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, see www.associated-admin.com or call 1-800-638-2972. 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 1-800-638-2972 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	**$300**/individual; **$600**/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 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. Network preventive care is covered before you meet your 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 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 plan (in-network and out-of-network providers combined): **$4,000**/individual; **$8,000**/family; Prescription drugs (in-network only): **$2,600**/individual; **$5,200**/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?	Premiums, balance-billing charges, penalties for failure to obtain preauthorization, health care this plan doesn't cover, and cost sharing for non-essential health benefits.	Even though you pay these expenses, they don't 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 medical providers, see www.carefirst.com or call 1-800-810-2583; for network mental health and substance use disorder providers, see www.carelonbehavioralhealth.com or call 1-800-353-3572; for network dental providers, see www.dentegra.com/felra-ufcw-veba-fund.html or call 1-877-280-4204.	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	20% coinsurance	20% coinsurance, plus balance-billed charges	None
	Specialist visit	20% coinsurance	20% coinsurance, plus balance-billed charges	None
	Preventive care/screening/ immunization	No charge. Deductible does not apply.	20% coinsurance, plus balance-billed charges.	Subject to age and frequency guidelines. You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for. Out-of-network well-child exams limited to 8 visits through age 5.
If you have a test	Diagnostic test (x-ray, blood work)	20% coinsurance	20% coinsurance, plus balance-billed charges	Must be provided by Quest or LabCorp, unless provided by an out-of-network provider at an in-network facility.
	Imaging (CT/PET scans, MRIs)	20% coinsurance	20% coinsurance, plus balance-billed charges	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.express-scripts.com	Generic drugs	8% coinsurance at Giant or Safeway pharmacies; 13% coinsurance at other network pharmacies	Not covered at out-of-network pharmacies. Rite Aid, Walmart, Walgreens and CVS are not in the network.	Deductible does not apply. Limit: Retail up to a 34-day supply; mail order up to a 100-day supply. If you request a brand name drug when a generic equivalent is available, you will pay the full cost of the brand name drug. No charge for ACA-required generic preventive drugs (e.g., contraceptives) or a brand name preventive drug if a generic is not medically appropriate. Certain specialty drugs require preauthorization or benefits are not covered. Certain specialty drugs must be ordered by phone through Accredo Specialty Pharmacy for which you will pay 8% coinsurance. For drugs listed on the SaveonSP program's current non-essential health benefit specialty drug list: No charge if you participate in the SaveonSP program, or 30% coinsurance if you do not participate in the program.
	Preferred brand drugs	8% coinsurance at Giant or Safeway pharmacies; 13% coinsurance at other network pharmacies, provided there is no generic equivalent	Not covered at out-of-network pharmacies. Rite Aid, Walmart, Walgreens and CVS are not in the network.	
	Specialty drugs	8% coinsurance	Not covered at out-of-network pharmacies. Rite Aid, Walmart, Walgreens and CVS are not in the network.	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance	20% coinsurance, plus balance-billed charges	Preauthorization through Conifer is required or benefits are not covered.
	Physician/surgeon fees	20% coinsurance	20% coinsurance, plus balance-billed charges	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 immediate medical attention	Emergency room care	$75 copay per visit, plus 20% coinsurance	$75 copay per visit, plus 20% coinsurance	Professional/physician charges may be billed separately. Copay waived if admitted.
	Emergency medical transportation	The lesser of 20% coinsurance or 100% after plan pays first $200.	The lesser of 20% coinsurance or 100% after plan pays first $200. Includes balance-billing charges except on air ambulance services	None
	Urgent care	20% coinsurance	20% coinsurance, plus balance-billed charges	None
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance	20% coinsurance, plus balance-billed charges	Preauthorization through Conifer is required or benefits are not covered. Authorization is required within 24 hours of an emergency admission or benefits are not covered.
	Physician/surgeon fees	20% coinsurance	20% coinsurance, plus balance-billed charges	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	20% coinsurance	20% coinsurance, plus balance-billed charges	None
	Inpatient services	20% coinsurance	20% coinsurance, plus balance-billed charges	Preauthorization through Carelon Health Services is required or benefits are not covered. Authorization is required within 24 hours of an emergency admission or benefits are not covered
If you are pregnant	Office visits	20% coinsurance	20% coinsurance, plus balance-billed charges	Cost sharing does not apply for ACA-required preventive screenings. Depending on the type of services, coinsurance and/or a deductible may apply. Maternity care may include tests and services described somewhere else in the SBC (e.g., ultrasound). 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	20% coinsurance	20% coinsurance, plus balance-billed charges	
	Childbirth/delivery facility services	20% coinsurance	20% coinsurance, plus balance-billed charges	

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	20% coinsurance	20% coinsurance, plus balance-billed charges	Preauthorization through Conifer is required or benefits are not covered.
	Rehabilitation services	20% coinsurance	20% coinsurance, plus balance-billed charges	Preauthorization through Conifer is required or benefits are not covered. Limit: 30 inpatient days/60 outpatient visits per year. Cardiac rehabilitation limited to 90 days per year.
	Habilitation services	Not covered	Not covered	You must pay 100% of these expenses, even in-network.
	Skilled nursing care	20% coinsurance	20% coinsurance, plus balance-billed charges	None
	Durable medical equipment	20% coinsurance	20% coinsurance, plus balance-billed charges	Preauthorization through Conifer is required or benefits are not covered. Rental benefit limited to purchase price.
	Hospice services	20% coinsurance	20% coinsurance, plus balance-billed charges	Preauthorization through Conifer is required or benefits are not covered. Must have life expectancy of six (6) months or less.
If your child needs dental or eye care	Children's eye exam	No charge	Not covered	Limit: One (1) exam every two (2) years. Vision benefits are provided through Superior Vision and are insured.
	Children's glasses	No charge	Not covered	Limit: One (1) pair every two (2) years; limited to certain frames. Vision benefits are provided through Superior Vision and are insured.
	Children's dental check-up	No charge	Reimbursed up to the amount of in-network covered charges in certain limited circumstances	Limit: One (1) exam every six (6) months. Not covered for children under age four (4). Dental benefits are provided through Dentegra and are insured.

* To the extent required under the federal No Surprises Act, out-of-network provider services will be covered at the copay and coinsurance rates applicable to in-network provider services, and balance billing will not apply.

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.)		
• Acupuncture • Habilitation services • Hearing aids	• Infertility treatment • Long-term care • Non-emergency care when traveling outside the U.S.	• Routine foot care • Weight loss programs (except as required by the Affordable Care Act)

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)		
• Bariatric surgery • Chiropractic care (limited to $1,000 per person per year)	• Cosmetic surgery (limited to reconstructive surgery following mastectomy or resulting from traumatic injury) • Dental care (Adult) (to plan limits)	• Private-duty nursing • Routine eye care (Adult)(to plan limits)

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 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 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 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 plan at 1-800-638-2972. You may also contact the Department of Labor's Employee Benefits Security Administration at 1-866-444-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 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	**$12,700**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$300
Copayments	$0
Coinsurance	$2,380
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$2,740**

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	**$5,600**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$300
Copayments	$0
Coinsurance	$570
What isn't covered	
Limits or exclusions	$0
The total Joe would pay is	**$870**

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	**$2,800**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$300
Copayments	$80
Coinsurance	$480
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$860**

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