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**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

\*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](http://www.associated-admin.com) or call 1-800-522-0456 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall <u>deductible</u> ?	<u>In-Network</u> : \$300/person; <u>Out-of-Network</u> : \$750/person; per calendar year	Generally, you must pay all of the costs from <u>providers</u> up to the <u>deductible</u> amount before this <u>plan</u> begins to pay.
Are there services covered before you meet your <u>deductible</u> ?	Yes <u>In-Network Preventive</u> care	For example, this <u>plan</u> covers certain <u>preventive services</u> without <u>cost-sharing</u> and before you meet your <u>deductible</u> . See a list of covered <u>preventive services</u> at <a href="https://www.healthcare.gov/coverage/preventive-care-benefits/">https://www.healthcare.gov/coverage/preventive-care-benefits/</a> .
Are there other <u>deductibles</u> for specific services?	No	You don't have to meet <u>deductibles</u> for specific services.
What is the <u>out-of-pocket limit</u> for this <u>plan</u> ?	<u>In-Network</u> : Medical: \$5,600. Rx: \$1,000. <u>Out-of-Network</u> : Medical: \$5,600; Rx: \$1,000	The <u>out-of-pocket limit</u> is the most you could pay in a year for covered services.
What is not included in the <u>out-of-pocket limit</u> ?	<u>Copayments</u> on certain services, <u>premiums</u> , <u>balance-billing</u> charges, and health care this <u>plan</u> doesn't cover	Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u> .
Will you pay less if you use a <u>network provider</u> ?	Yes. See <a href="http://www.anthem.com">www.anthem.com</a> or call 1-800-810-BLUE for a list of <u>network providers</u>	This plan uses a <u>provider network</u> . You will pay less if you use a <u>provider</u> in the <u>plan's network</u> . You will pay the most if you use an <u>out-of-network provider</u> , and you might receive a bill from a <u>provider</u> for the difference between the <u>provider's</u> charge and what your <u>plan</u> pays ( <u>balance billing</u> ). Be aware your <u>network provider</u> might use an <u>out-of-network provider</u> for some services (such as lab work). Check with your <u>provider</u> before you get services.
Do you need a <u>referral</u> to see a <u>specialist</u> ?	No	You can see the <u>specialist</u> you choose without a <u>referral</u> .



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 Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care <u>provider's office</u> or clinic	Primary care visit to treat an injury or illness	\$25 <u>copayment</u>	40% <u>coinsurance</u> of <u>UCR</u> , then 100% <u>coinsurance</u>	Out-of-network provider/\$60 maximum
	<u>Specialist</u> visit	\$40 <u>copayment</u>	40% <u>coinsurance</u> of <u>UCR</u> , then 100% <u>coinsurance</u>	Out-of-network provider/\$60 maximum
	<u>Preventive care/screening/immunization</u>	No charge. <u>Deductible</u> does not apply	40% <u>coinsurance</u> of <u>UCR</u> , then 100% <u>coinsurance</u>	None
If you have a test	<u>Diagnostic test</u> (x-ray, blood work)	30% <u>coinsurance</u>	40% <u>coinsurance</u> of <u>UCR</u> , then 100% <u>coinsurance</u>	None
	Imaging (CT/PET scans, MRIs)	30% <u>coinsurance</u>	40% <u>coinsurance</u> of <u>UCR</u> , then 100% <u>coinsurance</u>	<u>Preauthorization</u> 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 <u>prescription drug coverage</u> is available at <a href="http://www.Express-Scripts.com">www.Express-Scripts.com</a>	Generic drugs	Retail: 20% up to \$10; Mail: 20% up to \$20	Same as <u>In-network</u> , plus balance billing	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 <u>coinsurance</u> plus the difference between the cost of the brand name drug and the generic. Utilization Management Program in effect.
	Preferred brand drugs	Retail: 20% up to \$25; Mail: 20% up to \$50	Same as <u>In-network</u> , plus <u>balance billing</u>	<u>Preauthorization</u> 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
	Non-preferred brand drugs	Retail: 20% up to \$50; Mail: 20% up to \$100	Same as <u>In-network</u> , plus <u>balance billing</u>	
	<u>Specialty drugs</u>	Retail: 20% up to \$50; Mail: 20% up to \$100	Same as <u>In-network</u> , plus <u>balance billing</u>	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	30% <u>coinsurance</u>	Not covered	<u>Preauthorization</u> required for certain services. Failure may result in a denial or penalty of 50% up to \$500
	Physician/surgeon fees	30% <u>coinsurance</u>	40% <u>coinsurance</u> of <u>UCR</u> , then 100% <u>coinsurance</u>	
If you need immediate medical attention	<u>Emergency room care</u>	\$100 <u>copayment</u>	\$100 <u>copayment</u> and balance between charge and <u>In-network rate</u>	<u>Copayment</u> waived if admitted. Limited to initial visit for <b>Emergency Medical Conditions</b> as defined by the Summary Plan Description
	<u>Emergency medical transportation</u>	30% <u>coinsurance</u>	Same as <u>In-network</u> , plus <u>balance billing</u>	If air ambulance, medical condition must warrant air ambulance services
	<u>Urgent care</u>	\$25 <u>copayment</u>	40% <u>coinsurance</u> of <u>UCR</u> , then 100% <u>coinsurance</u>	Out-of-network provider/\$60 maximum

