital to avoid balance billing. Contact the Fund for more information.
	Physician/surgeon fees	25% coinsurance	50% coinsurance	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	25% coinsurance	50% coinsurance	None
	Inpatient services	25% coinsurance	50% coinsurance	Must be precertified by HMC to avoid a 20% penalty.
If you are pregnant	Office visits	25% coinsurance	50% coinsurance	• Cost sharing does not apply to preventive services. • Maternity care may include tests and services described elsewhere in the SBC (e.g., ultrasound). • Precertification required if hospital stay more than 48 hours (vaginal delivery) or 96 hours (C-section). • Prenatal care (other than ACA-required preventive screenings) is not covered for dependent children. • Delivery expenses are not covered for dependent children.
	Childbirth/delivery professional services	25% coinsurance	50% coinsurance	
	Childbirth/delivery facility services	25% coinsurance	50% coinsurance	

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 need help recovering or have other special health needs	Home health care	25% coinsurance	50% coinsurance	Nursing care in the home limited to 400 visits per person per lifetime. Homemaker services not covered.
	Rehabilitation services	25% coinsurance	50% coinsurance	None
	Habilitation services	25% coinsurance	50% coinsurance	Educational services, supplies, and equipment, including services for behavioral training, are not covered.
	Skilled nursing care	25% coinsurance	50% coinsurance	Must be precertified to avoid a 20% penalty. Nursing care in the home limited to 400 visits per person per lifetime. *Skilled nursing facility (SNF):* no coverage unless medically necessary. SNF must follow hospitalization.
	Durable medical equipment	25% coinsurance	50% coinsurance	Glucose home monitor – limited to one device every two years.
	Hospice services	25% coinsurance	50% coinsurance	No benefit unless care is managed through review organization (Anthem).
If your child needs dental or eye care	Children's eye exam	No charge	No charge	Pediatric vision benefits available through age 18.
	Children's glasses	Limited benefit may be available through separate vision program.		Annual benefit limit of $125 is reduced by the cost of eye-exam(s) already paid by the Fund.
	Children's dental check-up	Not covered	Not covered	Coverage available under a separate 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
- Dental care (Adult) (available through separate plan)
- Infertility treatment (except initial exam)
- Long-term care
- Weight loss programs (except as required by the health reform law)

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)		
• Acupuncture (benefit maximum of $1,000/calendar year combined with chiropractic care) • Bariatric Surgery • Chiropractic Care (benefit maximum of $1,000/calendar year combined with acupuncture)	• Hearing aids ($475 max for one aid or $785 max for two aids during any three-year period) • Non-emergency care when traveling outside U.S.	• Private duty nursing • Routine eye care (Adult) (maximum benefit of $125/year for exam, frames, and lenses) • Routine foot 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'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 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 the UFCW Trust Fund at 877-284-2320, extension 232. You may also contact the Department of Labor's Employee Benefits Security Administration at 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 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 877-284-2320
Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 877-284-2320
Chinese (中文): 如果需要中文的帮助请拨打这个号码 877-284-2320
Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 877-284-2320

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	$1,000
Specialist copayment	25%
Hospital (facility) coinsurance	25%
Other coinsurance	25%

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	$1,000
Copayments	$10
Coinsurance	$2,000
What isn't covered	
Limits or exclusions	$20
The total Peg would pay is	**$3,030**

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

The plan's overall deductible	$1,500**
Specialist copayment	25%
Hospital (facility) coinsurance	25%
Other coinsurance	25%

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	$1,070**
Copayments	$470
Coinsurance	$0
What isn't covered	
Limits or exclusions	$120
The total Joe would pay is	**$1,660****

**** Includes additional $500 penalty for not participating in Disease Management Program for diabetes**

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

The plan's overall deductible	$1,000
Specialist copayment	25%
Hospital (facility) coinsurance	25%
Other coinsurance	25%

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	$1,000
Copayments	$10
Coinsurance	$450
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,460**

** NOTE: These numbers assume the patient does not participate in the plan's wellness program. If you participate in the plan's wellness program, you may be able to reduce your cost. For more information about the wellness program, please contact: 1-877-284-2320.

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