2024 OPEN ENROLLMENT

October 2, 2023 - December 1, 2023

Your Guide to Completing 2024 Open Enrollment

Active Health Plan

UCBT Premier Edition

UFCW TRUST
Working For Your Benefit

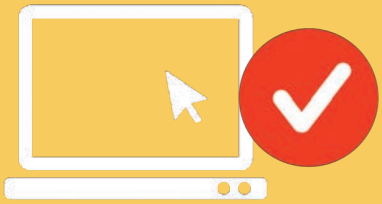
100% Union

2024 OPEN ENROLLMENT

COMPLETE THESE STEPS BY DECEMBER 1, 2023

Dependent Verification

Required to be completed by all Members currently covering a Spouse/Domestic Partner



Enrollment Steps

Required to be completed by all Active Members

Wellness Steps

Required for Wellness Program (HCP) participation in 2024

SCAN ME

Focus your smart device's camera on this image to log in and start your Open Enrollment.

Check your email or postal mail for your personalized Open Enrollment packet.
Log in or create your Participant Account at ufcwtrust.com to enroll online from October 2, 2023 to December 1, 2023.

If you have not already, please create a new account on **ufcwtrust.com** to log in and complete your Open Enrollment. For questions or to complete Open Enrollment over the phone, call (800) 552-2400 Monday through Friday, 8 a.m. to 5 p.m.

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Please read this page before beginning Open Enrollment

REQUIRED

You must complete all required Enrollment Steps to maintain coverage for the 2024 Plan Year (calendar year). If you do not complete Enrollment Steps by December 1, 2023, you and any currently enrolled Dependents will lose coverage effective January 1, 2024. Please review this guide carefully to ensure you understand your benefit options for the 2024 Plan Year.

REQUIRED

You must complete Dependent Verification if you are currently covering a Spouse/Domestic Partner. If you do not complete Dependent Verification by December 1, 2023, your currently enrolled Spouse/Domestic Partner will lose coverage effective January 1, 2024.

REQUIRED FOR WELLNESS PROGRAM

If you wish to participate in the 2024 Plan Year Wellness Program, which is sometimes referred to as "Health Care Partnership" ("HCP"), you and your enrolled Spouse/Domestic Partner must complete ALL Wellness Steps by December 1, 2023. If you have a currently enrolled Spouse/Domestic Partner, they must complete Wellness Steps even if you are disenrolling them from your Plan in 2024.

This guide details how your participation in the Wellness Program will lower your health care costs.

CHOICES

You may choose between the Premier PPO Plan and the Premier HMO Plan. You are also eligible to participate in the Wellness Program (HCP). By participating in the Wellness Program (HCP), your out-of-pockets cost will be less compared to not participating in the Wellness Program (HCP).

Please note, there is only one Premier PPO and one Premier HMO plan of benefits. This guide and other materials from the Trust Fund Office may use the term "HCP" and other related terms to help participants understand the differences associated with participating in the Wellness Program (HCP) versus not participating.

2024 OPEN ENROLLMENT

Participate in the Wellness Program (HCP) to receive HRA funding for the 2024 Plan Year!

Whether you enroll in PPO or HMO, your existing HRA will continue to be available when you complete Open Enrollment.

What is a Health Reimbursement Account?

When you participate in the Wellness Program (HCP), you and your family receive credits into the Health Reimbursement Account (HRA). You can use these HRA credits toward you and your enrolled Dependents' medical and prescription drug expenses that are not paid by the Plan, such as deductibles and copayments. You do not need to pay out-of-pocket for these expenses until the credits in your HRA are exhausted.

As long as you continue to enroll annually in the UCBT health plan, unused HRA credits are carried over into the next calendar year. The Plan will provide additional credits into your HRA each year that you continue to participate in the Wellness Program (HCP). Unlike a regular bank account, you cannot make deposits into your HRA or withdraw funds from it. Your HRA does not earn interest and it cannot be invested.

Health Reimbursement Account Funding

	Blue Shield of California PPO	Kaiser HMO
Wellness Program (HCP) Annual HRA Funding	• Employee Only: +$700 • Employee with Dependent(s): +$1,250	• Employee Only: +$700 • Employee with Dependent(s): +$1,250
Not Participating in the Wellness Program (HCP)	No Annual HRA Funding but any remaining HRA balance may be used.	No Annual HRA Funding but any remaining HRA balance may be used.

What can I use my HRA credits for?	• Your medical deductible • Your medical coinsurance • Your preferred prescription drug co-pays
Wellness Program (HCP) participants also enjoy:	• Reduced out-of-pocket costs • Reduced costs on hospital visits • Reduced costs for doctor visits • Reduced Dependent premiums

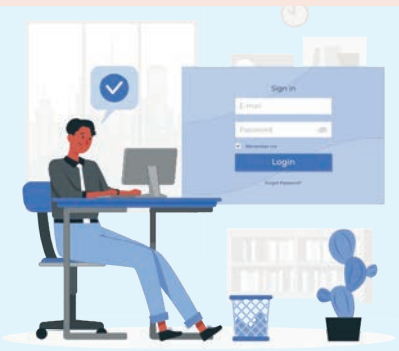
Open Enrollment Checklist

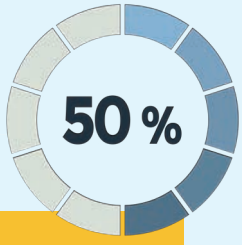
1 Dependent Verification

❑ **Complete Dependent Verification**

If you are currently covering a Spouse/Domestic Partner, upload your most recently filed Tax Return or a Recurring Household Bill as proof of your continued relationship. See page 8 for detailed instructions on completing Dependent Verification and the full Documentation Requirements.

2024 OPEN ENROLLMENT





2 Enrollment Steps

- ❑ **Enrollment Steps**
  Change or Confirm your Carriers and Dependents

- ❑ **Review Preliminary Elections**
  Review your Preliminary Elections Statement for accuracy.

- ❑ **Upload Proof Documents**
  Upload any required proof documents for newly enrolled Dependents. See page 12 for detailed instructions on how to upload documents.

- ❑ **Enrollment Approved**
  Once your Enrollment Steps have been approved, view your final Approved Confirmation Statement.

3 Wellness Steps

(Required for Wellness Program Participation in 2024)

- ❑ **Wellness Health Care Partnership (HCP) Agreement**
  Review and Accept the 2024 Wellness Agreement
  - ❑ Member
  - ❑ Spouse/Domestic Partner (If currently covered)

- ❑ **GINA Authorization**
  Review and Accept the 2024 GINA (Genetic Information Nondiscrimination Act) Authorization.
  - ❑ Spouse Only
    The GINA Authorization must be submitted prior to the Biometric Test results. Without the GINA Authorization the Trust Fund Office cannot process your Spouse's Biometric Tests.

- ❑ **Health Risk Questionnaire (HRQ)**
  Complete a survey about your health.
  - ❑ Member
  - ❑ Spouse/Domestic Partner (If currently covered)

- ❑ **Kaiser HIPAA (If Applicable)**
  Are you currently enrolled in Kaiser, or will be enrolled in Kaiser for 2024? The Kaiser HIPAA Authorization is required for Wellness Plan Participants to receive their HRA credits, and for the Trust Fund Office to receive your Biometric Test Results from Kaiser. See page 19.
  - ❑ Member
  - ❑ Spouse/Domestic Partner (If currently covered)

- ❑ **Biometric Tests**
  Review your Biometric Instructions (PPO or HMO) on page 20 for how to complete your Biometric Screening.
  - ❑ Member
  - ❑ Spouse/Domestic Partner (If currently covered)

- ❑ **Wellness 2024 Participation Approved**
  Wellness Steps for your Family have been reviewed by the Trust Fund Office and approved for participation in the Wellness Program (HCP) for 2024.

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Dependent Verification

Required for all Members currently covering a Spouse/Domestic Partner

If you are currently covering a Spouse/Domestic Partner, you must submit the required documents to the TFO by December 1, 2023, to continue their coverage in 2024.

Funding for your UCBT benefits is not unlimited. To make sure the Plan is providing benefits only to Dependents who meet the Plan's eligibility requirements, the Plan must regularly verify Dependent eligibility. Therefore, you are being asked to provide current proof of your continuous relationship with your Spouse/Domestic Partner.

You must submit one of the following as proof of current relationship:

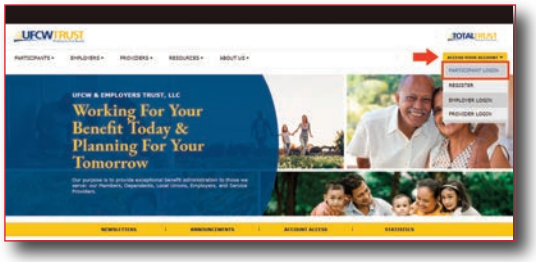
Type of document	Documentation requirements
Tax return	Page 1 of your most recently filed federal tax return with your spouse listed or acknowledgment of your tax extension (Form 4868) (Please cover up financial information)
Recurring household bill	Any of the following documents within the last 60 days. Spouse's name and Member's address must be listed on the document and match with our system. It must be a recurring statement. For privacy, financial information can be covered before sending to the TFO. • Utility Bill: Electric, Gas, Water, Phone, Cable, Internet, Cellular • Mortgage or Rent Statement • Car Payment Statement • Bank Statement • Credit Card Statement

All Members with a currently enrolled Spouse/Domestic Partner must complete Dependent Verification Steps by December 1, 2023. If you do not complete Dependent Verification Steps, coverage for your currently enrolled Spouse/Domestic Partner will terminate on January 1, 2024.

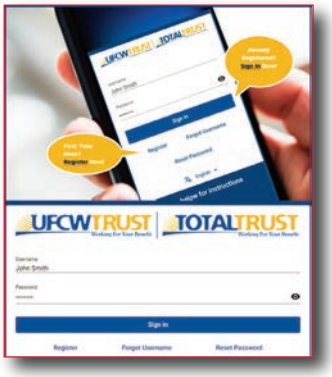
You must complete Dependent Verification even if you do not plan to cover your Spouse/Domestic Partner in Plan Year 2024.

Dependent Verification Step-by-Step Instructions

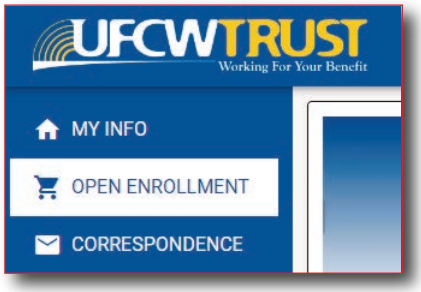
1 Visit **ufcwtrust.com** and select "Participant Login" under "Access Your Account."



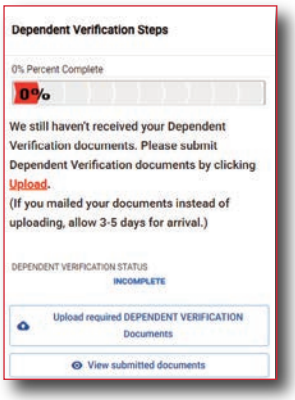
2 Log in or register on the site.



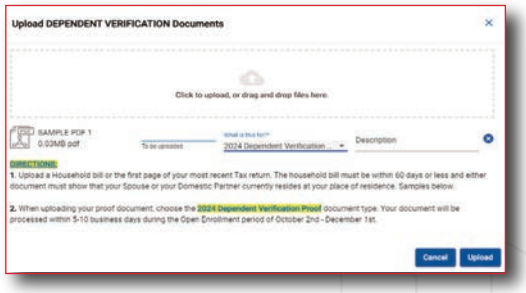
3 Select the "Open Enrollment" tab.



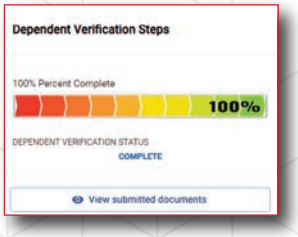
4 The Open Enrollment page displays your Dependent Verification Action Items and progress bar (if applicable). Your progress bar will update automatically once the TFO reviews and approves your submitted documentation (5-7 business days).



5 Select "Upload required DEPENDENT VERIFICATION Documents," and then select the scanned PDF or image from your device. Select "2024 Dependent Verification Proof" for the question "What is this for?" Select "Upload."



6 Your Dependent Verification Status will update to "Complete" once the TFO reviews and approves your submitted documentation (5-7 business days).



You can also submit your Dependent Verification documentation through postal mail, fax, or drop it off in-person to one of our offices:

- **Mail:** PO Box 4100, Concord, CA 94524-4100
- **Fax:** Health & Welfare Services Department at (925) 746-7549
- **Concord Drop Off:** 1000 Burnett Ave, Suite 110, Concord, CA 94520
- **Roseville Drop Off:** 2200 Professional Drive, Suite 200, Roseville, CA 95661

Please allow 5-7 business days for the TFO to review and approve your Dependent Verification.

Enrollment Steps

Required to be completed by all Active Members

Completing Enrollment Steps is **REQUIRED** for benefits coverage during the 2024 Plan Year. You must complete the Enrollment Steps by December 1, 2023.

During the Enrollment process you may change:

- **Your choice of Medical Carrier**
- **Your choice of Dental Carrier**
- **Who you are covering as Enrolled Dependents**
  - **Add new Dependents**
  - **Remove currently enrolled Dependents**

If you are adding new Dependents, you will need to submit the required documents as proof of your relationship with your Dependent. Follow the instructions on **ufcwtrust.com** to log in and upload the necessary documents (shown on page 12).

