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 deductible?	**$300** per person / **$900** per 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 this 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. The following do not count toward the deductible: pre-admission testing, hospice care, home health care, Included Health, and ACIP recommended immunizations.	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?	Yes. **$100** per lifetime for infertility treatment. There are no other specific deductibles.	You must pay all of the costs for these services up to the specific deductible amount before this plan begins to pay for these services.
What is the out-of-pocket limit for this plan?	**$2,500** per person / **$5,000** per 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?	Services for infertility treatment; penalties, premiums, balance billing charges, and health care this plan does not cover.	Even though you pay these expenses, they don't count toward the out-of-pocket-limit.
Will you pay less if you use a network provider?	Yes. *See www.umr.com for a list of network providers. **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.*	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 (a 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.

Important Questions	Answers	Why This Matters:
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
		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% coinsurance	20% coinsurance	Included Health Visits covered at 100% with no deductible requirement.
	Specialist visit	20% coinsurance	20% coinsurance	None
	Preventive care/screening/ immunization	20% coinsurance	20% coinsurance	No charge for routine/preventive immunizations.
If you have a test	Diagnostic test (x-ray, blood work)	20% coinsurance	20% coinsurance	No charge for pre-admission testing.
	Imaging (CT/PET scans, MRIs)	20% coinsurance	20% coinsurance	No charge for pre-admission testing.

Common Medical Event	Services You May Need	What You Will Pay		Common Limitations, Exceptions, & Other Important Information
		In-network (You will pay the least)	Out-of-network (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.savrx.com.	Generic drugs (Tier 1)	20% coinsurance, minimum $10, maximum $50	You must pay 100% up front and submit claim for reimbursement at 20% coinsurance, minimum $10, maximum $50	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).
	Preferred brand drugs (Tier 2)	20% coinsurance, minimum $10, maximum $50	You must pay 100% up front and submit claim for reimbursement at 20% coinsurance, minimum $10, maximum $50	
	Non-preferred brand drugs (Tier 3)	20% coinsurance, minimum $10, maximum $50	You must pay 100% up front and submit claim for reimbursement at 20% coinsurance, minimum $10, maximum $50	
	Specialty drugs (Tier 4)	20% coinsurance, minimum $10, maximum $50	Not covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance	20% coinsurance	None
	Physician/surgeon fees	20% coinsurance	20% coinsurance	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	Emergency room care	20% coinsurance	20% coinsurance	$250 copayment after 3rd visit/calendar year, then subject to deductible and coinsurance (waived if admitted to hospital).
	Emergency medical transportation	20% coinsurance	20% coinsurance	None
	Urgent care	20% coinsurance	20% coinsurance	None
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance	20% coinsurance	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% coinsurance	20% coinsurance	None
If you have mental health, behavioral health, or substance abuse needs	Outpatient services	20% coinsurance	20% coinsurance	None
	Inpatient services	20% coinsurance	20% coinsurance	Preauthorization is required.
If you are pregnant	Office visits	20% coinsurance	20% coinsurance	Coinsurance 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, deductible, copayment, or coinsurance may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e., ultrasound).
	Childbirth/delivery professional services	20% coinsurance	20% coinsurance	
	Childbirth/delivery facility services	20% coinsurance	20% coinsurance	

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	Home health care	No charge	No charge	40 maximum visits per calendar year (without additional approval from the plan).
	Rehabilitation services	20% coinsurance	20% coinsurance	None
	Habilitation services	Not covered	Not covered	None
	Skilled nursing care	20% coinsurance	20% coinsurance	30 maximum days per disability.
	Durable medical equipment	20% coinsurance	20% coinsurance	None
	Hospice service	No charge	No charge	None
If your child needs dental or eye care	Children's eye exam	20% coinsurance	20% coinsurance	1 maximum exam per calendar year, under age 19.
	Children's glasses	20% coinsurance	20% coinsurance	Limited to 1 pair of glasses/year, under age 19, covered at 100% up to $300, then covered at 50% thereafter.
	Children's dental check-up	No charge at a Delta Preferred Option network dentist	20% coinsurance out-of-network or at a Delta Premier network provider	Limited to 2 check-ups in 12 months, under age 19.

Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)

- Cosmetic surgery
- Habilitation services
- Hearing aids
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing
- Routine foot care
- Weight loss programs

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

- Acupuncture (Covered if performed by a medical doctor or a licensed acupuncturist under the supervision of a medical doctor)
- Bariatric surgery when medically necessary for treatment of morbid obesity
- Chiropractic care (up to $35/visit and $900/year)
- Dental care (Adult)
- Infertility treatment, up to $10,000 per lifetime
- Routine eye care (Adult)

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 plan's overall deductible	$300
Specialist coinsurance	20%
Hospital (facility) coinsurance	20%
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	**$12,800**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$300
Copayments	$0
Coinsurance	$2,300
What isn't covered	
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 plan's overall deductible	$300
Specialist coinsurance	20%
Hospital (facility) coinsurance	20%
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	**$7,400**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$300
Copayments	$0
Coinsurance	$1,400
What isn't covered	
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 plan's overall deductible	$300
Specialist coinsurance	20%
Hospital (facility) coinsurance	20%
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	**$1,900**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$300
Copayments	$0
Coinsurance	$300
What isn't covered	
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.