


Summary of Benefits and Coverage:


What this Plan Covers & What You Pay For Covered Services

Coverage for: Family Plan Type: **Prescription, Dental and Vision**

 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, call the Fund office at (833) 228-9212. 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](http://www.dol.gov/ebsa/healthreform) or call (833) 228-9212 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall <u>deductible</u> ?	\$ 0	See the Common Medical Events chart below for your costs for services this <u>plan</u> covers.
Are there services covered before you meet your <u>deductible</u> ?	Yes. Prescription drugs, dental and vision.	This <u>plan</u> covers some items and services even if you haven't yet met the <u>deductible</u> amount. But a <u>copayment</u> or <u>coinsurance</u> may apply.
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> ?	\$1,600 per year for single \$3,200 per year for family	
What is not included in the <u>out-of-pocket limit</u> ?		
Will you pay less if you use a <u>network provider</u> ?	Yes. Call (833) 228-9212 for name of mail order pharmacy	This <u>plan</u> uses a mandatory <u>mail order pharmacy</u> for all maintenance drugs.
Do you need a <u>referral</u> to see a <u>specialist</u> ?	No	You can see the <u>specialist</u> you chose you chose without a <u>referral</u> .

**NOTE: THIS SUMMARY COVERS ONLY YOUR PRESCRIPTION, DENTAL AND VISION BENEFITS. YOU MIGHT RECEIVE A SEPARATE SUMMARY OF BENEFITS AND COVERAGE FROM YOUR EMPLOYER DESCRIBING YOUR MAJOR MEDICAL BENEFITS.**

 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 <a href="#">provider's</a> office or clinic	Primary care visit to treat an injury or illness	Not Covered	Not Covered	---none---
	<a href="#">Specialist</a> visit	Not Covered	Not Covered	---none---
	<a href="#">Preventive care/screening/immunization</a>	Not Covered	Not Covered	---none---
If you have a test	<a href="#">Diagnostic test</a> (x-ray, blood work)	Not Covered	Not Covered	---none---
	Imaging (CT/PET scans, MRIs)	Not Covered	Not Covered	---none---
If you need drugs to treat your illness or condition More information about <a href="#">prescription drug coverage</a> is available. Call (833) 228-9212.	Generic drugs	\$5.00 copay/prescription for 30-day retail or 90-day mail order supply	N/A	The Trustees have adopted the exclusions and limitations on prescription drugs recommended by BeneCard. If you would like to see a list of these exclusions, please call the Fund office at 833-228-9212.
	Brand drugs	N/A	N/A	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	Not Covered	Not Covered	---none---
	Physician/surgeon fees	Not Covered	Not Covered	---none---
If you need immediate medical attention	<a href="#">Emergency room care</a>	Not Covered	Not Covered	---none---
	<a href="#">Emergency medical transportation</a>	Not Covered	Not Covered	---none---
	<a href="#">Urgent care</a>	Not Covered	Not Covered	---none---
If you have a hospital stay	Facility fee (e.g., hospital room)	Not Covered	Not Covered	---none---
	Physician/surgeon fees	Not Covered	Not Covered	---none---
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Not Covered	Not Covered	---none---
	Inpatient services	Not Covered	Not Covered	---none---
If you are pregnant	Office visits	Not Covered	Not Covered	---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)	
	Childbirth/delivery professional services	Not Covered	Not Covered	---none---
	Childbirth/delivery facility services	Not Covered	Not Covered	---none---
<b>If you need help recovering or have other special health needs</b>	<a href="#">Home health care</a>	Not Covered	Not Covered	---none---
	<a href="#">Rehabilitation services</a>	Not Covered	Not Covered	---none---
	<a href="#">Habilitation services</a>	Not Covered	Not Covered	---none---
	<a href="#">Skilled nursing care</a>	Not Covered	Not Covered	---none---
	<a href="#">Durable medical equipment</a>	Not Covered	Not Covered	---none---
	<a href="#">Hospice services</a>	Not Covered	Not Covered	---none---
<b>If your child needs dental or eye care</b>	Children's eye exam	1 exam	Reimbursed up to \$35	Coverage limited to one exam/calendar year.
	Children's glasses	Lenses fully covered. Frames: reimbursed up to \$60.	Lenses: reimbursed up to \$30-\$80 depending on type of lens. Frames: reimbursed up to \$40.	Coverage limited to frames and lenses once every calendar year. Contact lenses (cosmetic): \$175 allowance.
	Children's dental check-up	Diagnostic, preventive, restorative, periodontics and other services	Reimbursement based on total allowed charge for service. Provider may balance bill.	Orthodontia: \$1,500 individual lifetime maximum benefit.