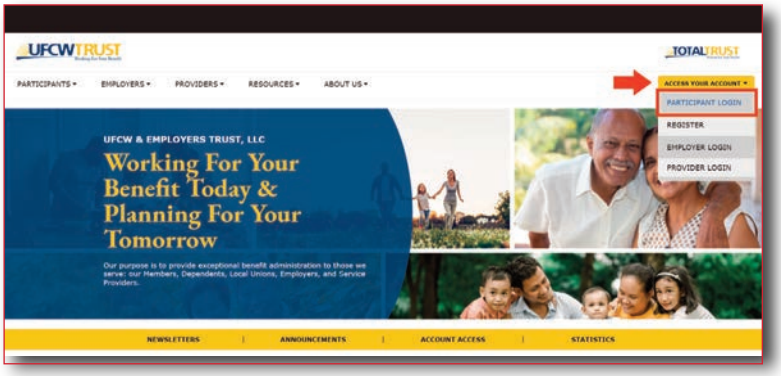
If you enroll by phone, the Trust Fund Office (TFO) will let you know what documents are required to be submitted to finalize your Dependent's enrollment. If the required documents are not received by the TFO by December 1, 2023, your newly added Dependents will not have coverage on January 1, 2024. Follow the instructions to upload the documents online or mail copies of the required documentation before December 1, 2023.

All Active Members must complete Enrollment Steps during the Open Enrollment period. If you do not complete Enrollment Steps by December 1, 2023, you and your enrolled Dependents will lose coverage on January 1, 2024.

If you are an Ultra Plan Member, you are receiving this Premier Plan guide because you are projected to Graduate into the Premier Plan on or before January 1, 2024. This guide reflects the benefits in 2024 that you are expected to be eligible for after your graduation.

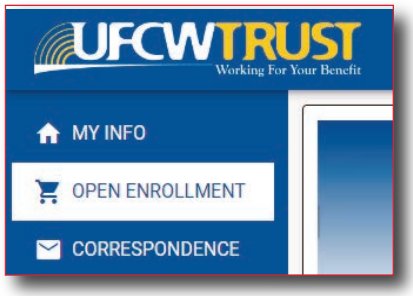
Enrollment Steps
Step-by-Step Instructions

1 Visit **ufcwtrust.com** and select "Participant Login" under "Access Your Account."



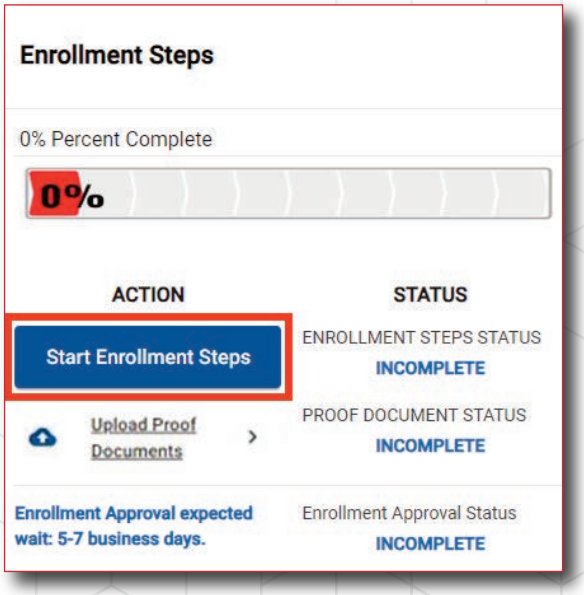
2 Log in or register on the site.

3 Select the "Open Enrollment" tab.



4 The Open Enrollment page displays your Enrollment Steps Action Items and progress bar. Your progress bar will update automatically as you complete Action Items, or once the TFO reviews and approves your submitted documents (5-7 business days).

Select "Start Enrollment Steps," to choose your Carriers and Dependents for Plan Year 2024.



Instructions for Uploading Proof Documents for Newly Added Dependents

If you are enrolling a new Dependent for the 2024 Plan Year, documentation is required to verify the eligibility of the Dependent. To upload, mail, or fax the required Dependent documentation, follow the steps shown below.

5 Select "Upload Proof Documents" to see a list of required documents. Select "Change" next to the document you are uploading and select the scanned PDF or image from your device. Select "Save." Documents you have uploaded will display a received timestamp next to the name.

Your Proof Documents Status, if applicable, will update to "Complete" once the TFO reviews and approves your submitted documentation (5-7 business days).

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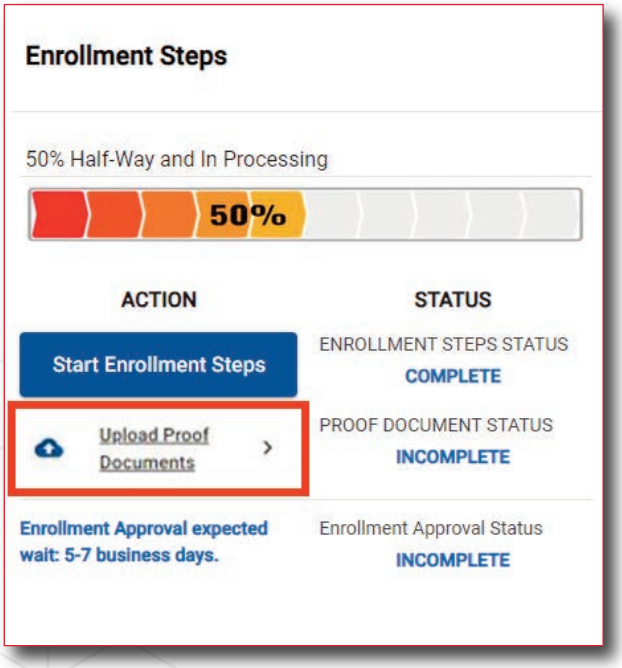

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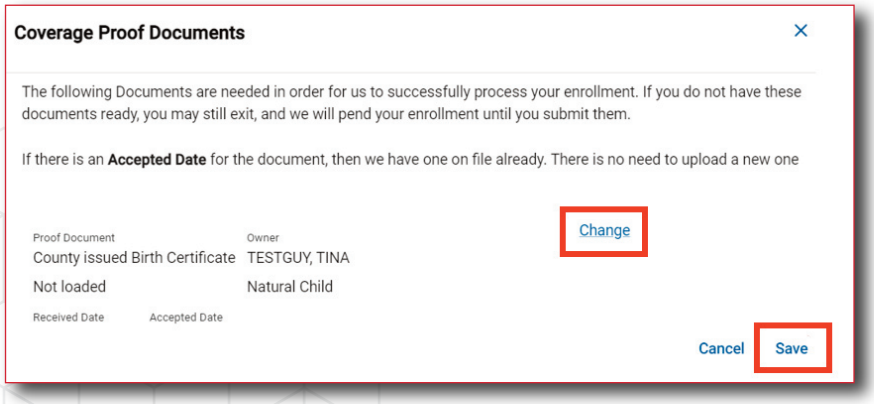
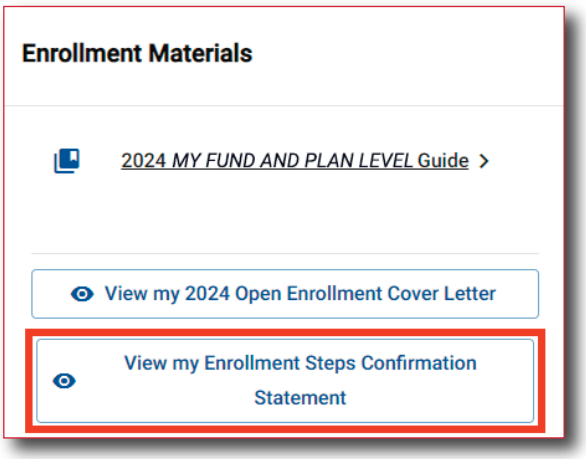


6 Once your enrollment steps have been submitted, please review your preliminary election statement to ensure your elections are accurate for the 2024 Plan Year.

Once you have completed all Enrollment Steps, your status bar will automatically update to 100% complete.

6a



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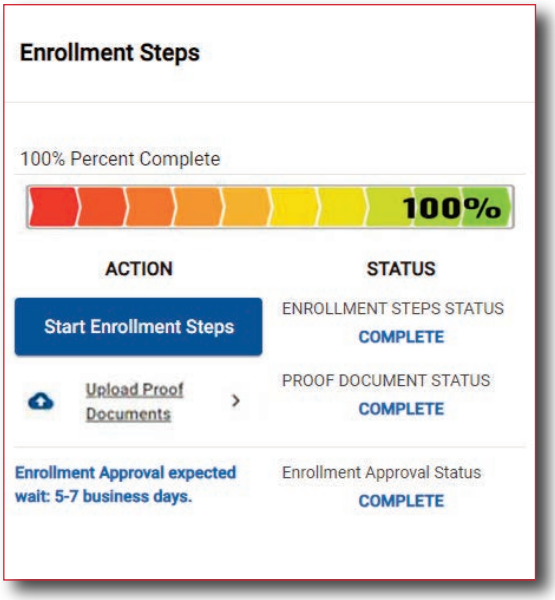


You can also submit your documentation through postal mail, fax, or drop it off in-person to one of our offices:

- **Mail:** PO Box 4100, Concord, CA 94524-4100
- **Fax:** Health & Welfare Services Department at (925) 746-7549
- **Concord Drop Off:** 1000 Burnett Ave, Suite 110, Concord, CA 94520
- **Roseville Drop Off:** 2200 Professional Drive, Suite 200, Roseville, CA 95661

Please allow 5-7 business days for the TFO to review and approve your Enrollment.

2024 OPEN ENROLLMENT

Wellness Steps

Required for Wellness Program (HCP) participation in 2024

If you want to participate in the Wellness Program (HCP) in 2024, you must complete Wellness Steps A, C, and D below by December 1, 2023. If your Spouse/Domestic Partner is currently enrolled under your coverage, they must complete Wellness Steps A, B, C, and D below.

A **Health Care Partnership Agreement (HCP Agreement)**

B **Spouse must also complete the GINA Authorization (Members and Domestic Partners are not required to complete the GINA Authorization)**

C **Health Risk Questionnaire (HRQ)**

D **Biometric Screening**

If you are enrolled in Kaiser, or will be enrolled in Kaiser for 2024, you and your Spouse/Domestic Partner must also complete the **Kaiser HIPAA Authorization Wellness Step**. Any Dependent Children age 18 and over are required to complete a paper Kaiser HIPAA Authorization Form (See page 19).

If you and your currently enrolled Spouse/Domestic Partner do not individually complete all Wellness Steps, you and your Dependents will not be eligible to participate in the Wellness Plan (HCP) effective January 1, 2024. Your currently enrolled Spouse/Domestic Partner must still complete Wellness Steps even if you are dropping them from your plan for 2024.

Who needs to complete Wellness Steps?

? **Is your Spouse/Domestic Partner currently enrolled in your coverage?**

→ **YES** → **Both of you must individually complete Wellness Steps**

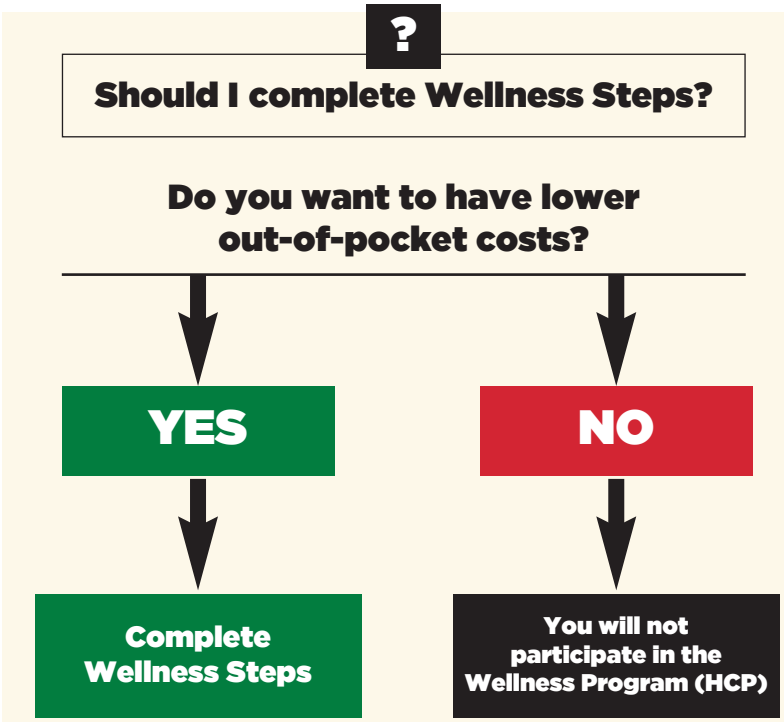
→ **NO** → **Only you need to complete Wellness Steps**

2024 OPEN ENROLLMENT

Benefits of Wellness Steps

The benefits of participating in the Wellness Program (HCP) include lower weekly Dependent premiums, higher benefit coverage, and funding into a Health Reimbursement Account (HRA) for your medical and prescription out-of-pocket expenses. The chart below has additional details on how the Wellness Program (HCP) reduces your out-of-pocket costs for doctor visits, hospital stays, and more.

All Members and currently enrolled Spouses/ Domestic Partners who wish to participate in the UCBT Wellness Program (HCP) in 2024 MUST complete Wellness Steps. Your Individual and Family Wellness Step completion status can be reviewed on the Open Enrollment page of your Participant Account at **ufcwtrust.com**.



	UCBT Wellness Program Health Care Partnership (HCP)	Not Participating in the Wellness Program
Annual costs	Reduced out-of-pocket costs	Non-reduced out-of-pocket costs
Doctor visits	Reduced costs for doctor visits	Non-reduced cost for doctor visits
Hospital stays	Reduced costs for hospital stays	Non-reduced cost on hospital stays
Dependent Premiums	Reduced weekly premiums Premier Member: None Spouse/Domestic Partner: $20/week Per child*: $10/week *No additional weekly premium charge after three children	Non-reduced weekly premiums Premier Member: None Spouse/Domestic Partner: $30/week Per child*: $15/week *No additional weekly premium charge after three children

Wellness Steps
Step-by-Step Instructions

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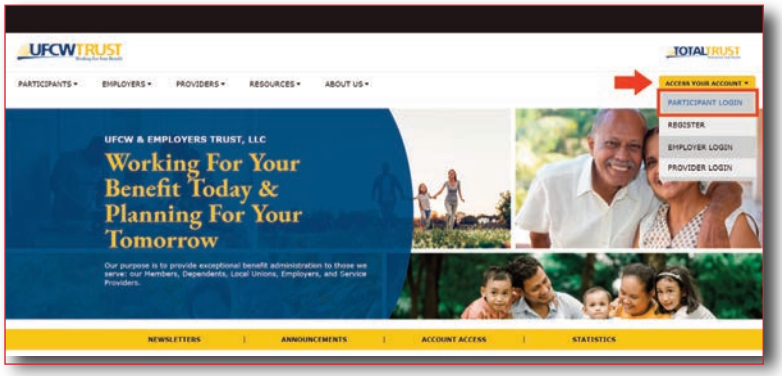

Visit **ufcwtrust.com** and select "Participant Login" under "Access Your Account."

