



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.

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](http://www.dol.gov/ebsa/healthreform) or call 877-284-2320 to request a copy.

Important Questions	Answers	Why This Matters:
<p>What is the overall <a href="#">deductible</a>?</p>	<p><a href="#">Network (PPO) Providers</a>: \$1,000 per person or \$2,000 per family.  <a href="#">Out-of-network (Non-PPO) Providers</a>: \$1,200 per person or \$2,400 per family. <a href="#">Plan deductibles</a>, <a href="#">coinsurance</a>, and <a href="#">prescription drug copayments</a> are payable from your Health Reimbursement Account (HRA).</p>	<p>Generally, you must pay all of the costs from <a href="#">providers</a> up to the <a href="#">deductible</a> amount before this <a href="#">plan</a> begins to pay. If you have other family members on the <a href="#">plan</a>, each family member must meet their own individual <a href="#">deductible</a> until the total amount of <a href="#">deductible</a> expenses paid by all family members meets the overall family <a href="#">deductible</a>.</p>
<p>Are there services covered before you meet your <a href="#">deductible</a>?</p>	<p>Yes, certain <a href="#">preventive care</a> services and most <a href="#">prescription drugs</a> are covered before you meet the <a href="#">deductible</a>.</p>	<p>This <a href="#">plan</a> covers some items and services even if you haven't yet met the <a href="#">deductible</a> amount, but a <a href="#">copayment</a> or <a href="#">coinsurance</a> may apply. For example, this <a href="#">plan</a> covers certain <a href="#">preventive services</a> without <a href="#">cost-sharing</a> and before you meet your <a href="#">deductible</a>. See a list of covered <a href="#">preventive services</a> at <a href="https://www.healthcare.gov/coverage/preventive-care-benefits/">https://www.healthcare.gov/coverage/preventive-care-benefits/</a>.</p>
<p>Are there other <a href="#">deductibles</a> for specific services?</p>	<p>No</p>	<p>You don't have to meet <a href="#">deductibles</a> for specific services.</p>
<p>What is the <a href="#">out-of-pocket limit</a> for this <a href="#">plan</a>?</p>	<p><b>Medical <a href="#">out-of-pocket limit</a></b> (for services from <a href="#">network providers</a>): \$3,500 person or \$7,000 family.  <b>Prescription drug <a href="#">out-of-pocket limit</a></b> (applicable to <a href="#">network prescription drug copayments</a>): \$5,200 person or \$10,400 family.</p>	<p>The <a href="#">out-of-pocket limit</a> is the most you could pay in a year for covered services. If you have other family members in this <a href="#">plan</a>, they have to meet their own <a href="#">out-of-pocket limits</a> until the overall family <a href="#">out-of-pocket limit</a> has been met.</p>
<p>What is not included in the <a href="#">out-of-pocket limit</a>?</p>	<p><b>For the medical <a href="#">out-of-pocket limit</a></b> (applicable to <a href="#">network providers</a>): <a href="#">premiums</a>, <a href="#">balance billing</a> charges, health care this <a href="#">plan</a> doesn't cover, <a href="#">out-of-network coinsurance</a>, penalties for failure to obtain precertification or to participate in the disease management program, and <a href="#">prescription drugs</a> (except certain injectables).  <b>For the <a href="#">prescription drug out-of-pocket limit</a></b> (applicable to <a href="#">prescription drugs</a> obtained from <a href="#">network pharmacies</a>): expenses for non-<a href="#">formulary</a> drugs without a PBM-approved medical exception, most injectable drugs, <a href="#">premiums</a>, <a href="#">balance billing</a> charges, expenses for drugs obtained from out-of-network pharmacies, and health care this <a href="#">plan</a> doesn't cover.</p>	<p>Even though you pay these expenses, they do not count toward the <a href="#">out-of-pocket limit</a>.</p>

Important Questions	Answers	Why This Matters:
Will you pay less if you use a <a href="#">network provider</a> ?	Yes. For <a href="#">network providers</a> , contact Anthem: 855-686-5613 or <a href="http://www.anthem.com/ca">www.anthem.com/ca</a> ; outside of California call 800-810-2583. For podiatry <a href="#">providers</a> , call Podiatry Plan, Inc. at 800-367-7762 or <a href="http://www.podiatryplan.com">www.podiatryplan.com</a> . For mental health/substance abuse <a href="#">providers</a> , contact HMC HealthWorks EMAP: 800-461-9179 or <a href="https://hmc.personaladvantage.com">https://hmc.personaladvantage.com</a> .	This <a href="#">plan</a> uses a <a href="#">provider network</a> . You will pay less if you use a <a href="#">provider</a> in the plan's <a href="#">network</a> . You will pay the most if you use an <a href="#">out-of-network provider</a> , and you might receive a bill from a <a href="#">provider</a> for the difference between the <a href="#">provider's</a> charge and what your <a href="#">plan</a> pays ( <a href="#">balance billing</a> ). Be aware your <a href="#">network provider</a> might use an <a href="#">out-of-network provider</a> for some services (such as lab work). Check with your <a href="#">provider</a> before you get services.
Do you need a <a href="#">referral</a> to see a <a href="#">specialist</a> ?	No.	You can see the <a href="#">specialist</a> you choose without a <a href="#">referral</a> .



