UFCW Local 1500 AFL-CIO, CLC

WELFARE & PENSION FUNDS

425 MERRICK AVENUE, WESTBURY, NY 11590
TEL: 516-214-1300

December 21, 2020

RE: Summary of Benefit and Coverages ("SBC") & Summary of Material Modification ("SMM")

Dear Plan Participant & Eligible Dependents (where applicable):

Enclosed you will find the Summary of Benefits and Coverage ("SBC") and a Summary of Material Modification ("SMM") for the UFCW Local 1500 Welfare Fund.

Affordable Care Act (ACA) Requirements for SBCs

The SBC provides a general description of the health benefits provided by the UFCW Local 1500 Welfare Fund. SBCs are required to be sent to you according to the Patient Protection and Affordable Care Act (ACA).

The SBC is designed so that individuals can compare their benefit coverage with other plans available on the insurance marketplace (otherwise known as the "exchange"), and the premium associated with certain coverage. Your health coverage is provided based on a Collective Bargaining Agreement between your employer(s) and the UFCW Local 1500.

Included in the SBC are three examples regarding the costs associated with certain common medical events: having a baby, managing type 2 diabetes, and healing a bone fracture. The examples show the health care costs that you incur and what the Fund will cover. **As you read these examples, it is very important to note that the charges for these medical events are based upon national averages and do not reflect what the actual services may cost in your area.** Similarly, your course of treatment might also be very different depending on your doctor's approach, your age, your other health issues, and many other factors. These examples are included to help you compare how different health plans might cover the same condition—not for predicting your own actual health care expenses.

You may find that the SBC uses terminology that may seem unfamiliar to you. The SBC refers to a "Glossary of Health Coverage and Medical Terms" (The Glossary), which cannot be customized for our Fund. Therefore, we recommend that you refer to your SPD and the other materials describing your benefits that you have received from the Fund if you do not understand some of the terms in the Glossary.

Summary of Material Modification ("SMM")

The SMM advises you of benefit improvements to the Plan. The SMM addresses the increase in reimbursements for dental and optical (vision) benefits for services rendered on or after March 1, 2021. You are urged to read the SMM and keep it with your Summary Plan Description for future reference.

For More Information

If you have any questions about your coverage, please call Associated Administrators, LLC at (855) 266-1500.

Sincerely,

The Board of Trustees

UFCW Local 1500 Welfare Fund: Part-Time ACA Plan

Coverage for: Individual + Spouse* | Plan Type: EPO

***This Plan covers Employees only. Spouses are covered for Dental and Vision benefits only.**

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, 1-800-522-0456. 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.associated-admin.com or call 1-800-522-0456 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	$5,600/per calendar year.	The Fund pays the 1st $400 @ 100% of the Anthem allowance for all eligible expenses, then **deductible** is applied. Generally, you must pay all of the costs from **providers** up to the **deductible** amount before this **plan** begins to pay.
Are there services covered before you meet your deductible?	Yes. **Preventive** care and the 1st $400 @ 100% of the Anthem allowance for all eligible expenses	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?	For Medical Benefits $5,600, for Prescription Drug Benefits $1,000	The **out-of-pocket limit** is the most you could pay in a year for covered services.
What is not included in the out-of-pocket limit?	**Copayments** on certain services, **premiums**, **balance-billing** charges, and 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.anthem.com or call 1-800-810-BLUE for a list of **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 (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	No charge	Not Covered	None
	Specialist visit	No charge	Not Covered	None
	Preventive care/screening/ immunization	No charge. **Deductible** does not apply	Not Covered	None
If you have a test	Diagnostic test (x-ray, blood work)	No Charge	Not Covered	None
	Imaging (CT/PET scans, MRIs)	No Charge	Not Covered	**Preauthorization** required. Failure may result in a denial or penalty of 50% up to $500
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	Retail: $20 Mail: $40	Not Covered	Retail limited to 34-day supply; mail order limited to 90 day supply. If you can obtain a brand name medication when a generic equivalent is available, you pay the generic **coinsurance** plus the difference between the cost of the brand name drug and the generic. Utilization Management Program in effect. **Preauthorization** required for some drugs. Failure to do so may result in a denial of benefits. For more information contact Express Scripts at 1-877-861-8145
	Preferred brand drugs	Retail: $30 Mail: $60	Not Covered	
	Non-preferred brand drugs	Retail: $60 Mail: $120	Not Covered	
	Specialty drugs	Same as non-preferred	Not Covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	No Charge	Not Covered	**Preauthorization** required for certain services. Failure may result in a denial or penalty of 50% up to $500
	Physician/surgeon fees	No Charge	Not Covered	
If you need immediate medical attention	Emergency room care	$100 **copayment**	$100 **copayment** and balance between charge and **In-network rate**	**Copayment** waived if admitted. Limited to initial visit for **Emergency Medical Conditions** as defined by the Summary Plan Description
	Emergency medical transportation	No Charge	Balance between charge **and In-network rate**	If air ambulance, condition must warrant air ambulance services
	Urgent care	No Charge	Not Covered	None
If you have a hospital stay	Facility fee (e.g., hospital room)	No Charge	Not Covered – except in emergencies. Balance between charge **and In-network rate**	**Preauthorization** required. Failure may result in a denial or penalty of 50% up to $500. Semi-private room and board allowed only