2

Log in or register on the site.

3

Select the "Open Enrollment" tab.

4

The Open Enrollment page displays your Wellness Steps Action Items and progress bar. Your progress bar will update automatically as you complete Action Items, or once the TFO reviews and approves your submitted documents (5-7 business days).

To Get Started, select the "Wellness (HCP) Agreement" and select "Start." After reviewing the agreement, check the box at the bottom of the e-form to agree. Select "Submit," "OK, "and then "Finish Form." Your e-signed Agreement status will automatically update to "Complete." Continue to the next step.

NOTE: Some Participants will not see all Wellness Steps displayed in the example picture. Your Open Enrollment tab will only display Wellness Steps applicable to you.

Wellness Steps
Step-by-Step Instructions (cont.)

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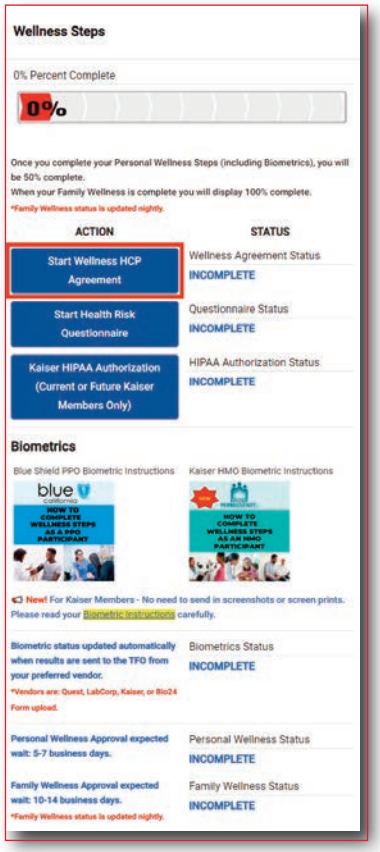

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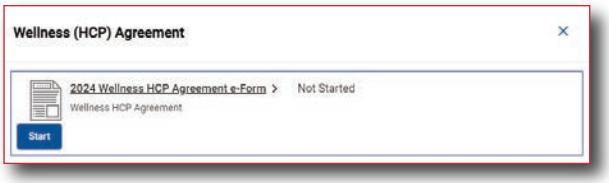

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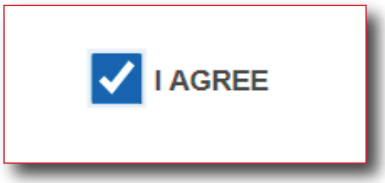

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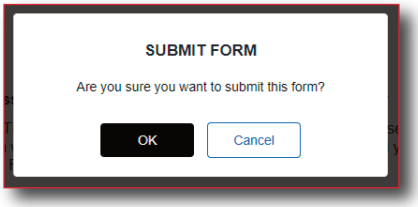

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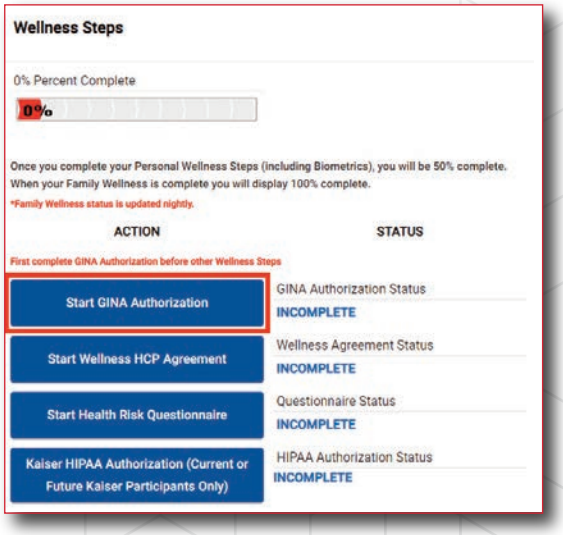
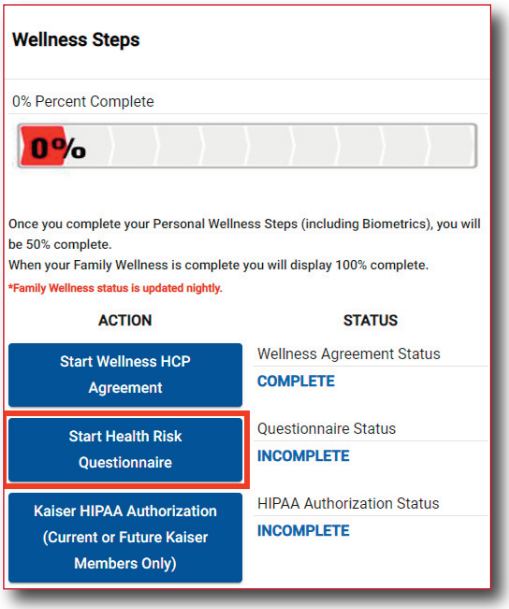
5 If you are an enrolled Spouse, complete your GINA Authorization (the Member and Domestic Partner will not see this step). Complete the GINA Authorization in the same way as the "Wellness (HCP) Agreement" e-form was completed.

WARNING: The GINA Authorization is only applicable to an enrolled Spouse completing Wellness Steps. The GINA Authorization must be completed by the Spouse prior to submitting Proof of Completed Biometrics.



Wellness Steps
Step-by-Step Instructions (cont.)

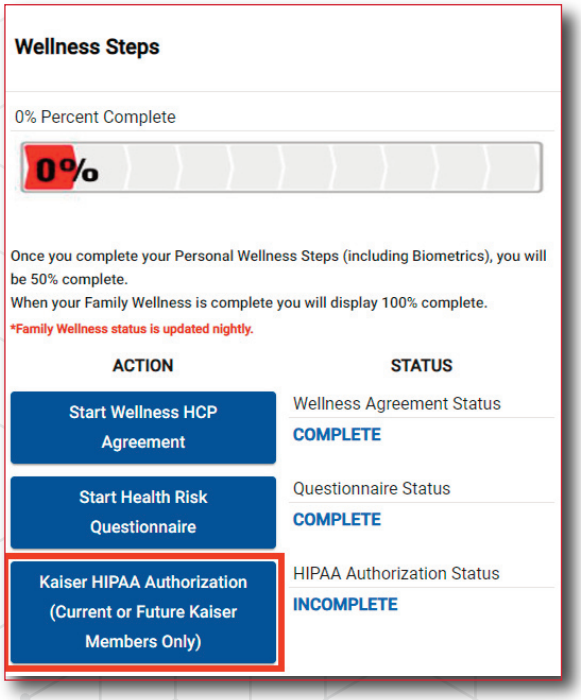
6 Complete your Health Risk Questionnaire (HRQ). This questionnaire is comprised of 24 questions to help you identify healthier life habits and recommendations. The HRQ takes between 5-10 minutes to complete. If you need to save your progress and return at a later time, use the "Save" and "Log Out" buttons inside the e-form. Otherwise, complete the form, select "Submit Form," "OK," and then "Finish Form," to complete this Wellness Step.



7 If you are a current or future Kaiser Participant (Member, or Spouse or Domestic Partner), review and agree to the Kaiser HIPAA Authorization. Select "Kaiser HIPAA Authorization." After reviewing the agreement, select "Authorize HIPAA Agreement." Select "Yes" to authorize the Agreement. Then, select "Save."

NOTE: Enrolled Dependent Children (age 18+) must complete a paper Kaiser HIPAA Authorization. See page 19.

7a



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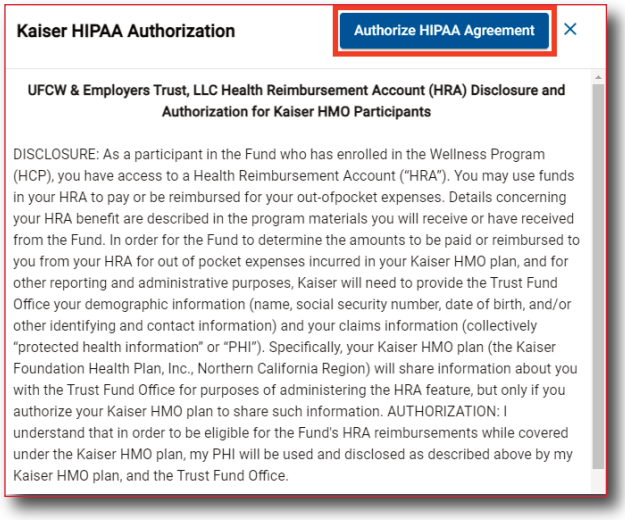


Kaiser HIPAA (if applicable)

For Kaiser Members participating in the Wellness Program (HCP), the Kaiser HIPAA Authorization allows the Trust Fund Office (TFO) to apply available credits in your HRA toward deductibles and coinsurance when you and your Dependents use Kaiser services. Signing this HIPAA form is required for Wellness Program (HCP) participation every year for you and your enrolled Dependents who are age 18 and over.

If you are currently enrolled, or if you are enrolling in Kaiser HMO coverage for the 2024 Plan Year, you, the Member, and your Spouse/Domestic Partner (if applicable), will complete an electronic HIPAA Authorization when you complete your Wellness Steps on the Open Enrollment website. This Authorization will also allow the TFO to receive your Biometric test information from Kaiser.

Your enrolled children turning age 18 on or before January 2024 must sign a paper form. You may download a copy of the Kaiser HIPAA Authorization Form from the Open Enrollment website, or by logging into your Participant Account online at **ufcwtrust.com**. You can then upload a scanned JPG or PDF copy of the signed form to your Participant Account.

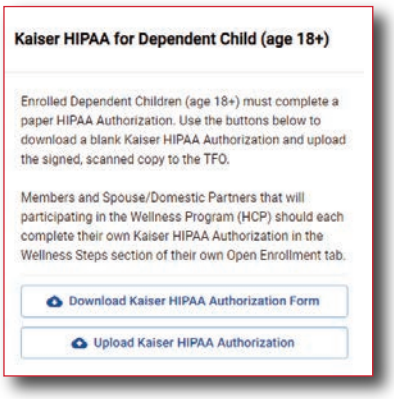
Directions for Kaiser HIPAA Authorization for Dependent Child (Age 18+)

8 Select "Download Kaiser HIPAA Authorization Form" in the "Kaiser HIPAA for Dependent Child (age 18+)" section, and download and print the form. Have the Dependent Child sign and date the Authorization. Scan or take a clear photograph of the complete form.

Select "Upload Kaiser HIPAA Authorization," and select the scanned PDF or image from your device. Select "Kaiser HIPAA Authorization Form" for the question "What is this for?"

Select "Upload."

8a



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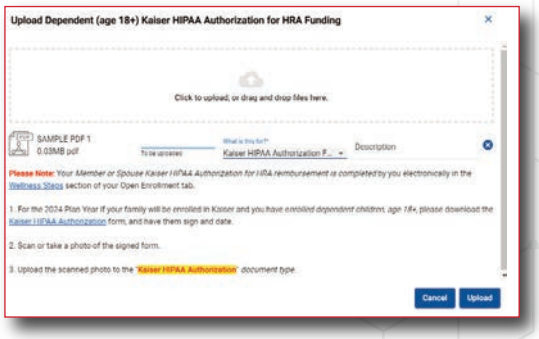


You can also submit your form through postal mail, fax, or drop it off in-person to one of our offices:

- **Mail:** PO Box 4100, Concord, CA 94524-4100
- **Fax:** Health & Welfare Services Department at (925) 746-7549
- **Concord Drop Off:** 1000 Burnett Ave, Suite 110, Concord, CA 94520
- **Roseville Drop Off:** 2200 Professional Drive, Suite 200, Roseville, CA 95661

Please allow 5-7 business days for the TFO to review and approve your submitted form.

Instructions for Uploading Biometric Screening Documentation

PPO

PPO Members who complete a Biometrics Appointment through **Quest** or **Labcorp** according to the PPO Biometrics Instructions do not need to upload their results. Please allow 7-10 business days after your completed appointment for the Biometrics Status to change to Complete.

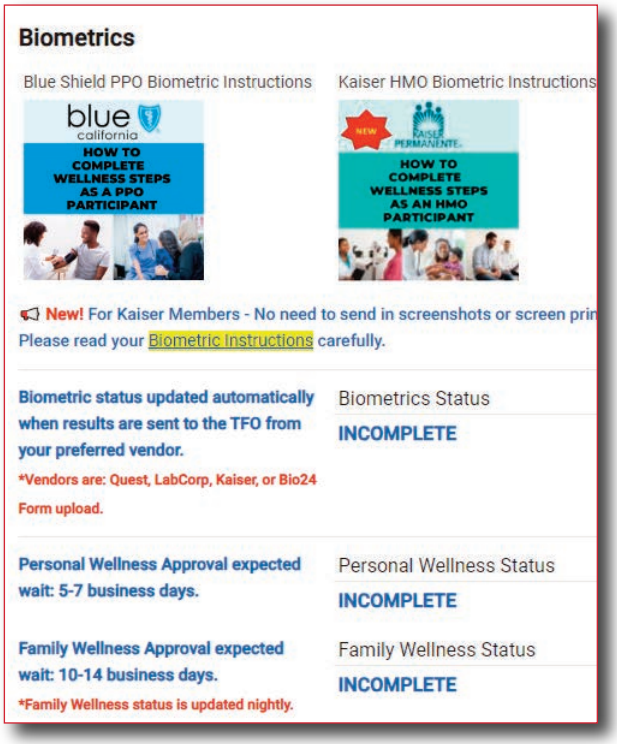
HMO

HMO Members who complete their Biometric Tests with **Kaiser** (or are not required to take Biometrics Tests because they have existing test results on file, per the requirements in the HMO Biometrics Instructions), do not need to upload their results. Please allow 7-10 business days after you have completed tests (if required) and submitted your Kaiser HIPAA Authorization to the TFO for the Biometric Status to change to Complete.