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 <a href="#">provider's</a> office or clinic	<a href="#">Primary care</a> visit to treat an injury or illness	25% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	None
	<a href="#">Specialist</a> visit	25% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	None
	<a href="#">Preventive care/screening/immunization</a>	No charge, <a href="#">deductible</a> does not apply	50% <a href="#">coinsurance</a>	You may have to pay for services that are not preventive. Ask your <a href="#">provider</a> if the services you need are preventive. Then check what your <a href="#">plan</a> will pay for.
If you have a test	<a href="#">Diagnostic test</a> (x-ray, blood work)	25% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	None
	Imaging (CT/PET scans, MRIs)	25% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	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)	
<b>If you need drugs to treat your illness or condition</b> More information about <a href="#">prescription drug coverage</a> is available at <a href="http://www.caremark.com">www.caremark.com</a>	<a href="#">Formulary</a> generic drugs	The greater of \$10 <a href="#">copay</a> per prescription or 10% <a href="#">coinsurance</a> (\$7 for certain maintenance drugs).	Not covered.	<ul style="list-style-type: none"> <li>• <a href="#">Deductible</a> does not apply.</li> <li>• Covers a 30-day or 31-90-day supply.</li> <li>• <a href="#">Copays</a> shown are for a 30-day supply. Up to 90-day supply can be obtained for 2 <a href="#">copays</a>.</li> <li>• <a href="#">Prescription drug copays</a> are payable from your Health Reimbursement Account (HRA) if you opt in.</li> <li>• Certain maintenance medications used to treat hypertension, high cholesterol, diabetes, osteoporosis, glaucoma, and asthma are eligible for reduced <a href="#">copays</a>.</li> <li>• Emergency benefits for <a href="#">out-of-network</a> pharmacies: you pay applicable <a href="#">copay</a> plus \$25 and any <a href="#">balance billing</a>. <a href="#">Plan</a> pays the lesser of purchase price or average wholesale price (AWP), less applicable <a href="#">copay(s)</a>.</li> <li>• No charge for ACA-required <a href="#">preventive care</a> drugs (usually generic, with some exceptions if a generic is medically inappropriate) purchased at a <a href="#">network</a> pharmacy with a prescription from a physician.</li> </ul>
	<a href="#">Formulary</a> brand drugs	The greater of \$30 <a href="#">copay</a> per prescription or 25% <a href="#">coinsurance</a> (\$15 for certain maintenance drugs).	Not covered	
	Non- <a href="#">formulary</a> generic or brand drugs	The greater of \$50 <a href="#">copay</a> per prescription or 50% <a href="#">coinsurance</a> (\$25 for certain maintenance drugs).	Not covered	
	Specialty drugs (including injectable drugs)	25% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	
<b>If you have outpatient surgery</b>	Facility fee (e.g., ambulatory surgery center)	25% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a> plus any charges over the \$1,000 benefit maximum	For out-of-network Ambulatory Surgery Facilities (outpatient surgery centers), the <a href="#">Plan's</a> maximum payment is limited to \$1,000. You are responsible for all charges over \$1,000.
	Physician/surgeon fees	25% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	Coverage for out-of-network TMJ surgery is limited to \$2,100 per period of disability.

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 immediate medical attention	<a href="#">Emergency room care</a>	25% <a href="#">coinsurance</a>	25% <a href="#">coinsurance</a>	Professional/physician charges may be billed separately.
	<a href="#">Emergency medical transportation</a>	25% <a href="#">coinsurance</a>	25% <a href="#">coinsurance</a>	None
	<a href="#">Urgent care</a>	25% <a href="#">coinsurance</a>	25% <a href="#">coinsurance</a>	None
If you have a hospital stay	Facility fee (e.g., hospital room)	25% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	Must be precertified to avoid a 20% penalty. The <a href="#">allowed amount</a> 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 <a href="#">allowed amount</a> , even if you use a <a href="#">network</a> hospital. Use a designated hospital to avoid <a href="#">balance billing</a> . Contact the Fund for more information.
	Physician/surgeon fees	25% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	25% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	None
	Inpatient services	25% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	Must be precertified by HMC to avoid a 20% penalty.
If you are pregnant	Office visits	25% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	<ul style="list-style-type: none"> <li>• <a href="#">Cost sharing</a> does not apply to certain <a href="#">preventive services</a>.</li> <li>• Maternity care may include tests and services described elsewhere in the SBC (e.g., ultrasound).</li> <li>• Precertification required if hospital stay more than 48 hours (vaginal delivery) or 96 hours (C-section).</li> <li>• Prenatal care (other than ACA-required preventive <a href="#">screenings</a>) is not covered for dependent children.</li> <li>• Delivery expenses are not covered for dependent children.</li> </ul>
	Childbirth/delivery professional services	25% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	
	Childbirth/delivery facility services	25% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	