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)	
	Physician/surgeon fees	No Charge	Not Covered	**Preauthorization** required for certain services. Failure may result in a denial or penalty of 50% up to $500
If you need mental health, behavioral health, or substance abuse services	Outpatient services	No Charge	Not Covered	None
	Inpatient services	No Charge	Not Covered	**Preauthorization** required. Failure may result in a denial or penalty of 50% up to $500. Semi-private room and board allowed only
If you are pregnant	Office visits	No Charge	Not Covered	Cost sharing does not apply to certain preventive services. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound)
	Childbirth/delivery professional services	No Charge	Not Covered	
	Childbirth/delivery facility services	No Charge	Not Covered	**Preauthorization** should be obtained within first 3 months of pregnancy, but not required
If you need help recovering or have other special health needs	Home health care	No Charge	Not Covered	200 visits/year. 40 visits/year without prior hospitalization not to exceed 200 visit/year combined maximum. **Preauthorization** required. Failure may result in a denial or penalty of 50% up to $500
	Rehabilitation services	No Charge	Not Covered	30 visits/year for each service. **Preauthorization** required. Failure may result in a denial or penalty of 50% up to $500
	Habilitation services	No Charge	Not Covered	
	Skilled nursing care	No Charge	Not Covered	60 days/year. **Preauthorization** required. Failure may result in a denial or penalty of 50% up to $500
	Durable medical equipment	No Charge	Not Covered	**Preauthorization** required. Failure may result in a denial or penalty of 50% up to $500
	Hospice services	No Charge	Not Covered	210 days/lifetime. **Preauthorization** required. Failure may result in a denial or penalty of 50% up to $500
If your child needs dental or eye care	Children's eye exam	Not covered for children	Not covered for children	
	Children's glasses	Not covered for children	Not covered for children	
	Children's dental check-up	Not covered for children	Not covered for children	

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
- Hearing Aids
- Infertility Treatment
- Long-term care
- No coverage for spouse, except Dental and Vision benefits
- 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 (if prescribed for rehabilitation purposes)
- Bariatric Surgery
- Chiropractic care
- Dental care (Adult)
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing
- 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 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 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 1-800-522-0456. 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.

Language Access Services:
Spanish (Español): Para obtener asistencia en Español, llame al 1-800-522-0456 Ext. 1336

———————————*To see examples of how this plan might cover costs for a sample medical situation, see the next section.*———————————

* For more information about limitations and exceptions, see the plan or policy document at www.associated-admin.com

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	$5,600
Specialist *[cost sharing]*	$0
Hospital (facility) *[cost sharing]*	0%
Other *[cost sharing]*	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	$5,600
Copayments	$60
Coinsurance	$0
What isn't covered	
Limits or exclusions	$10
The total Peg would pay is	**$5,670**

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

The plan's overall deductible	$5,600
Specialist *[cost sharing]*	$0
Hospital (facility) *[cost sharing]*	0%
Other *[cost sharing]*	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	$1,200
Copayments	$800
Coinsurance	$0
What isn't covered	
Limits or exclusions	$70
The total Joe would pay is	**$2,070**

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

The plan's overall deductible	$5,600
Specialist *[cost sharing]*	$0
Hospital (facility) *[cost sharing]*	0%
Other *[cost sharing]*	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	$2,400
Copayments	$10
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$2,410**

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