9 Both the Member and the enrolled Spouse or Domestic Partner (if applicable) must individually complete their own proof of Biometrics. Select the "Biometric Instructions" that pertain to you. For example, if you are currently a Blue Shield PPO Participant, you will select the "Blue Shield PPO Biometric Instructions."

For PPO Participants, the most convenient way to complete your Biometrics Tests is by booking a Biometrics Appointment with Quest or Labcorp. If you complete your appointment with Quest or Labcorp, your results will be sent to the TFO automatically. If you complete your Biometrics Tests with your physician, continue to the next step to upload your completed BIO24 form signed by your authorized medical provider.

For HMO Participants, review the instructions to confirm that you need Biometrics Tests. If tests are required, schedule your tests with Kaiser. Your results will be sent to the TFO automatically after you have submitted your Kaiser HIPAA Authorization to the TFO.



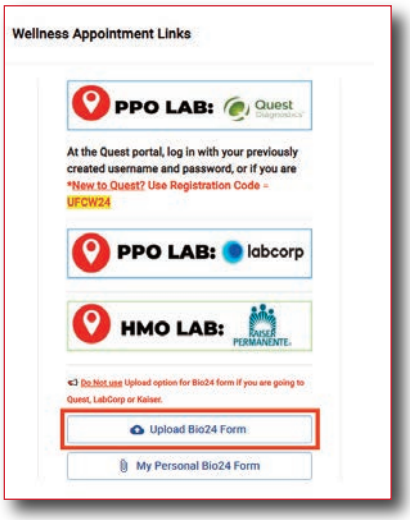
How to Upload Proof of Completed Biometrics

Quest, Labcorp, and Kaiser results are sent to the TFO automatically. You will only need to upload your Proof of Biometrics if you complete your biometrics tests with your physician (the BIO24 form must be signed by your authorized medical provider.)

10 Select the "Upload Bio24 Form" button in your Wellness Appointment Links section and select the scanned BIO24 form on your device. Select "Proof of Biometrics" for the question "What is this for?" and then select "Upload."

Your Personal Biometrics Status will update to "Complete" once the TFO reviews and approves your submitted documentation (5-7 business days).

10a



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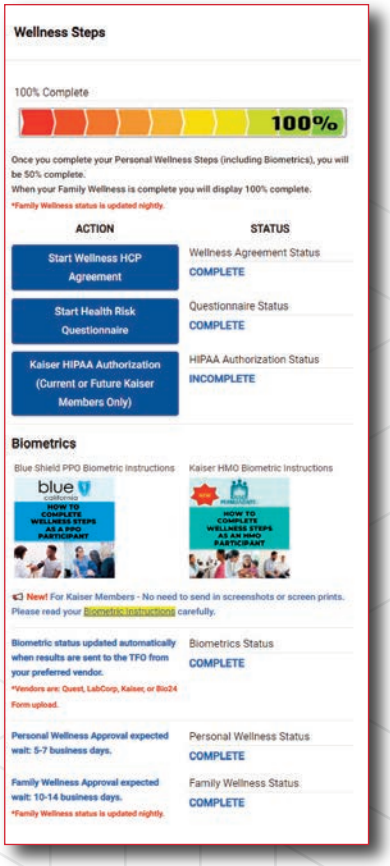
11 Once you and your Spouse/Domestic Partner (if applicable) have both completed all Wellness Steps, your Family Wellness status will update, and your status bar will automatically update to 100% complete.

WARNING: Both the Member and the enrolled Spouse or Domestic Partner (if applicable) must individually complete their own Wellness Steps for a household to be complete and participate in the Wellness (HCP) Program for 2024 Plan Year. If you are dropping your Spouse/Domestic Partner from your plan for the 2024 Plan Year, they must still complete Wellness Steps for your household to participate in the 2024 Wellness Program.



Health Reimbursement Account (HRA) for Kaiser Members

Once you and your covered Dependents (age 18 or older) have submitted your Kaiser HIPAA Authorization Form(s) to the Trust Fund Office (TFO), using your available HRA balance will be seamless.

This is how the process will go for you and your enrolled Dependents (together as "you" or "your" below) when you use Kaiser services:

- Check-in for your Kaiser medical appointment as normal.
- The Kaiser system will indicate you have a Health Reimbursement Account, so Kaiser frontline staff will not ask you to pay your deductible or co-insurance before you receive treatment for most medical services. Kaiser staff will not know your account balance, so you'll need to direct any questions about HRA balances to the TFO.
- You will be asked to pay out-of-pocket for certain services that are elective in nature like cosmetic surgery or if you're referred to a non–Kaiser provider or facility.
- Kaiser will first send your claim to the TFO for payment.
- The TFO will pay Kaiser using your HRA credits.
- You will receive an Explanation of Benefits (EOB) in the mail from the TFO showing how the HRA credits were applied to the claim.
- If the available credits in your HRA are less than your share of the cost for the claim, or if your treatment is not a Covered Service, the EOB will also show an unpaid balance. The unpaid balance is your out-of-pocket expense. It is the amount you owe Kaiser.
- You will receive a bill from Kaiser for the unpaid balance.

Your Kaiser Experience

No payment at check-in for most medical services at Kaiser facilities

Kaiser processes the medical claim and submits to the account

Member will be billed if account funds are used up, and for any services that aren't eligible for reimbursement

solidaritus

Personalized Care
Personalized Service
New Solidaritus Health Centers specifically for UFCW Trust Members

Solidaritus Health will soon be opening in the following neighborhoods to specifically serve UFCW Trust Members:

- Rocklin
- San Jose
- South San Francisco

To sign up on the Waiting List, log into your Participant Account on **ufcwtrust.com**, and look for the instructions in your Health Centers section.

If you are a current Kaiser Member and you would like to switch to PPO coverage to enroll in the Health Care Centers, please be aware there is a Waiting List. Immediate enrollment/participation in the Health Care Centers is not guaranteed.

Zero Out-of-Pocket Costs*

No copays. **No** deductibles. **No** cost for covered labs.
*Discounted prescription medicine dispensed at Solidaritus Health Centers will be billed at the standard UCBT prescription copay or less.

Three Trips in One

In addition to seeing your personal Solidaritus physician, your Solidaritus health center is also equipped to provide certain lab work and prescription medications within its license. If appropriate, you may see your personal physician, get lab work completed, and receive the first fill on your prescription all at the same visit in just one trip.

Who is Eligible

To be eligible as a future patient of a Solidaritus Health Center, you must either be a Premier PPO Plan Member or a Non-Medicare Retiree with PPO coverage. Space is limited. To express your interest in becoming a future patient of a Solidaritus Health Center, sign up for the Waiting List on **ufcwtrust.com** today!

Additional Plan Information to Assist You in Selecting the Plan Option That is Best for You

Premier Plan Comparisons outline the benefits provided under the Blue Shield PPO Plan, the Kaiser HMO Plan, the various dental plan options, and prescription drug and vision coverage.

Frequently Asked Questions (FAQs) provide answers to some commonly asked questions about Coordination of Benefits (COB). Read the FAQs to understand how this Plan pays benefits when your Spouse/Domestic Partner also has the option to enroll in coverage under UCBT or other group coverage.

The **Summaries of Benefits and Coverages (SBCs)** for the Premier Plan are provided to you as required by the Affordable Care Act (ACA, also known as Health Care Reform). The SBCs summarize your health care benefits and coverage using a uniform glossary of terms commonly used in the health insurance industry. Please note that in accordance with legal requirements, the coverage examples in the SBCs do not take into account the possible reduction in your costs when you participate in the Wellness Program (HCP) or any additional cost associated with being identified but not agreeing to participate in a Disease Management program. SBCs are separated by plan type as follows:

- Blue Shield: Premier PPO
- Kaiser: Premier HMO

The TFO has also sent an electronic copy of your Cover Letter to your **ufcwtrust.com** Account. Log into your account and view the Cover Letter in the Open Enrollment section.

Summary of Material Modifications

The SMM on plan changes effective January 1, 2024, reviews the new Kaiser Plan available to UCBT Premier Plan Participants, the additional Disability Extensions available to Members and the new eligibility rules for New Hires.

Summary of Material Modifications

Notice to Participants in the UFCW Comprehensive Benefits Trust

This notice is a Summary of Material Modifications ("SMM") that describes changes to the terms of the Plan. Please read it carefully and keep it with your Summary Plan Description and other Plan information so that you will have complete information about your health benefits. If there is any discrepancy between the Plan information previously provided to you and the changes described in this notice, the rules described in this notice will govern. The Trustees of the Plan reserve the right to amend, modify or terminate the Plan at any time. For further information regarding these changes to the Plan, please contact the Trust Fund Office (TFO) at (800) 552-2400.

New Kaiser HMO Option (Ultra Plan Members)
Effective January 1, 2024

Prior to January 1, 2024, participants who were covered under the Ultra Plan were only eligible to enroll in the Indemnity PPO Plan option.

Effective January 1, 2024, a Kaiser HMO option will be added to the Ultra Plan, allowing Ultra Plan Participants to enroll in either the Indemnity PPO Plan option or the Kaiser HMO Plan option. The Kaiser HMO Plan benefits under the Ultra Plan closely match the Ultra Plan Indemnity PPO Plan benefits, with one level for those who participate in the UCBT Wellness Program (also known as Health Care Partnership (HCP)) and another level for those who do not. Review the most recent Summary of Benefits and Coverages (SBCs) and Plan comparison charts for Kaiser HMO Plan details.

Eligibility for Benefits Start on 4th Month of Employment (Applicable to Newly Hired Employees)
Effective January 1, 2024

Prior to January 1, 2024, a newly hired employee became eligible for benefits after five months of employment, provided sufficient hours were worked to meet the qualifying hours requirement.

Effective January 1, 2024, newly hired employees will become eligible for benefits after three months of employment (as long as the qualifying hours requirement is met). For example, if your hire date is January 1, 2024, and you have worked at least the minimum qualifying hours in January and February, you are eligible to enroll in benefits effective April 1, 2024. The qualifying hours requirement can be found on page 7 of your current SPD.

Disability Extension Benefit Change (All Active Members)
Effective January 1, 2024

For Premier and Ultra Plan Participants: Disability Extensions for which a Premier or Ultra Plan participant may be eligible are increased from a maximum of four months in a rolling 36-month period to a maximum of nine months in a rolling 36-month period. Disability Extensions will continue to run concurrently with FMLA.

Standard Plan Participants: Disability Extensions for which a Standard Plan participant may be eligible are increased from a maximum of three months to a maximum of nine months in a rolling 36-month period. However, Standard Plan Participants must have been eligible for benefits for at least 12 months under the UCBT Plan before they qualify for a Disability Extension. Disability Extensions will continue to run concurrently with FMLA.

These Disability Extension changes are effective for qualifying participants on or after January 1, 2024. You will need to submit a completed Disability Extension Form if you believe you qualify for additional extensions. If you have already submitted a completed Disability Extension Form, contact the Trust Fund Office and we will reprocess the Disability Extension for you. For additional information, please contact the Trust Fund Office.

Receipt of this notice does not constitute a determination of your eligibility. If you wish to verify eligibility, or if you have any questions regarding these Plan changes, please contact the Trust Fund Office (TFO) at (800) 552-2400.

In accordance with ERISA reporting requirements, this document serves as your Summary of Material Modifications to the Plan.

Summary of Benefits and Coverage

UFCW Comprehensive Benefits Trust
Premier PPO

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 1-800-552-2400 or visit us at www.ufcwtrust.com. 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 https://www.healthcare.gov/sbc-glossary or call 1-800-552-2400 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	PPO and Out-of-Area Providers: $900/individual, $1,800/individual plus one dependent, $1,850/individual plus two or more dependents. Non-PPO Providers: $1,100/individual, $2,200/individual plus one dependent, $2,450/individual plus two or more dependents.	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 family members meets the overall family deductible.
Are there services covered before you meet your deductible?	Yes. PPO and Out-of-Area Preventive care, outpatient prescription drugs and Non-PPO outpatient dialysis 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?	No.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	If you participate in the plan's Health Care Partnership (HCP), the amounts will be: PPO and Out-of-Area providers: $2,900/ individual, $5,800/ individual plus one dependent, $7,850/family; Prescription drugs (PPO): $6,550/individual, $13,100/individual plus one dependent, $11,050/family. If you do not participate in the plan's Health Care Partnership (HCP), the amounts will be: PPO and Out-of-Area providers (including medical deductible and coinsurance): $5,900/individual, $11,800/individual plus one dependent, $12,800/ family; Prescription drugs (PPO): $3,550/individual, $7,100/individual plus one dependent, $6,100/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.