**Excluded Services & Other Covered Services:**

<b>Services Your <a href="#">Plan</a> Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other <a href="#">excluded services</a>.)</b>		
<ul style="list-style-type: none"> <li>• Acupuncture</li> <li>• Bariatric Surgery</li> <li>• Chiropractic care</li> <li>• Cosmetic surgery</li> </ul>	<ul style="list-style-type: none"> <li>• Hearing aids</li> <li>• Infertility treatment</li> <li>• Long-term care</li> <li>• Non-emergency care when traveling outside the U.S.</li> </ul>	<ul style="list-style-type: none"> <li>• Private-duty nursing</li> <li>• Routine foot care</li> <li>• Weight loss programs</li> </ul>
<b>Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your <a href="#">plan</a> document.)</b>		
<ul style="list-style-type: none"> <li>• Dental care (adult)</li> </ul>	<ul style="list-style-type: none"> <li>• Routine eye care (adult)</li> </ul>	<ul style="list-style-type: none"> <li>•</li> </ul>

**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, 1-866-444-EBSA (3272) or [www.dol.gov/ebsa/healthreform](http://www.dol.gov/ebsa/healthreform), or you may contact

the Fund at (833) 228-9212. 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: U.S. Department of Labor, Employee Benefits Security Administration, 1-866-444-EBSA (3272) or [www.dol.gov/ebsa/healthreform](http://www.dol.gov/ebsa/healthreform), or you may contact the Fund at (833) 228-9212.

**Does this plan provide Minimum Essential Coverage? Yes**

If you don't have [Minimum Essential Coverage](#) for a month, you'll 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.

**Does this plan meet the Minimum Value Standards? No**

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.*—————

**\*Although coverage provided by the School Cafeteria Employees UNITE HERE Local No. 634 Health & Welfare Fund does not meet the Minimum Value Standard, your employer-provided major medical coverage and the prescription drug coverage under this Fund, *taken together*, might meet the minimum value standard.**

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
- [Specialist](#) Not covered
- Hospital (facility) Not covered
- Prescription copayment \$5.00

**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*)

<b>Total Example Cost</b>	<b>\$12,800</b>
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In this example, Peg would pay:

<i>Cost Sharing</i>	
Deductibles	\$0
Copayments	\$0
Coinsurance	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$12,800
<b>The total Peg would pay is</b>	<b>\$12,800</b>

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

- The [plan's](#) overall [deductible](#) \$0
- [Specialist](#) Not covered
- Hospital (facility) Not covered
- Prescription copayment \$5.00

**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*)

<b>Total Example Cost</b>	<b>\$7,400</b>
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In this example, Joe would pay:

<i>Cost Sharing</i>	
Deductibles	\$0
Copayments	\$60
Coinsurance	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$7,340
<b>The total Joe would pay is</b>	<b>\$7,340</b>

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

- The [plan's](#) overall [deductible](#) \$0
- [Specialist](#) Not covered
- Hospital (facility) Not covered
- Prescription copayment \$5.00

**This EXAMPLE event includes services like:**  
 Emergency room care (*including medical supplies*)  
 Diagnostic test (*x-ray*)  
 Durable medical equipment (*crutches*)  
 Rehabilitation services (*physical therapy*)

<b>Total Example Cost</b>	<b>\$1,900</b>
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In this example, Mia would pay:

<i>Cost Sharing</i>	
Deductibles	\$0
Copayments	\$0
Coinsurance	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$1,900
<b>The total Mia would pay is</b>	<b>\$1,900</b>