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, contact 1-800-800-8860. 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 1-800-800-8860 to request a copy.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	**$0** in-network; **$500** Individual/ **$1,000** Family out-of-network; Doesn't apply to preventive care. Co-pays do not apply to the deductible.	You must pay all the costs up to the deductible amount before this plan begins to pay for covered services you use. Check your Summary Plan Description to see when the deductible starts over (usually, but not always, January 1st). See the chart starting on page 2 for how much you pay for covered services after you meet the deductible.
Are there services covered before you meet your deductible?	Yes. Certain preventive care, office visits and prescription drugs are covered before you meet your deductible.	This plan covers some items and services even if you have not met the deductible amount. However, you may have to pay a copayment or co-insurance.
Is there an out–of–pocket limit on my expenses?	Yes. $1,500 Individual/$3,000 Family in-network; $3,000 Individual/$6,000 Family out-of-network	The out-of-pocket limit is the most you could pay during a calendar year for your share of the cost of covered services up to the annual limit. This limit helps you plan for health care expenses.
What is not included in the out–of–pocket limit?	Premiums, deductibles, balance-billed charges, & health care this plan doesn't 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.bcbst.com or call 1-800-800-8860 to obtain network providers.	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. Check with your provider before you get services.
Do I need a referral to see a specialist?	No. You don't need a referral to see a specialist.	You can see the specialist you choose without permission from this plan.

- All co-payment and co-insurance costs shown in this chart are after your deductible has been met, if a deductible applies.

Common Medical Event	Services You May Need	Your cost if you use a Network Provider	Your cost if you use a Out-of-Network Provider	Limitations & Exceptions
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$10 co-pay/visit	40% co-insurance	none
	Specialist visit	$20 co-pay/visit	40% co-insurance	none
	Other practitioner office visit	$10 co-pay/visit	40% co-insurance	Therapy visits for physical, speech, manipulative, home health and occupational therapy limited to 30 per type per year. (Limits do not apply to services for treatment of autism spectrum disorders) Cardiac/pulmonary rehabilitation visits limited to 36 per year. Acupuncture limited to 12 visits per year. The above therapies are only covered in-network. Some therapies require prior authorization.
	Preventive care/screening/immunization	No charge	Not covered	none
If you have a test	Diagnostic test (x-ray, blood work) in office	No charge	40% co-insurance	none
	Imaging (CT/PET scans, MRIs)	$50 co-pay	40% co-insurance	none
If you need drugs to treat your illness or condition. More information about prescription drug coverage is available at www.savrx.com	Generic drugs	$5 co-pay retail for 30-day supply: $0 or $10 co-pay mail order for 90-day supply	You must pay all expenses and file a claim for reimbursement	Generic drugs filled for high cholesterol, high blood pressure, congestive heart failure and diabetes may be obtained for *free* through mail order. Please contact 1-800-800-8860 or visit www.savrx.com for more information.

If you need drugs to treat your illness or condition **More information about prescription drug coverage is available at** www.savrx.com				Brand drugs filled when a generic is equivalent will require the member to pay the cost of the brand drug that exceeds the generic costs, plus the applicable copay. Some drugs require prior authorization.
	Preferred brand drugs	$20 co-pay retail for 30-day supply: $40 co-pay mail order for 90-day supply	You must pay all expenses and file a claim for reimbursement	
	Non-preferred brand drugs	$45 co-pay retail for 30-day supply: $90 co-pay mail order for 90-day supply	You must pay all expenses and file a claim for reimbursement	
	Self-Administered Specialty drugs	$75 co-pay	You must pay all expenses and file a claim for reimbursement.	30-day supply. Prior authorization may be required.
	Provider-administered specialty drugs	No additional co-pay	Not covered	——————none——————
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	$50 co-pay	40% co-insurance	Prior authorization required for certain outpatient procedures. Benefits may be reduced to 50% if not obtained.
	Physician/surgeon fees	No additional co-pay	40% co-insurance	——————none——————
If you need immediate medical attention	Emergency room services	$75 co-pay	$75 co-pay	——————none——————
	Emergency medical transportation	No additional co-pay	No additional co-pay	——————none——————
	Urgent care	See limitations	See limitations	Urgent care benefits determined by place of service, such as physician office or ER.
If you have a hospital stay	Facility fee (e.g., hospital room)	$100 co-pay	40% co-insurance	Prior authorization required. Benefits may reduce to 50% if not obtained.
	Physician/surgeon fee	No additional co-pay	40% co-insurance	——————none——————