Important Questions	Answers	Why This Matters:
What is not included in the out-of-pocket limit?	Premiums, balance-billing charges, penalties for failure to obtain precertification, charges from Non-PPO providers (unless Out-of-Area), and health care not covered by this plan. Prescription drug expenses are not included in the medical out-of-pocket limit. Medical expenses, costs for non-formulary drugs, and any amount above the standard copay for a drug in an MPD class that is not a lower cost alternative without a medical exception are not included in the prescription drug out-of-pocket limit.	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.blueshieldca.com or www.ufcwtrust.com, or call 1-800-258-3091 for a list of PPO medical providers. To talk to a provider 24/7, call 1-800-835-2362 or visit Teladoc.com. For a list of PPO Podiatry providers, call Podiatry Plan, Inc. at 1-800-367-7762. For a list of PPO Mental Health and Substance Abuse providers, call HMC at 1-877-845-7440.	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
		PPO Provider (You will pay the least)	Out-of-Area Provider	Non-PPO 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	15% coinsurance if you participate in the HCP, otherwise 20% coinsurance	**15% coinsurance if you participate in the HCP, otherwise **20% coinsurance	**50% coinsurance	Teladoc covered at no charge, deductible does not apply; all other virtual visits covered at regular coinsurance after deductible, as applicable. All podiatry services require precertification or there are no benefits available. Benefits for PPO podiatry services are subject to scheduled amounts. In this chart, where you see "**", it means that for Non-PPO providers, you pay amounts above the Plan's Allowed charge, except as provided under the No Surprises Act.
	Specialist visit	15% coinsurance if you participate in the HCP, otherwise 20% coinsurance	**15% coinsurance if you participate in the HCP, otherwise **20% coinsurance	**50% coinsurance	

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

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		PPO Provider (You will pay the least)	Out-of-Area Provider	Non-PPO Provider (You will pay the most)	
	Preventive care/screening/ immunization	No charge. Deductible does not apply.	**No charge up to Allowed Charge. Deductible does not apply.	Not covered.	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.
If you have a test	Diagnostic test(x-ray, blood work)	15% coinsurance if you participate in the HCP, otherwise 20% coinsurance	**15% coinsurance if you participate in the HCP, otherwise **20% coinsurance	**50% coinsurance	None.
	Imaging (CT/PET scans, MRIs)				
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.elixirsolutions.com	Formulary generic drugs	Deductible does not apply. 30-day supply: $10 copay/fill 90-day supply (maintenance medications only): $20 copay/fill.	Not covered except for emergencies or when there is not a UCBT Network pharmacy within a 10-mile radius of a non-network pharmacy.		You are responsible for the lesser of the purchase price, the Average Wholesale Price, or the applicable copay. No charge for generic FDA approved contraceptives (or brand if generic is medically inappropriate). A Market Priced Drug (MPD) program applies to certain prescription drug classes. Higher cost-sharing may apply if recommended alternatives are not utilized. *See the Prescription Drug Program chapter of your SPD (and SMM). Drugs purchased at Non-Network pharmacies and additional amounts paid for a drug not listed under the MPD program are not included in your prescription drug out-of-pocket limit. Maintenance meds for select conditions have reduced copays.
	Formulary brand drugs	Deductible does not apply. 30-day supply: $20 copay/fill 90-day supply (maintenance medications only): $40 copay/fill.			
	Non-formulary drugs	30-day supply: $35 copay/fill 90-day supply (maintenance medications only): $70 copay/fill	Not covered except for emergencies or when there is not a UCBT Network pharmacy within a 10-mile radius of a non-network pharmacy.		

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

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		PPO Provider (You will pay the least)	Out-of-Area Provider	Non-PPO Provider (You will pay the most)	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	15% coinsurance if you participate in the HCP, otherwise 20% coinsurance	**15% coinsurance if you participate in the HCP, otherwise **20% coinsurance	**50% coinsurance	Maximum benefit for Non-PPO surgical facility is $1,000.
	Physician/surgeon fees	15% coinsurance if you participate in the HCP, otherwise 20% coinsurance	**15% coinsurance if you participate in the HCP, otherwise **20% coinsurance	**50% coinsurance	None.
If you need immediate medical attention	Emergency room care	15% coinsurance if you participate in the HCP, otherwise 20% coinsurance	**15% coinsurance if you participate in the HCP, otherwise **20% coinsurance	**15% coinsurance if you participate in the HCP, otherwise **20% coinsurance	Professional/physician charges may be billed separately. Normal coinsurance will apply for visits that are not for an emergency medical condition. *See the Schedule of Medical Benefits chapter of your SPD.
	Emergency medical transportation	15% coinsurance if you participate in the HCP, otherwise 20% coinsurance	**15% coinsurance if you participate in the HCP, otherwise **20% coinsurance	**15% coinsurance if you participate in the HCP, otherwise **20% coinsurance	Non-emergency medical transportation is not covered.
	Urgent care	15% coinsurance if you participate in the HCP, otherwise 20% coinsurance	**15% coinsurance if you participate in the HCP, otherwise **20% coinsurance	**50% coinsurance	None.
If you have a hospital stay	Facility fee (e.g., hospital room)	15% coinsurance if you participate in the HCP, otherwise 20% coinsurance	**15% coinsurance if you participate in the HCP, otherwise **20% coinsurance	**50% coinsurance	Requires precertification for all elective admissions. Private room is covered only if Medically Necessary.
	Physician/surgeon fees				None.

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

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		PPO Provider (You will pay the least)	Out-of-Area Provider	Non-PPO Provider (You will pay the most)	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	15% coinsurance if you participate in the HCP, otherwise 20% coinsurance	**15% coinsurance if you participate in the HCP, otherwise **20% coinsurance	**50% coinsurance	Teladoc covered at no charge, deductible does not apply; all other virtual visits covered at regular coinsurance after deductible, as applicable.
	Inpatient services				Requires precertification for all elective admissions.
If you are pregnant	Office visits	15% coinsurance if you participate in the HCP, otherwise 20% coinsurance	**15% coinsurance if you participate in the HCP, otherwise **20% coinsurance	**50% coinsurance. Preventive services are not covered.	Cost sharing does not apply for preventive services. Maternity care may include tests and services described somewhere else in SBC (i.e., ultrasound). Depending on the type of service, a coinsurance and deductible may apply. Prenatal care (other than ACA-required preventive screenings) is not covered for dependent children.
	Childbirth/delivery professional services	15% coinsurance if you participate in the HCP, otherwise 20% coinsurance	**15% coinsurance if you participate in the HCP, otherwise **20% coinsurance	50% coinsurance	
	Childbirth/delivery facility services	15% coinsurance if you participate in the HCP, otherwise 20% coinsurance	**15% coinsurance if you participate in the HCP, otherwise **20% coinsurance	**50% coinsurance	

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

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		PPO Provider (You will pay the least)	Out-of-Area Provider	Non-PPO Provider (You will pay the most)	
If you need help recovering or have other special health needs	Home health care	15% coinsurance if you participate in the HCP, otherwise 20% coinsurance	**15% coinsurance if you participate in the HCP, otherwise **20% coinsurance	**50% coinsurance	Requires precertification for inpatient admissions.
	Rehabilitation services	15% coinsurance if you participate in the HCP, otherwise 20% coinsurance	**15% coinsurance if you participate in the HCP, otherwise **20% coinsurance	**50% coinsurance	Requires precertification for inpatient admissions.
	Habilitation services	Not covered	Not covered	Not covered	You must pay 100% of this service, even in-network.
	Skilled nursing care	15% coinsurance if you participate in the HCP, otherwise 20% coinsurance	**15% coinsurance if you participate in the HCP, otherwise **20% coinsurance	**50% coinsurance	Requires precertification for inpatient admissions. Confinement payable up to 120 days per person per year.
	Durable medical equipment	15% coinsurance if you participate in the HCP, otherwise 20% coinsurance	**15% coinsurance if you participate in the HCP, otherwise **20% coinsurance	**50% coinsurance	Rental charges that exceed the reasonable purchase price of the equipment are not covered.
	Hospice services	15% coinsurance if you participate in the HCP, otherwise 20% coinsurance	**15% coinsurance if you participate in the HCP, otherwise **20% coinsurance	**50% coinsurance	Covered if expected to live 6 months or less.
If your child needs dental or eye care	Children's eye exam	Not covered	Not covered	Not covered	If you elect dental or vision coverage, it will be available under a separate dental or vision plan.
	Children's glasses	Not covered	Not covered	Not covered	
	Children's dental check-up	Not covered	Not covered	Not covered	

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

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 • Dental care (Adult or Child) • Habilitation services	• Long-term care	• Routine eye care (Adult or Child) • Weight loss programs (except as required by the health reform law)

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)		
• Acupuncture (combined max of $500/year for chiropractor/acupuncture/acupressure) • Bariatric surgery • Chiropractic care (combined max of $500/year for chiropractor/acupuncture/acupressure)	• Hearing aids (max of $800 during a 36 month period) • Infertility treatment (evaluation and diagnosis)	• Non-emergency care when traveling outside the U.S. (medical care only) • Private-duty nursing • Routine foot 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: the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/agencies/ebsa/. 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 Trust Fund Office at 1-800-552-2400. You may also contact the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/agencies/ebsa/.

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 1-800-999-1999.
Chinese (中文): 如果需要中文的帮助，请拨打这个号码 1-800-999-1999.
Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-800-999-1999.

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	$900
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	$900
Copayments	$10
Coinsurance	$2,260
What isn't covered	
Limits or exclusions	$20
The total Peg would pay is	**$3,190**

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

The plan's overall deductible	$900
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	$900
Copayments	$360
Coinsurance	$210
What isn't covered	
Limits or exclusions	$0
The total Joe would pay is	**$1,470**

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

The plan's overall deductible	$900
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	$900
Copayments	$10
Coinsurance	$380
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,290**

2024 OPEN ENROLLMENT

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

Summary of Benefits and Coverage

UFCW Comprehensive Benefits Trust
Premier HMO

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.kp.org/plandocuments or call 1-800-278-3296 (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.healthcare.gov/sbc-glossary or call 1-800-278-3296 (TTY: 711) to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	$900 Individual / $1,800 Individual + 1 / $1,850 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. Preventive care and services indicated in chart starting on page 2.	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?	No.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	**Medical**: $5,350 Individual / $10,700 Individual + 1 / $10,700 Family ($2,900 Individual / $5,800 Individual + 1 / $7,850 Family if you participate in the HCP wellness program) **Prescription Drug**: $4,100 Individual / $8,200 Individual + 1 / $8,200 Family ($6,550 Individual / $13,100 Individual + 1 / $11,050 Family if you participate in the HCP wellness program)	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, health care this plan doesn't cover, and services indicated in chart starting on page 2.	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.kp.org or call 1-800-278-3296 (TTY: 711) 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.

Important Questions	Answers	Why This Matters:
Do you need a referral to see a specialist?	Yes, but you may self-refer to certain specialists.	This plan will pay some or all of the costs to see a specialist for covered services but only if you have a referral before you see the specialist.

⚠ 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
		Plan Provider (You will pay the least)	Non-Plan 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 (15% coinsurance if you participate in the HCP wellness program)	Not Covered	None
	Specialist visit	20% coinsurance (15% coinsurance if you participate in the HCP wellness program)	Not Covered	None
	Preventive care/screening/ immunization	No Charge, deductible does not apply.	Not Covered	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.
If you have a test	Diagnostic test (x-ray, blood work)	20% coinsurance (15% coinsurance if you participate in the HCP wellness program)	Not Covered	None
	Imaging (CT/PET scans, MRIs)	20% coinsurance (15% coinsurance if you participate in the HCP wellness program)	Not Covered	None

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Plan Provider (You will pay the least)	Non-Plan 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.elixirsolutions.com	Generic drugs	Deductible does not apply. 30-day supply: $10 copayment / fill 90-day supply (maintenance medications only): $20 copayment / fill	Not Covered	• **Prescription drug coverage is available primarily through Elixir Solutions. Limited coverage is available for certain self-injectable drugs through Kaiser.** Contact the Fund Office at (800) 552-2400 for cost sharing information and on how these benefits work together. • If you are covered by another plan, and have your prescription filled under that plan, the Fund will reimburse the other plan's copayment plus $1 for each prescription (does not apply to spouse or domestic partner) • No charge for generic FDA approved contraceptives (or brand if generic is medically inappropriate). You pay 100% at out-of-network pharmacies except for emergencies or if you don't have a network pharmacy within a 10-mile radius of a non-network pharmacy. • You are responsible for the lesser of the purchase price or AWP less applicable copayment. Maintenance medications for select conditions have reduced copayments. • Higher cost-sharing may apply if recommended alternatives are not utilized. *See the Prescription Drug Program chapter of your SPD.
	Preferred brand drugs	Deductible does not apply. 30-day supply: $20 copayment / fill 90-day supply (maintenance medications only): $40 copayment / fill	Not Covered	
	Non-preferred brand drugs	Deductible does not apply. 30-day supply: $35 copayment / fill 90-day supply (maintenance medications only): $70 copayment / fill	Not Covered	
	Specialty drugs	Same as preferred brand drugs	Not Covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance (15% coinsurance if you participate in the HCP wellness program)	Not Covered	None
	Physician/surgeon fees	20% coinsurance (15% coinsurance if you participate in the HCP wellness program)	Not Covered	None

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Plan Provider (You will pay the least)	Non-Plan Provider (You will pay the most)	
If you need immediate medical attention	Emergency room care	20% coinsurance (15% coinsurance if you participate in the HCP wellness program)	20% coinsurance (15% coinsurance if you participate in the HCP wellness program)	None
	Emergency medical transportation	20% coinsurance (15% coinsurance if you participate in the HCP wellness program)	20% coinsurance (15% coinsurance if you participate in the HCP wellness program)	None
	Urgent care	20% coinsurance (15% coinsurance if you participate in the HCP wellness program)	20% coinsurance (15% coinsurance if you participate in the HCP wellness program)	Non-Plan providers covered when temporarily outside the service area.
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance (15% coinsurance if you participate in the HCP wellness program)	Not Covered	None
	Physician/surgeon fees	20% coinsurance (15% coinsurance if you participate in the HCP wellness program)	Not Covered	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	20% coinsurance / individual visit, 20% coinsurance for other outpatient services (15% coinsurance / individual visit, 15% coinsurance for other outpatient services, if you participate in the HCP wellness program)	Not Covered	20% coinsurance / group visit (15% coinsurance / group visit if you participate in the HCP wellness program)
	Inpatient services	20% coinsurance (15% coinsurance if you participate in the HCP wellness program)	Not Covered	None

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Plan Provider (You will pay the least)	Non-Plan Provider (You will pay the most)	
If you are pregnant	Office visits	No Charge, deductible does not apply.	Not Covered	Depending on the type of services, a copayment, coinsurance, or deductible may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound.)
	Childbirth/delivery professional services	20% coinsurance (15% coinsurance if you participate in the HCP wellness program)	Not Covered	None
	Childbirth/delivery facility services	20% coinsurance (15% coinsurance if you participate in the HCP wellness program)	Not Covered	None
If you need help recovering or have other special health needs	Home health care	No Charge, deductible does not apply.	Not Covered	Up to 2 hours maximum / visit, up to 3 visits maximum / day, up to 100 visits maximum / year.
	Rehabilitation services	Inpatient/Outpatient: 20% coinsurance (15% coinsurance if you participate in the HCP wellness program)	Not Covered	None
	Habilitation services	20% coinsurance (15% coinsurance if you participate in the HCP wellness program)	Not Covered	None
	Skilled nursing care	20% coinsurance (15% coinsurance if you participate in the HCP wellness program)	Not Covered	Up to 100 days maximum / benefit period.
	Durable medical equipment	20% coinsurance, deductible does not apply. (15% coinsurance, deductible does not apply, if you participate in the HCP wellness program)	Not Covered	Requires prior authorization.
	Hospice services	No Charge, deductible does not apply.	Not Covered	None
If your child needs dental or eye care	Children's eye exam	No charge, deductible does not apply.	Not Covered	Vision exam is available through Kaiser. If you elect additional vision coverage, it will be through a separate vision plan.
	Children's glasses	Not Covered	Not Covered	
	Children's dental check-up	Not Covered	Not Covered	If you elect dental coverage, it will be available through a separate dental plan.

