UFCW LOCAL 1262 AND
SHOPRITE WELFARE FUND
1389 BROAD STREET, CLIFTON, N.J. 07013

ADMINISTRATOR
FRANK M. VACCARO

Cover letter for Summary of Benefits and Coverage (SBC)

The Fund is required by the Affordable Care Act (ACA) to distribute this SBC to participants. The SBC provides the following information:

- Answers to Important Questions about plan coverage; summary information concerning your available medical and prescription coverage, as well as a brief overview of dental and vision coverage for eligible dependent children
- Excluded services and other covered services
- Your Rights to Continue Coverage and Your Grievance and Appeals Rights
- Whether your Plan provides Minimum Essential Coverage that satisfies your obligation under the ACA's individual responsibility requirement and whether your Plan provides a level of benefits the ACA refers to as minimum value
- Disclosure of Grandfathered Status if your plan is grandfathered
- Language Access Services
- Coverage Examples and link to a Uniform Glossary

Please share this SBC with your family members who are eligible for health coverage under the Fund.

Note:
Receipt of this document is not a guarantee of coverage or eligibility for coverage under the Fund. Refer to your Summary Plan Description and any subsequent Summaries of Material Modifications for a more complete description of your Plan and its eligibility rules.

TTY: 711

The Trustees encourage participants with a hearing or speech disability to utilize 711 dialing services (wherever you are) when contacting the Fund Office.

Use your TTY (Text Telephone) or dial 711 on your telephone and you will be connected to an operator. Provide the operator with the Fund Office's telephone number 1-800-522-4161 and they will relay your call.

Just dial 711. It's fast, functional and free. For more information, please contact the Fund for a User Guide.

For More Information

If you have any questions regarding coverage provided by the Fund:
Call the Fund at 1-800-522-4161

You can view the Uniform Glossary at:
www.dol.gov/ebsa/healthreform or www.cciio.cms.gov
or call the Fund Office to request a copy

Carta de Presentación para el Sumario de Beneficios y Cobertura (SBC)

El Fondo es requerido por la Ley de Cuidado de Salud Asequible (ACA) a distribuir este SBC a los participantes. El SBC proporciona la siguiente información:

- Respuestas a Preguntas Importantes sobre la cobertura del plan; información sumaria sobre su cobertura médica y recetas disponible, así como una breve descripción de la cobertura dental y vision para los niños dependientes elegibles
- Servicios excluidos y otros servicios cubiertos
- Sus Derechos a Continuar la Cobertura y Su Agravio y Derechos de Apelación
- Si su Plan proporciona Cobertura Esencial Mínima que satisface su obligación bajo la ACA de requisito de la responsabilidad individual y si su Plan ofrece un nivel de beneficios que el ACA se refiere a un valor mínimo o no
- Divulgación del Plan de Salud Extento si su plan es un Plan de Salud Extento
- Servicios de Acesso a Idiomas
- Ejemplos de Cobertura y enlace a un Glosario Uniforme

Por favor comparta este SBC con los miembros de su familia quienes son elegibles para la cobertura de salud bajo el Fondo.

Nota:
Recibir a este documento no es una garantía de cobertura o eligibilidad para cobertura bajo el Fondo. Consulte su Descripción Resumida del Plan y cualquier Sumarios de Modificaciones Materiales subsecuente para una descripción más completa de su Plan y las reglas de elegibilidad.

TTY:711

Los Comisarios inviten a los participantes con dificultades de audición o de hablar utilizar a los servicios de llamada de 711 (su locación no importa) cuando se llama a la oficina del Fondo.

Utiliza su TdeT (teléfono de texto) o marquee 711 sobre su teléfono y usted hablará con una operadora. Da a la operadora el número de teléfono de la oficina del Fondo 1-800-522-4161 y ella dirigirá su llamada.

Simplemente marque al 711. Es rápido, funcional y gratis. Si necesita más información, pongase en contacto con el Fondo para una guía del uso.

Para Más Información

Si tiene pregunta cualquiera sobre la cobertura proporcionada por el Fondo:
Llame al Fondo a 1-800-522-4161

Puede ver el Glosario Uniforme en:
www.dol.gov/ebsa/healthreform or www.cciio.cms.gov
o llame a la oficina del Fondo para solicitar una copia