If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	$10 co-pay	20% co-insurance	——————none——————
	Mental/Behavioral health inpatient services	$100 co-pay	40% co-insurance	——————none——————
	Substance use disorder outpatient services	$10 co-pay	20% co-insurance	——————none——————
	Substance use disorder inpatient services	$100 co-pay	40% co-insurance	——————none——————
If you are pregnant	Prenatal and postnatal care	No additional co-pay	40% co-insurance	Initial co-pay of $20 for maternity applies
	Delivery and all inpatient services	$100 co-pay	40% co-insurance	——————none——————
If you need help recovering or have other special health needs	Home health care	No additional co-pay	Not covered	——————none——————
	Rehabilitation services	$10 co-pay if in an office	Not covered	Therapy visits for physical, speech, manipulative, home health and occupational therapy limited to 30 per type per year. (Limits do not apply to services for treatment of autism spectrum disorders) Cardiac/pulmonary rehabilitation visits limited to 36 per year. Acupuncture limited to 12 visits per year. Some therapies require prior authorization.
	Habilitation services	$10 co-pay if in an office	Not covered	Therapy visits limited to 30 per type per year.
	Skilled nursing care	No additional co-pay	Not covered	Skilled nursing & Rehabilitation facility limited to 60 days/year combined.
	Durable medical equipment (DME)	No additional co-pay	Not covered	——————none——————
	Hospice service	No additional co-pay	Not covered	Inpatient hospice requires prior authorization.
If your child needs dental or eye care	Eye exam	Not Covered	Not Covered	——————none——————
	Glasses	Not Covered	Not Covered	——————none——————
	Dental check-up	Not Covered	Not Covered	——————none——————

* For more information about limitations and exceptions, contact the Fund office at 1-800-800-8860 to request a Summary Plan Description.

Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover **(This isn't a complete list. Check your policy or plan document for other excluded services.)**

- Bariatric Surgery
- Cosmetic surgery
- Dental care
- Long-term care
- Routine eye care
- Routine foot care for non-diabetics
- Weight loss programs

Other Covered Services **(This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)**

- Chiropractic care
- Hearing aids
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing
- Infertility treatment

* For more information about limitations and exceptions, contact the Fund office at 1-800-800-8860 to request a Summary Plan Description.

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 at 1-866-444-3272 or www.dol.gov/ebsa, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cciio.com.gov, or the Plan at 1-800-800-8860. 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 **grievance for** any reason to your plan. For more information about our rights, this notice, or assistance, contact: UFW Insurance Fund, 1910 Air Lane Drive, Nashville, Tennessee 37210. You may also call the Fund office at 1-800-800-8860.

Does this Coverage Provide Minimum Essential Coverage? Yes. If you don't have **Minimum Essential Coverage** for a month, you will have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

The Affordable Care Act requires most people to have health care coverage that qualifies as "minimum essential coverage." **This plan does provide minimum essential coverage.**

Does this Plan meet the Minimum Value Standard? Yes. If your **plan** does not 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:

ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-800-800-8860.

注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電1-800-800-8860.

* For more information about limitations and exceptions, contact the Fund office at 1-800-800-8860 to request a Summary Plan Description.

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	$0.00
Specialist copayment	$20.00
Hospital (facility) co-pay	$100
Other coinsurance	0%

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	$0
Copayments	$110
Coinsurance	$0
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$170**

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

The plan's overall deductible	$0.00
Specialist copayment	$20.00
Hospital (facility) co-pay	$100
Other coinsurance	0%

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	$0
Copayments	$290
Coinsurance	$0
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$310**

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

The plan's overall deductible	$0.00
Specialist copayment	$20.00
Hospital (facility) co-pay	$100
Other coinsurance	0%

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	$0
Copayments	$120
Coinsurance	
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$120**

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