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.)

- Children's glasses
- Cosmetic surgery
- Dental Care (Adult and child)
- 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 (combined max of $500/year for chiropractor/acupuncture/acupressure)
- Bariatric surgery
- Chiropractic care (combined max of $500/year for chiropractor/acupuncture/acupressure
- Hearing aids (max of $800 during a 36 month period)
- 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 s shown in the chart below. 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 agencies in the chart below.

Contact Information for Your Rights to Continue Coverage & Your Grievance and Appeals Rights:

Kaiser Permanente Member Services	1-800-278-3296 (TTY: 711) or www.kp.org/memberservices
Department of Labor's Employee Benefits Security Administration	1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform
Department of Health & Human Services, Center for Consumer Information & Insurance Oversight	1-877-267-2323 x61565 or www.cciio.cms.gov
California Department of Insurance	1-800-927-HELP (4357) or www.insurance.ca.gov
California Department of Managed Healthcare	1-888-466-2219 or www.healthhelp.ca.gov/

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 1-800-788-0616 (TTY: 711)

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-278-3296 (TTY: 711)

Chinese (中文): 如果需要中文的帮助， **请拨打这个号码**1-800-757-7585 (TTY: 711)

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-800-278-3296 (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	$900
Specialist coinsurance	20%
Hospital (facility) coinsurance	20%
Other (blood work) 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	$900
Copayments	$10
Coinsurance	$2,050
What isn't covered	
Limits or exclusions	$20
The total Peg would pay is	**$2,980**

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

The plan's overall deductible	$900
Specialist coinsurance	20%
Hospital (facility) coinsurance	20%
Other (blood work) 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	$900
Copayments	$360
Coinsurance	$190
What isn't covered	
Limits or exclusions	$0
The total Joe would pay is	**$1,450**

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

The plan's overall deductible	$900
Specialist coinsurance	20%
Hospital (facility) coinsurance	20%
Other (x-ray) 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	$900
Copayments	$10
Coinsurance	$380
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,290**

NOTE: These numbers assume the patient does not participate in the plan's wellness program. If you participate in the plan's wellness program, you may be able to reduce your cost. For more information about the wellness program, please contact: 1-800-552-2400.

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

Nondiscrimination Notice

Kaiser Permanente does not discriminate on the basis of age, race, ethnicity, color, national origin, cultural background, ancestry, religion, sex, gender identity, gender expression, sexual orientation, marital status, physical or mental disability, source of payment, genetic information, citizenship, primary language, or immigration status.

Language assistance services are available from our Member Service Contact Center 24 hours a day, 7 days a week (except closed holidays). Interpreter services, including sign language, are available at no cost to you during all hours of operation. Auxiliary aids and services for individuals with disabilities are available at no cost to you during all hours of operation**.** We can also provide you, your family, and friends with any special assistance needed to access our facilities and services. You may request materials translated in your language at no cost to you. You may also request these materials in large text or in other formats to accommodate your needs at no cost to you. For more information, call **1-800-464-4000** (TTY **711**).

A grievance is any expression of dissatisfaction expressed by you or your authorized representative through the grievance process. For example, if you believe that we have discriminated against you, you can file a grievance. Please refer to your *Evidence of Coverage or Certificate of Insurance* or speak with a Member Services representative for the dispute-resolution options that apply to you.

You may submit a grievance in the following ways:

- **By phone:** Call member services at **1-800-464-4000** (TTY **711**) 24 hours a day, 7 days a week (except closed holidays).
- **By mail:** Call us at **1-800-464-4000** (TTY **711**) and ask to have a form sent to you.
- **In person:** Fill out a Complaint or Benefit Claim/Request form at a member services office located at a Plan Facility (go to your provider directory at **kp.org/facilities** for addresses)
- **Online:** Use the online form on our website at **kp.org**

Please call our Member Service Contact Center if you need help submitting a grievance.

The Kaiser Permanente Civil Rights Coordinator will be notified of all grievances related to discrimination on the basis of race, color, national origin, sex, age, or disability. You may also contact the Kaiser Permanente Civil Rights Coordinator directly at:

Northern California
Civil Rights/ADA Coordinator
1800 Harrison St.
16th Floor
Oakland, CA 94612

Southern California
Civil Rights/ADA Coordinator
SCAL Compliance and Privacy
393 East Walnut St.,
Pasadena, CA 91188

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at *ocrportal.hhs.gov/ocr/portal/lobby.jsf* or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Ave. SW, Room 509F, HHH Building, Washington, DC 20201, 1-800-368-1019, 1-800-537-7697 (TTY). Complaint forms are available at *hhs.gov/ocr/office/file/index.html.*

Aviso de no discriminación

Kaiser Permanente no discrimina a ninguna persona por su edad, raza, etnia, color, país de origen, antecedentes culturales, ascendencia, religión, sexo, identidad de género, expresión de género, orientación sexual, estado civil, discapacidad física o mental, fuente de pago, información genética, ciudadanía, lengua materna o estado migratorio.

La Central de Llamadas de Servicio a los Miembros brinda servicios de asistencia con el idioma las 24 horas del día, los 7 días de la semana (excepto los días festivos). Se ofrecen servicios de interpretación sin costo alguno para usted durante el horario de atención, incluido el lenguaje de señas. Se ofrecen aparatos y servicios auxiliares para personas con discapacidades sin costo alguno durante el horario de atención. También podemos ofrecerle a usted, a sus familiares y amigos cualquier ayuda especial que necesiten para acceder a nuestros centros de atención y servicios. Puede solicitar los materiales traducidos a su idioma sin costo para usted. También los puede solicitar con letra grande o en otros formatos que se adapten a sus necesidades sin costo para usted. Para obtener más información, llame al **1-800-788-0616** (TTY **711**).

Una queja es una expresión de inconformidad que manifiesta usted o su representante autorizado a través del proceso de quejas. Por ejemplo, si usted cree que ha sufrido discriminación de nuestra parte, puede presentar una queja. Consulte su *Evidencia de Cobertura (Evidence of Coverage)* o *Certificado de Seguro (Certificate of Insurance)*, o comuníquese con un representante de Servicio a los Miembros para conocer las opciones de resolución de disputas que le corresponden.

Puede presentar una queja de las siguientes maneras:

- **Por teléfono:** Llame a servicio a los miembros al **1-800-788-0616** (TTY **711**) las 24 horas del día, los 7 días de la semana (excepto los días festivos).
- **Por correo postal:** Llámenos al **1-800-788-0616** (TTY **711**) y pida que se le envíe un formulario.
- **En persona:** Llene un formulario de Queja Formal o Reclamo/Solicitud de Beneficios en una oficina de servicio a los miembros ubicada en un Centro de Atención del Plan (consulte su directorio de proveedores en **kp.org/facilities** [haga clic en "Español"] para obtener las direcciones).
- **En línea:** Use el formulario en línea en nuestro sitio web en **kp.org/espanol**.

Llame a nuestra Central de Llamadas de Servicio a los Miembros si necesita ayuda para presentar una queja.

Se le informará al Coordinador de Derechos Civiles de Kaiser Permanente (Civil Rights Coordinator) de todas las quejas relacionadas con la discriminación por motivos de raza, color, país de origen, género, edad o discapacidad. También puede comunicarse directamente con el coordinador de derechos civiles de Kaiser Permanente en:

Northern California
Civil Rights/ADA Coordinator
1800 Harrison St.
16th Floor
Oakland, CA 94612

Southern California
Civil Rights/ADA Coordinator
SCAL Compliance and Privacy
393 East Walnut St.,
Pasadena, CA 91188

También puede presentar una queja formal de derechos civiles de forma electrónica ante la Oficina de Derechos Civiles (Office for Civil Rights) en el Departamento de Salud y Servicios Humanos de los Estados Unidos (U.S. Department of Health and Human Services) mediante el Portal de Quejas Formales de la Oficina de Derechos Civiles (Office for Civil Rights Complaint Portal), en *ocrportal.hhs.gov/ocr/portal/lobby.jsf* (en inglés) o por correo postal o por teléfono a: U.S. Department of Health and Human Services, 200 Independence Ave. SW, Room 509F, HHH Building, Washington, D.C. 20201, 1-800-368-1019, 1-800-537-7697 (TTY). Los formularios de queja formal están disponibles en *hhs.gov/ocr/office/file/index.html* (en inglés).

無歧視公告

Kaiser Permanente禁止以年齡、人種、族裔、膚色、原國籍、文化背景、血統、宗教、性別、性別認同、性別表達、性取向、婚姻狀況、生理或心理殘障、付款來源、遺傳資訊、公民身份、主要語言或移民身份為由而歧視任何人。

會員服務聯絡中心每週7天每天24小時提供語言協助服務（節假日除外）。本機構在全部營業時間內免費為您提供口譯服務，包括手語服務，以及殘障人士輔助器材和服務。我們還可為您和您的親友提供使用本機構設施與服務所需要的任何特別協助。您可免費索取翻譯成您的語言的資料。您還可免費索取符合您需求的大號字體或其他格式的版本。若需更多資訊，請致電**1-800-757-7585**（TTY **711**）。

申訴指任何您或您的授權代表透過申訴程序來表達不滿的做法。例如，如果您認為自己受到歧視，即可提出申訴。若需瞭解適用於自己的爭議解決選項，請參閱《承保範圍說明書》*(Evidence of Coverage)* 或《保險證明書》*(Certificate of Insurance)*，或諮詢會員服務代表。

您可透過以下方式提出申訴：

- **透過電話：**請致電**1-800-757-7585**（TTY **711**）與會員服務部聯絡，服務時間為每週7天，每天24小時（節假日除外）。
- **透過郵件：**請致電**1-800-757-7585**（TTY **711**）與我們聯絡並請我們將表格寄給您。
- **親自遞交：**在計劃設施的會員服務辦事處填寫投訴或福利理索賠／申請表（請參閱**kp.org/facilities**上的保健業者名錄以查看地址）
- **線上：**使用我們網站上的線上表格，網址為**kp.org**

如果您在提交申訴時需要協助，請致電我們的會員服務聯絡中心。

涉及人種、膚色、原國籍、性別、年齡或殘障歧視的一切申訴都將通知Kaiser Permanente的民權事務協調員 (Civil Rights Coordinator)。您也可與Kaiser Permanente的民權事務協調員直接聯絡，地址：

Northern California
Civil Rights/ADA Coordinator
1800 Harrison St.
16th Floor
Oakland, CA 94612

Southern California
Civil Rights/ADA Coordinator
SCAL Compliance and Privacy
393 East Walnut St.,
Pasadena, CA 91188

您還可以電子方式透過民權辦公室的投訴入口網站 (Office for Civil Rights Complaint Portal) 向美國衛生與民眾服務部 (U.S. Department of Health and Human Services) 民權辦公室 (Office for Civil Rights) 提出民權投訴，網址是*ocrportal.hhs.gov/ocr/portal/lobby.jsf*或者按照如下資訊採用郵寄或電話方式聯絡：U.S. Department of Health and Human Services, 200 Independence Ave. SW, Room 509F, HHH Building, Washington, DC 20201, 1-800-368-1019, 1-800-537-7697 (TTY)。投訴表可從網站*hhs.gov/ocr/office/file/index.html*下載。

Thông Báo Không Kỳ Thị

Kaiser Permanente không phân biệt đối xử dựa trên tuổi tác, chủng tộc, sắc tộc, màu da, nguyên quán, hoàn cảnh văn hóa, tổ tiên, tôn giáo, giới tính, nhận dạng giới tính, cách thể hiện giới tính, khuynh hướng tình dục, gia cảnh, khuyết tật về thể chất hoặc tinh thần, nguồn tiền thanh toán, thông tin di truyền, quốc tịch, ngôn ngữ chính, hay tình trạng di trú.