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 1-800-522-4161 (TTY: 711). 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 1-800-522-4161 (TTY: 711) to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	Calendar Year: $2,000/Individual or $4,000/Child(ren) (where eligible for dependent child coverage)	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. Preventive care, prescription drug coverage, emergency room care and in-network dental and vision care are 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 https://www.healthcare.gov/coverage/preventive-care-benefits/.
Are there other deductibles for specific services?	Yes. Out-of-network Dental: $15/individual or $30/Child(ren) (where eligible). There are no other specific deductibles.	You must pay all of the costs for these services up to the specific deductible amount before this plan begins to pay for these services.
What is the out-of-pocket limit for this plan?	$8,550 individual (Medical - $7,695 & prescription drug coverage - $855)/$17,100 Child(ren) (where eligible) ($15,390 & $1,710)	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, vision and dental charges, penalties for failure to obtain preauthorization 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.HorizonBlue.com (call 1-800-355-BLUE [2583]) or call 1-800-522-4161 (TTY: 711) for a list of network providers.	This plan uses a provider network and there is no coverage for out-of-network providers in most instances. 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 anesthesia and 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 copay/office visit	Not covered	Deductible applies.
	Specialist visit	$40 copay/office visit ($20 copay/maternity visit)	Not covered	Deductible applies.
	Preventive care/screening/ immunization	No charge	Covered up to allowance if no provider within 50 miles.	You may have to pay for services that aren't preventive. Ask your provider if the services you need are preventive. Then check what your plan will pay for. Age and frequency limits may apply.
If you have a test	Diagnostic test (x-ray, blood work)	No charge	Not covered	None
	Imaging (CT/PET scans, MRIs)	30% coinsurance	Not covered	Deductible applies. Preauthorization is required.
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	$5 copay/prescription (retail) & $10 copay/ prescription (mail order)	Not covered	Covers up to a 34-day supply/100 pills (retail); 90-day supply of maintenance medications (mail order or mail at retail).
	Preferred brand drugs	$15 copay/prescription (retail) & $30 copay/ prescription (mail order)	Not covered	
	Non-preferred brand drugs	$30 copay/prescription (retail) & $60 copay/ prescription (mail order)	Not covered	
	Specialty drugs	$5/$15/$30 copays (retail)	Not covered	Covers up to a 34-day supply/100 pills. Preauthorization is required.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	30% coinsurance	Not covered	Deductible applies. Preauthorization is required.
	Physician/surgeon fees	30% coinsurance	Not covered	Deductible applies. Preauthorization is required.

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	$500 copay/visit (waived if admitted)	$500 copay/visit (waived if admitted)	You are responsible for out-of-network charges exceeding the Plan's maximum allowed amount. No coverage for non-emergencies.
	Emergency medical transportation	No charge	No charge	
	Urgent care	$50 copay/visit	Not covered	Deductible applies.
If you have a hospital stay	Facility fee (e.g., hospital room)	$250 copay + 30% coinsurance	Not covered	Deductible applies. Preauthorization is required.
	Physician/surgeon fees	30% coinsurance	Not covered	Deductible applies. Preauthorization is required.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$20 copay/ office visit (other services + 30% coinsurance)	Not covered	Deductible applies. Contact Beacon Health Options (1-800-843-5503) to ensure that all services are covered.
	Inpatient services	$250 copay + 30% coinsurance	Not covered	Deductible applies. Preauthorization is required for inpatient services.
If you are pregnant	Office visits	$20 copay/initial visit (to confirm pregnancy)	Not covered	Deductible applies. No charge after 1st visit.
	Childbirth/delivery professional services	30% coinsurance	Not covered	Deductible applies.
	Childbirth/delivery facility services	$250 copay + 30% coinsurance	Not covered	Deductible applies.
If you need help recovering or have other special health needs	Home health care	$40 copay/visit + 30% coinsurance	Not covered	Deductible applies. Services limited to 60 visits per yr. (each visit – 2 hours / maximum of 16 hours per day). Preauthorization is required.
	Rehabilitation services	Inpatient facility: $250 copay + 30% coinsurance Outpatient facility: 30% coinsurance $40 copay/ office visit (also applies for short term therapies)	Not covered	Deductible applies. Limited to 90 days/visits for all therapies combined and for inpatient and outpatient services combined per year. Failure to obtain required preauthorization for outpatient hospital may result in a claim denial.

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)	
	Habilitation services	30% coinsurance	Not covered	Deductible applies. Preauthorization is required.
	Skilled nursing care	30% coinsurance	Not covered	Deductible applies. Covered only if prior hospitalization and limited to 90 days per yr. Failure to obtain required preauthorization may result in a claim denial.
	Durable medical equipment	30% coinsurance	Not covered	Deductible applies. Preauthorization required. All rentals or purchases must be through an in-network Horizon Care @ Home provider.
	Hospice services	30% coinsurance	Not covered	Deductible applies. Preauthorization is required. Limit 10 days for respite care.
If your child needs dental or eye care (where eligible)	Children's eye exam	No charge	Approved vision fees	Limited to one exam per calendar year.
	Children's glasses	$10 copay for lenses	Approved vision fees	Limited to one pair of glasses/frames or contact lenses per calendar year.
	Children's dental check-up	No charge	Approved dental fees	Out-of-network deductible applies.

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
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing
- 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 (limited to diagnoses for certain adult post-op dental pain, nausea & vomiting associated chemotherapy or pregnancy) • Bariatric surgery (if medically necessary)	• Chiropractic care (Limited to 20 visits per year for restorative care only.) • Dental care ($2,500 annual maximum – member only)	• Routine eye care

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: 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 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 1-800-522-4161 (TTY: 711). 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 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 [1-800-522-4161 (TTY: 711)].]

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	$2,000
Specialist copayment	$40
Hospital (facility) coinsurance	30%
Other coinsurance	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	$2,000
Copayments	$10
Coinsurance	$2,700
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$4,770**

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

The plan's overall deductible	$2,000
Specialist copayment	$40
Hospital (facility) coinsurance	30%
Other coinsurance	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	$1,800
Copayments	$200
Coinsurance	$0
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$2,020**

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

The plan's overall deductible	$2,000
Specialist copayment	$40
Hospital (facility) coinsurance	30%
Other coinsurance	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	$1,400
Copayments	$400
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,800**

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