\* For more information about limitations and exceptions, see the plan or policy document at [www.associated-admin.com](http://www.associated-admin.com)

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you have a hospital stay	Facility fee (e.g., hospital room)	30% <u>coinsurance</u>	Not covered except in emergencies. Emergency: 30% of <u>UCR</u> rate, then 100% <u>coinsurance</u>	<u>Preauthorization</u> required. Failure may result in a denial or penalty of 50% up to \$500. Semi-private room and board allowed only
	Physician/surgeon fees	30% <u>coinsurance</u>	40% <u>coinsurance</u> of <u>UCR</u> , then 100% <u>coinsurance</u>	<u>Preauthorization</u> required for certain services. Failure may result in a denial or penalty of 50% up to \$500
	Outpatient services	\$25 <u>copayment</u>	40% <u>coinsurance</u> of <u>UCR</u> , then 100% <u>coinsurance</u>	None
If you need mental health, behavioral health, or substance abuse services	Inpatient services	30% <u>coinsurance</u>	Not covered except in emergencies. Emergency: 30% <u>coinsurance</u> up to <u>allowed</u> amount, then 100% <u>coinsurance</u>	<u>Preauthorization</u> required. Failure may result in a denial or penalty of 50% up to \$500. Semi-private room and board allowed only
	Office visits	\$25 <u>copayment</u>	40% <u>coinsurance</u> of <u>UCR</u> , then 100% <u>coinsurance</u>	Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound). Out-of-network provider/\$60 maximum
If you are pregnant	Childbirth/delivery professional services	30% <u>coinsurance</u>	40% <u>coinsurance</u> of <u>UCR</u> , then 100% <u>coinsurance</u>	None
	Childbirth/delivery facility services	30% <u>coinsurance</u>	Not covered	<u>Preauthorization</u> should be obtained within first 3 months of pregnancy, but not required
	<u>Home health care</u>	30% <u>coinsurance</u>	40% <u>coinsurance</u> of <u>UCR</u> , then 100% <u>coinsurance</u>	In-Network – 200 visits/year. Out-of-Network – 40 visits/year. <u>Preauthorization</u> required. Failure may result in a denial or penalty of 50% up to \$500
If you need help recovering or have other special health needs	<u>Rehabilitation services</u>	30% <u>coinsurance</u>	40% <u>coinsurance</u> of <u>UCR</u> , then 100% <u>coinsurance</u>	30 visits/year for each service. Includes physical, speech, occupational and orthoptic therapies. Out-of-network provider/\$60 maximum.
	<u>Habilitation services</u>	30% <u>coinsurance</u>	40% <u>coinsurance</u> of <u>UCR</u> , then 100% <u>coinsurance</u>	<u>Preauthorization</u> required. Failure may result in a denial or penalty of 50% up to \$500
	<u>Skilled nursing care</u>	30% <u>coinsurance</u>	Not covered	60 days/year. <u>Preauthorization</u> required. Failure may result in a denial or penalty of 50% up to \$500
	<u>Durable medical equipment</u>	30% <u>coinsurance</u>	40% <u>coinsurance</u> of <u>UCR</u> , then 100% <u>coinsurance</u>	<u>Preauthorization</u> required. Failure may result in a denial or penalty of 50% up to \$500
	<u>Hospice services</u>	30% <u>coinsurance</u>	Not covered	210 days per lifetime. <u>Preauthorization</u> required. Failure may result in a denial or penalty of 50% up to \$500

\* For more information about limitations and exceptions, see the plan or policy document at [www.associated-admin.com](http://www.associated-admin.com)



Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If your child needs dental or eye care	Children's eye exam	Not covered for children	Not covered for children	
	Children's glasses			
	Children's dental check-up			

**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.)**

• Bariatric Surgery	• Infertility Treatment	• Routine foot care
• Cosmetic Surgery	• Long-term care	• Weight loss programs
• Hearing Aids	• Private Duty Nursing	

**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)	• Dental Care (Adult)	• Routine eye care (Adult)
• Chiropractic care	• Non-emergency care when traveling outside the U.S.	

**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](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 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](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 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](http://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](#) \$300
- [Specialist \[copayment\]](#) \$40
- [Hospital \(facility\) \[cost sharing\]](#) 30%
- [Other \[cost sharing\]](#) 30%

**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	\$10
Coinsurance	\$3,700
<i>What isn't covered</i>	
Limits or exclusions	\$0
<b>The total Peg would pay is</b>	<b>\$4,110</b>

**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 \[copayment\]](#) \$40
- [Hospital \(facility\) \[cost sharing\]](#) 30%
- [Other \[cost sharing\]](#) 30%

**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	\$700
Coinsurance	\$130
<i>What isn't covered</i>	
Limits or exclusions	\$40
<b>The total Joe would pay is</b>	<b>\$1,170</b>

**Mia's Simple Fracture**

(in-network emergency room visit and follow up care)

- The [plan's overall deductible](#) \$300
- [Specialist \[copayment\]](#) \$40
- [Hospital \(facility\) \[cost sharing\]](#) 30%
- [Other \[cost sharing\]](#) 30%

**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	\$200
Coinsurance	\$600
<i>What isn't covered</i>	
Limits or exclusions	\$0
<b>The total Mia would pay is</b>	<b>\$1,100</b>

The [plan](#) would be responsible for the other costs of these EXAMPLE covered services.