Các dịch vụ trợ giúp ngôn ngữ hiện có từ Trung Tâm Liên Lạc ban Dịch Vụ Hội Viên của chúng tôi 24 giờ trong ngày, 7 ngày trong tuần (ngoại trừ ngày lễ). Dịch vụ thông dịch, kể cả ngôn ngữ ký hiệu, được cung cấp miễn phí cho quý vị trong giờ làm việc. Các phương tiện trợ giúp và dịch vụ bổ sung cho những người khuyết tật được cung cấp miễn phí cho quý vị trong giờ làm việc. Chúng tôi cũng có thể cung cấp cho quý vị, gia đình và bạn bè quý vị mọi hỗ trợ đặc biệt cần thiết để sử dụng cơ sở và dịch vụ của chúng tôi. Quý vị có thể yêu cầu miễn phí tài liệu được dịch ra ngôn ngữ của quý vị. Quý vị cũng có thể yêu cầu miễn phí các tài liệu này dưới dạng chữ lớn hoặc dưới các dạng khác để đáp ứng nhu cầu của quý vị. Để biết thêm thông tin, gọi **1-800-464-4000** (TTY **711**).

Một phàn nàn là bất cứ thể hiện bất mãn nào được quý vị hay vị đại diện được ủy quyền của quý vị trình bày qua thủ tục phàn nàn. Ví dụ, nếu quý vị tin rằng chúng tôi đã kỳ phân biệt đối xử với vị, quý vị có thể đệ đơn phàn nàn. Vui lòng tham khảo Chứng *Từ Bảo Hiểm (Evidence of Insurance)* hay *Chứng Nhận Bảo Hiểm (Certificate of Insurance)*, hoặc nói chuyện với một nhân viên ban Dịch Vụ Hội Viên để biết các lựa chọn giải quyết tranh chấp có thể áp dụng cho quý vị.

Quý vị có thể nộp đơn phàn nàn bằng các hình thức sau đây:

- **Qua điện thoại**: Gọi cho ban dịch vụ hội viên theo số **1-800-464-4000** (TTY **711**) 24 giờ trong ngày, 7 ngày trong tuần (ngoại trừ đóng cửa ngày lễ).
- **Qua bưu điện:** Gọi cho chúng tôi theo số **1-800-464-4000** (TTY **711**) và yêu cầu được gửi một mẫu đơn.
- **Trực tiếp:** Điền một mẫu đơn Than Phiền hay Yêu Cầu Quyền Lợi/Yêu Cầu tại một văn phòng ban dịch vụ hội viên tại một Cơ Sở Thuộc Chương Trình (xem danh mục nhà cung cấp của quý vị tại **kp.org/facilities** để biết địa chỉ)
- **Trực tuyến:** Sử dụng mẫu đơn trực tuyến trên trang mạng của chúng tôi tại **kp.org**

Xin gọi Trung Tâm Liên Lạc ban Dịch Vụ Hội Viên của chúng tôi nếu quý vị cần trợ giúp nộp đơn phàn nàn.

Điều Phối Viên Dân Quyền (Civil Rights Coordinator) Kaiser Permanente sẽ được thông báo về tất cả phàn nàn liên quan tới việc kỳ thị trên cơ sở chủng tộc, màu da, nguyên quán, giới tính, tuổi tác, hay tình trạng khuyết tật. Quý vị cũng có thể liên lạc trực tiếp với Điều Phối Viên Dân Quyền Kaiser Permanente tại:

Northern California
Civil Rights/ADA Coordinator
1800 Harrison St.
16th Floor
Oakland, CA 94612

Southern California
Civil Rights/ADA Coordinator
SCAL Compliance and Privacy
393 East Walnut St.,
Pasadena, CA 91188

Quý vị cũng có thể đệ đơn than phiền về dân quyền với Bộ Y Tế và Nhân Sinh Hoa Kỳ (U.S. Department of Health and Human Services), Phòng Dân Quyền (Office of Civil Rights) bằng đường điện tử thông qua Cổng Thông Tin Phòng Phụ Trách Khiếu Nại về Dân Quyền (Office for Civil Rights Complaint Portal), hiện có tại *ocrportal.hhs.gov/ocr/portal/lobby.jsf*, hay bằng đường bưu điện hoặc điện thoại tại: U.S. Department of Health and Human Services, 200 Independence Ave. SW, Room 509F, HHH Building, Washington, D.C. 20201, 1-800-368-1019, 1-800-537-7697 (TTY). Mẫu đơn than phiền hiện có tại *hhs.gov/ocr/office/file/index.html.*

NOTICE OF LANGUAGE ASSISTANCE

English: This is important information from Kaiser Permanente. If you need help understanding this information, please call **1-800-464-4000** and ask for language assistance. Help is available 24 hours a day, 7 days a week, excluding holidays.

Arabic: تحتوي هذه الوثيقة على معلومات مهمة من Kaiser Permanente. إذا كنت بحاجة للمساعدة في فهم هذه المعلومات، يرجى الاتصال على الرقم **1-800-464-4000** وطلب مساعدة لغوية. المساعدة متوفرة على مدار الساعة طيلة أيام الأسبوع، باستثناء أيام العطلات الرسمية.

Armenian: Սա կարևոր տեղեկություն է «Kaiser Permanente»-ից: Եթե այս տեղեկությունը հասկանալու համար Ձեզ օգնություն է հարկավոր, խնդրում ենք զանգահարել **1-800-464-4000** հեռախոսահամարով և օժանդակություն ստանալ լեզվի հարցում: Զանգահարեք օրը 24 ժամ, շաբաթը 7 օր՝ բացի տոն օրերից:

Chinese: 這是來自 Kaiser Permanente 的重要資訊。如果您需要協助瞭解此資訊，請致電 **1-800-757-7585** 尋求語言協助。我們每週 7 天，每天 24 小時皆提供協助（節假日休息）。

Farsi: این اطلاعات مهمی از سوی Kaiser Permanente می باشد. اگر در فهمیدن این اطلاعات به کمک نیاز دارید، لطفاً با شماره **1-800-464-4000** تماس گرفته و برای امداد زبانی درخواست کنید. کمک و راهنمایی در 24 ساعت شبانروز و 7 روز هفته، شامل روزهای تعطیل موجود است.

Hindi: यह Kaiser Permanente की ओर से महत्वपूर्ण सूचना है। यदि आपको इस सूचना को समझने के लिए मदद की जरूरत है, तो कृपया **1-800-464-4000** पर फोन करें और भाषा सहायता के लिए पूछें। सहायता छुट्टियों को छोड़कर, सप्ताह के सातों दिन, दिन के 24 घंटे, उपलब्ध है।

Hmong: Qhov xov xwm no tseem ceeb los ntawm Kaiser Permanente. Yog koj xav tau kev pab kom nkag siab cov xov xwm no, thov hu rau **1-800-464-4000** thiab thov kev pab txhais lus. Muaj kev pab 24 teev ib hnub twg, 7 hnub ib lim tiam twg, tsis xam cov hnub caiv.

Japanese: Kaiser Permanente から重要なお知らせがあります。この情報を理解するためにヘルプが必要な場合は、 **1-800-464-4000** に電話して、言語サービスを依頼してください。このサービスは年中無休（祝祭日を除く）でご利用いただけます。

Khmer:នេះគឺជាព័ត៌មានសំខាន់ មកពី Kaiser Permanente។ បើសិនអ្នកត្រូវការជំនួយ ឲ្យបានយល់ដឹងព័ត៌មាននេះ សូមទូរស័ព្ទទៅលេខ **1-800-464-4000** និងស្នើសុំជំនួយខាងភាសា។ ជំនួយគឺមាន 24 ម៉ោងមួយថ្ងៃ 7 ថ្ងៃមួយអាទិត្យ រួមទាំងថ្ងៃបុណ្យផង។

Korean: 본 정보는 Kaiser Permanente 에서 전하는 중요한 메시지입니다. 본 정보를 이해하는 데 도움이 필요하시면, **1-800-464-4000** 번으로 전화해 언어 지원 서비스를 요청하십시오. 요일 및 시간에 관계없이 언제든지 도움을 제공해 드립니다(공휴일 제외).

Laotian: ນີ້ແມ່ນຂໍ້ມູນສຳຄັນຈາກ Kaiser Permanente. ຖ້າວ່າ ທ່ານຕ້ອງການຄວາມຊ່ວຍເຫຼືອໃນການຊ່ວຍໃຫ້ເຂົ້າໃຈຂໍ້ມູນນີ້, ກະຣຸນາໂທຣ **1-800-464-4000** ແລະຂໍເອົາການຊ່ວຍເຫຼືອດ້ານພາສາ. ການຊ່ວຍເຫຼືອມີໃຫ້ຕະຫຼອດ 24 ຊົ່ວໂມງ, 7 ວັນຕໍ່ອາທິດ, ບໍ່ລວມວັນພັກຕ່າງໆ.

Navajo: Díí éí hane’ bíhólníihii át’éego Kaiser Permanente yee nihalne’. Díí hane’ígíí doo hazhó’ó bik’i’diitįįhgóó t’áá shǫǫdí koji’ hodíilnih **1-800-464-4000** áko saad bee áká i’iilyeed yídíikił. Kwe’é áká aná’álwo’ t’áá áłahjį’ naadiindíį’ ahéé’ílkidgóó dóó tsosts’id jį́ ąą’át’é. Dahodílzingóne’ éí dá’deelkaal.

Punjabi: ਇਹ Kaiser Permanente ਵਲੋਂ ਜ਼ਰੂਰੀ ਜਾਣਕਾਰੀ ਹੈ। ਜੇ ਤੁਹਾਨੂੰ ਇਸ ਜਾਣਕਾਰੀ ਨੂੰ ਸਮਝਣ ਲਈ ਮਦਦ ਦੀ ਲੋੜ ਹੈ, ਤਾਂ ਕਿਰਪਾ ਕਰਕੇ **1-800-464-4000** 'ਤੇ ਫ਼ੋਨ ਕਰੋ ਅਤੇ ਭਾਸ਼ਾ ਸਹਾਇਤਾ ਲਈ ਪੁੱਛੋ। ਮਦਦ, ਛੁੱਟੀਆਂ ਨੂੰ ਛੱਡ ਕੇ, ਹਫ਼ਤੇ ਦੇ 7 ਦਿਨ, ਅਤੇ ਦਿਨ ਦੇ 24 ਘੰਟੇ ਮੌਜੂਦ ਹੈ।

Russian: Это важная информация от Kaiser Permanente. Если Вам требуется помощь, чтобы понять эту информацию, позвоните по номеру **1-800-464-4000** и попросите предоставить Вам услуги переводчика. Помощь доступна 24 часа в сутки, 7 дней в неделю, кроме праздничных дней.

Spanish: La presente incluye información importante de Kaiser Permanente. Si necesita ayuda para entender esta información, llame al **1-800-788-0616** y pida ayuda linguística. Hay ayuda disponible 24 horas al día, siete días a la semana, excluidos los días festivos.

Tagalog: Ito ay importanteng impormasyon mula sa Kaiser Permanente. Kung kailangan ninyo ng tulong para maunawan ang impormasyong ito, mangyaring tumawag sa **1-800-464-4000** at humingi ng tulong kaugnay sa lengguwahe. May makukuhang tulong 24 na oras bawat araw, 7 araw bawat linggo, maliban sa mga araw na pista opisyal.

Thai: นี่เป็นข้อมูลสำคัญจาก Kaiser Permanente หากคุณต้องการความช่วยเหลือในการทำความเข้าใจข้อมูลนี้ กรุณาโทรไปยังหมายเลข **1-800-464-4000** เพื่อขอความช่วยเหลือด้านภาษา สามารถโทรติดต่อได้ตลอด 24 ชั่วโมงทุกวัน ยกเว้นวันหยุดเทศกาล.

Vietnamese: Đây là thông tin quan trọng từ Kaiser Permanente. Nếu quý vị cần được giúp đỡ để hiểu rõ thông tin này, vui lòng gọi số **1-800-464-4000** và yêu cầu được cấp dịch vụ về ngôn ngữ. Quý vị sẽ được giúp đỡ 24 giờ trong ngày, 7 ngày trong tuần, trừ ngày lễ.

2024 Premier Medical Carrier Comparison Chart

Effective January 1, 2024

Please note: **There is only one Premier PPO and one Premier HMO Plan of benefits.** This comparison and other materials from the Fund Office may use the term "HCP" and other related terms solely for the purposes of making it easier for participants to understand the differences associated with participating in the Wellness Program (HCP) versus not participating. You can participate in the Wellness Program (HCP) whether you enroll in the Premier PPO or the Premier HMO Plan.