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	<a href="#">Home health care</a>	25% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	Nursing care in the home limited to 400 visits per person per lifetime. Homemaker services not covered.
	<a href="#">Rehabilitation services</a>	25% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	None
	<a href="#">Habilitation services</a>	25% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	Educational services, supplies, and equipment, including services for behavioral training, are not covered.
	<a href="#">Skilled nursing care</a>	25% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	Must be precertified to avoid a 20% penalty. Nursing care in the home limited to 400 visits per person per lifetime. <i>Skilled nursing facility (SNF)</i> : no coverage unless <a href="#">medically necessary</a> . SNF must follow <a href="#">hospitalization</a> .
	<a href="#">Durable medical equipment</a>	25% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	Glucose home monitor – limited to one device every two years.
	<a href="#">Hospice services</a>	25% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	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 <a href="#">plan</a> .

### Excluded Services & Other Covered Services:

Services Your <a href="#">Plan</a> Generally Does NOT Cover (Check your policy or <a href="#">plan</a> document for more information and a list of any other <a href="#">excluded services</a> .)		
<ul style="list-style-type: none"> <li>• Cosmetic surgery</li> <li>• Dental care (Adult) (available through separate <a href="#">plan</a>)</li> </ul>	<ul style="list-style-type: none"> <li>• Infertility treatment (except initial exam)</li> </ul>	<ul style="list-style-type: none"> <li>• Long-term care</li> <li>• Weight loss programs (except as required by the health reform law)</li> </ul>

**Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your [plan](#) document.)**

- Acupuncture (benefit maximum of \$800/calendar year combined with chiropractic care)
- Bariatric Surgery
- Chiropractic Care (benefit maximum of \$800/calendar year combined with acupuncture)
- Hearing aids (\$475 max for one aid or \$630 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](http://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](http://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](http://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, kwijigo 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 <a href="#">plan's</a> overall <a href="#">deductible</a>	\$1,000
■ <a href="#">Specialist copayment</a>	25%
■ Hospital (facility) <a href="#">coinsurance</a>	25%
■ Other <a href="#">coinsurance</a>	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*)

<b>Total Example Cost</b>	<b>\$12,700</b>
---------------------------	-----------------

In this example, Peg would pay:

Cost Sharing	
<a href="#">Deductibles</a>	\$1,000
<a href="#">Copayments</a>	\$0
<a href="#">Coinsurance</a>	\$2,500
What isn't covered	
Limits or exclusions	\$20
<b>The total Peg would pay is</b>	<b>\$3,520</b>

### Managing Joe's Type 2 Diabetes

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

■ The <a href="#">plan's</a> overall <a href="#">deductible</a>	\$1,500**
■ <a href="#">Specialist copayment</a>	25%
■ Hospital (facility) <a href="#">coinsurance</a>	25%
■ Other <a href="#">coinsurance</a>	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*)

<b>Total Example Cost</b>	<b>\$5,600</b>
---------------------------	----------------

In this example, Joe would pay:

Cost Sharing	
<a href="#">Deductibles</a>	\$1,070**
<a href="#">Copayments</a>	\$470
<a href="#">Coinsurance</a>	\$0
What isn't covered	
Limits or exclusions	\$120
<b>The total Joe would pay is</b>	<b>\$1,660**</b>

\*\* 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 <a href="#">plan's</a> overall <a href="#">deductible</a>	\$1,000
■ <a href="#">Specialist copayment</a>	25%
■ Hospital (facility) <a href="#">coinsurance</a>	25%
■ Other <a href="#">coinsurance</a>	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*)

<b>Total Example Cost</b>	<b>\$2,800</b>
---------------------------	----------------

In this example, Mia would pay:

Cost Sharing	
<a href="#">Deductibles</a>	\$1,000
<a href="#">Copayments</a>	\$0
<a href="#">Coinsurance</a>	\$450
What isn't covered	
Limits or exclusions	\$0
<b>The total Mia would pay is</b>	<b>\$1,450</b>

\*\* 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.