2024 UCBT Premier Medical Carrier Comparison Chart

	Blue Shield of California PPO	Kaiser HMO
Choice of Providers	Must use Blue Shield of California providers to receive higher benefits ("in-network or PPO benefits"). Except in emergencies, lower benefits apply if NOT using in-network Blue Shield of California providers ("out-of-network or non-PPO benefits"). Participants outside California should use the BlueCard network.	Must use a Kaiser provider in order to receive benefits. Except for emergencies, no benefits will be provided for services rendered by non-Kaiser providers.
Weekly Premiums A Premium is the contribution amount you pay when you enroll your dependents. Per Child premiums are for each of the first three children and then $0 for any additional children.	**UCBT Wellness Program (HCP) Weekly Premium Rates** • Employee: $0 • Spouse/Domestic Partner: $20 • Per Child: $10 **Not participating in Wellness Program Weekly Premium Rates** • Employee: $0 • Spouse/Domestic Partner: $30 • Per Child: $15	**UCBT Wellness Program (HCP) Weekly Premium Rates** • Employee: $0 • Spouse/Domestic Partner: $20 • Per Child: $10 **Not participating in Wellness Program Weekly Premium Rates** • Employee: $0 • Spouse/Domestic Partner: $30 • Per Child: $15
Calendar Year Deductible (In-Network) Except for ACA preventive care services, you must pay all costs up to the deductible amount before the plan begins to pay for covered services you use. Copayments, coinsurance and non-covered expenses do not count toward the deductible.	**UCBT Wellness Program (HCP) Determined by Covered Dependents** Available HRA funds will be used to pay for your deductible until either the deductible is met or the HRA funds are exhausted. • Employee Only: $900 • Employee with 1 Dependent: $1,800 • Employee with 2+ Dependents: $1,850 **Not participating in Wellness Program Determined by Covered Dependents** • Employee Only: $900 • Employee with 1 Dependent: $1,800 • Employee with 2+ Dependents: $1,850	**UCBT Wellness Program (HCP) Determined by Covered Dependents** Available HRA funds will be used to pay for your deductible until either the deductible is met or the HRA funds are exhausted. • Employee Only: $900 • Employee with 1 Dependent: $1,800 • Employee with 2+ Dependents: $1,850 **Not participating in Wellness Program Determined by Covered Dependents** • Employee Only: $900 • Employee with 1 Dependent: $1,800 • Employee with 2+ Dependents: $1,850

2024 UCBT Premier Medical Carrier Comparison Chart

	Blue Shield of California PPO	Kaiser HMO
Calendar Year Deductible (Out-of-Network) You must pay all the costs up to the deductible amount before the plan begins to pay for covered services you use. Copayments, coinsurance and non-covered expenses do not count toward the deductible.	• Employee Only: $1,100 • Employee with 1 Dependent: $2,200 • Employee with 2+ Dependents: $2,450 HRA funding will be used to pay your annual deductible until either the deductible is met or the HRA funding is exhausted.	No out-of-network benefits, except for emergency care.
Calendar Year Out-Of-Pocket Maximum (Medical In-Network and Out-of-Area) The calendar year in-network (PPO) and out-of-area (OOP) medical limit is the most you could pay during a calendar year for your share of the cost of covered medical services. This includes your coinsurance and deductible for PPO and out-of-area medical services. Premiums, balance-billed charges, non-covered expenses, charges in excess of benefit maximums, prescription drug, dental and vision expenses, and out-of-network coinsurance do not count toward the PPO and out-of-area out-of-pocket limit.	**UCBT Wellness Program (HCP)** • Employee Only: $2,900 • Employee with 1 Dependent: $5,800 • Employee with 2+ Dependents: $7,850 **Not participating in Wellness Program** • Employee Only: $5,900 • Employee with 1 Dependent: $11,800 • Employee with 2+ Dependents: $12,800	**UCBT Wellness Program (HCP)** • Employee Only: $2,900 • Employee with 1 Dependent: $5,800 • Employee with 2+ Dependents: $7,850 **Not participating in Wellness Program** • Employee Only: $5,350 • Employee with 1 Dependent: $10,700 • Employee with 2+ Dependents: $10,700
Calendar Year Out-Of-Pocket Maximum (OOP) (Medical Out-of-Network)	No maximum (unlimited out-of-pocket)	No maximum (unlimited out-of-pocket)
Calendar Year Out-Of-Pocket (OOP) Maximum (Prescription In-Network and Out-of-Area) The calendar year in-network and out-of-area prescription OOP limit is the most you could pay during a calendar year for your share of the cost of covered prescription drugs. The prescription drug out-of-pocket limit does not include any drugs purchased at out-of-network pharmacies and/or any additional amount paid for a non-preferred drug under the MPD program.	**UCBT Wellness Program (HCP)** • Employee Only: $6,550 • Employee with 1 Dependent: $13,100 • Employee with 2+ Dependents: $11,050 **Not participating in Wellness Program** • Employee Only: $3,550 • Employee with 1 Dependent: $7,100 • Employee with 2+ Dependents: $6,100	**UCBT Wellness Program (HCP)** • Employee Only: $6,550 • Employee with 1 Dependent: $13,100 • Employee with 2+ Dependents: $11,050 **Not participating in Wellness Program** • Employee Only: $4,100 • Employee with 1 Dependent: $8,200 • Employee with 2+ Dependents: $8,200
Calendar Year Out-Of-Pocket Maximum (Prescription Out-of-Network)	No maximum (unlimited out-of-pocket)	No maximum (unlimited out-of-pocket)

2024 UCBT Premier Medical Carrier Comparison Chart

	Blue Shield of California PPO	Kaiser HMO
ACA Preventive Services (In-Network)	100% of covered charges	100% of covered charges
ACA Preventive Services (Out-of-Network)	Not covered	Not covered
Patient Coinsurance Coinsurance is your share of the costs of a covered service, calculated as a percent of the allowed amount for the service after you satisfy your deductible. For example, if the plan's Allowed Amount for a hospital stay is $10,000, your coinsurance of 20% would be $2,000, if you have already met your deductible.	Applies to all covered services such as hospitalization, outpatient hospital services, primary care and specialist office visits, urgent care, emergency room. **In-Network** **UCBT Wellness Program (HCP)** – 15% **Not participating in Wellness Program** – 20% **Out-of-Network** 50% of Allowed Amount plus Billed Charges above Allowed Amount	Applies to all covered services such as hospitalization, outpatient hospital services, primary care and specialist office visits, urgent care, emergency room. **In-Network** **UCBT Wellness Program (HCP)** – 15% **Not participating in Wellness Program** – 20% **Out-of-Network** Not covered

2024 Prescription Benefit Summary at Network Pharmacies

To maximize your benefit and reduce out-of-pocket costs, fill your prescriptions at UCBT In-Network Pharmacies.

	Maintenance Drugs for Select Conditions	Maintenance Drugs for Other Conditions	Other Drugs
Preferred Generic	30-day supply: $7 90-day supply: $14	30-day supply: $10 90-day supply: $20	30-day supply: $10
Preferred Brand	30-day supply: $15 90-day supply: $30	30-day supply: $20 90-day supply: $40	30-day supply: $20
Non-Preferred	30-day supply: $25 90-day supply: $50	30-day supply: $35 90-day supply: $70	30-day supply: $35
	Costs in excess of the benchmarked drug cost are not covered by the Plan. Members pay the excess costs in addition to the above copays.		
Member Submitted Claims	Available only for emergencies and out-of-area users. Lesser of purchase price or AWP less applicable copayment.		

2024 Vision Benefit Summary

To maximize your benefit and reduce out-of-pocket costs, see Vision Service Plan (VSP) In-Network Provider(s) for your vision care.

Exam, Lenses and Frames	VSP Network Provider: $5 deductible, exam is covered once every calendar year; lenses and frames are covered once every calendar year, up to wholesale allowance. Non-VSP Provider: Covered up to Plan Allowances, member pays 100% of costs above Allowance.

2024 Dental Benefit Summary

	Cigna Dental PPO	Cypress Dental PPO	Delta Dental DPO	Liberty Dental DMO
Choice Of Providers	You may select any dentist of your choice. Using a dentist in-network with Cigna Dental will lower your out-of-pocket expense.	You may select any dentist of your choice. Using a dentist in-network with Cypress Dental will lower your out-of-pocket expense.	You may select any dentist of your choice. Using a dentist in-network with Delta Dental will lower your out-of-pocket expense.	You must use the Liberty DMO providers. If you go to a non-network provider, you will have to pay 100% of the charges incurred.
Calendar Year Deductible	None	None	None	None
Calendar Year Benefit Maximum	$2,500 per person No calendar year benefit maximum for Pediatric Dental Care.	$2,500 per person No calendar year benefit maximum for Pediatric Dental Care.	$2,500 per person No calendar year benefit maximum for Pediatric Dental Care.	No maximum
Covered Expenses (In-Network)	Contracted Cigna Dental rates	Contracted Cypress Dental rates	Contracted Delta Dental rates	Contracted Liberty rates
Covered Expenses (Out-Of-Network)	Cigna Dental schedule allowances	Indemnity dental schedule allowances	Delta Dental schedule allowances	No out-of-network benefits
Preventive & Diagnostic	100% of covered expenses	100% of covered expenses	100% of covered expenses	Network provider services are provided after you pay the applicable copayment.
Basic Restorative	80% of covered expenses	80% of covered expenses	80% of covered expenses	Network provider services are provided after you pay the applicable copayment.
Major Restorative	70% of covered expenses	70% of covered expenses	70% of covered expenses	Network provider services are provided after you pay the applicable copayment.
Orthodontic Benefit	75% of covered expenses, up to $2,000 per person lifetime	75% of covered expenses, up to $2,000 per person lifetime	75% of covered expenses, up to $2,000 per person lifetime	Orthodontic benefit is provided through Liberty Dental DMO. • $1,300 copay for limited treatment • $1,550 copay for transitional and adolescent comprehensive treatment • $1,695 copay for adult comprehensive treatment

Do you and your Spouse/Domestic Partner both work?

Do you have multiple health insurance plans and insurance coverages?

Read these FAQs to help understand how it all works.

Frequently Asked Questions About Coordination Of Benefits (COB)

If your Spouse/Domestic Partner, or any of your Dependent Children work and their job provides health care benefits, or if any of you is eligible for Medicare, it is important for you to understand how your UCBT Active or Retiree benefits will coordinate with their other coverage through work or Medicare. Review the information below and take the time to log into **ufcwtrust.com** to review your coverage. This will help avoid confusion and could help you avoid paying for unnecessary out-of-pocket expenses.

Non-Duplication of Benefits

Question 1: What is the Non-Duplication of Benefits rule?

Answer: The UCBT Plan uses Non-Duplication of Benefits rules to calculate benefit payments when the UCBT Plan is the secondary coverage and pays after another health plan. The UCBT Plan pays after another health plan when that other health plan is the primary coverage for you, your Spouse/Domestic Partner, or your Dependent Child. If the other plan pays more than what the UCBT Plan would have paid if the UCBT Plan was the only coverage, the UCBT plan as the secondary plan would not pay any additional benefits. The UCBT Plan will pay benefits only if the primary plan's payment was less than the amount the UCBT Plan would have paid if the UCBT Plan were the only coverage. In other words, when the UCBT pays secondary, the UCBT Plan does not duplicate the payments under the primary coverage.

Example 1: If the primary plan paid 80% of the UCBT Plan's allowed amount for a service, and the UCBT Plan would have paid 75% of the allowed amount for that same service if it were the only plan providing benefits, the UCBT Plan will not pay any additional amounts for that service. The patient will be responsible for the remaining 20% of the cost.

Example 2: If the primary plan paid 70% of the UCBT Plan's allowed amount for a service and the UCBT Plan would have paid 75% of the allowed amount for that same service if it were the only plan providing benefits, the UCBT Plan would pay an additional 5% of the UCBT Plan's allowed amount for that service. The patient will be responsible for the remaining 25% of the UCBT Plan's allowed amount (plus any additional amounts if the primary plan's allowed amount was greater that the UCBT Plan's allowed amount for the service, and any additional billed charges if the services

were performed by an out of network provider).

If you and your Spouse/Domestic Partner both are covered as Members under a UCBT Plan but do not qualify for Dual Coverage, the UCBT Plan will pay each Member's claims as primary under their respective plan and then apply non-duplication to the secondary claim.

Dual Coverage

"Dual Coverage" refers to the coverage available to couples (you and your Spouse/Domestic Partner) when both are Members of the UCBT Active Plan or the UCBT Retiree Health Plan – for example, both are Active Members, both are Retirees, or one is an Active Member and one is a Retiree. When both individuals are enrolled in a UCBT Plan and both meet the requirements as described below, the couple is eligible for Dual Coverage. Dual Coverage provides 100% Coordination of Benefits. This means that generally you will have lower out of pocket expense than if you didn't have Dual Coverage.

Question 2: I am covered under the UCBT Active Plan as a member because I work in the industry. My Spouse/Domestic Partner is also covered under the UCBT Active Plan as a member because they work in the industry. What do we need to do to qualify for Dual Coverage?

Answer: In order to qualify for Dual Coverage, you must meet the following eligibility requirements:

a. Both of you must enroll in the same medical carrier (either PPO or HMO).

b. Both of you must cover each other as a Dependent and cover all of the same Dependent Children. In other words, all of your enrolled household members will have two coverages through UCBT. You and your Spouse/Domestic Partner will each pay Dependent premiums that cover the Spouse/Domestic Partner and all Dependent Children.

c. Both of you must complete the Wellness Steps to participate in the Wellness Program (HCP). If one of you does not participate in the Wellness Program, both of you will not qualify for Dual Coverage, even if you meet the a. and b. requirements above. Instead of Dual Coverage and 100% Coordination of Benefits, benefits will be coordinated based on the Non-Duplication of Benefits rules. See answer to Question 1 above to understand what Non-Duplication of Benefits means.

Question 3: I am an active member and my Spouse/Domestic Partner is a retired member. How do we qualify for Dual Coverage?

Answer: In order to qualify for Dual Coverage, both of you must meet the eligibility requirements described in Answer 2 above, with the following clarifications:

- If any of your children are eligible for coverage as a Dependent Child under the Active Plan but are not eligible to be covered under the Retiree Plan (either because of the child's age or the Retiree having less than 25 years of credited service), the Dependent Child may be covered under the Active Plan only and you will still qualify for Dual Coverage.

- Although Retirees are not eligible to participate in the Wellness Program (HCP), both you and your Spouse/Domestic Partner must still complete the Wellness Steps, because the UCBT Active Plan requires both the Active Member and the Member's enrolled Spouse/Domestic Partner to complete the required Wellness Steps for the family to be eligible to participate in the Wellness Program (HCP).

Question 4: Both my Spouse/Domestic Partner and I are retired UCBT members. How do we qualify for Dual Coverage?

Answer: In order to qualify for Dual Coverage, both of you must meet the eligibility requirements described in a. and b. under Answer 2 above, with the following clarifications:

- If any of your children are eligible for coverage as a

Dependent Child under one Member's Retiree coverage but not the other Member's Retiree coverage (because one of the Retiree Members has 25 years or more of credited service, while the other Retiree Member has less than 25 years of credited service), the Dependent Child may be covered under one Member's Retiree Plan only and you will still qualify for Dual Coverage.

- There is no Wellness Program (HCP) for UCBT Retirees.

Other Insurance Information

Question 5: What if I am a UCBT Active Plan member and my covered Spouse/Domestic partner works elsewhere?

Answer: If your Spouse/Domestic Partner is working and is offered group health insurance through their employer, they must enroll in that other insurance and select the option that is the most comparable to the UCBT Plan, regardless of the cost; otherwise their benefits under the UCBT Plan will be reduced by 60%.

If health insurance is not offered by your Spouse/Domestic Partner's employer, you must submit a letter from their employer (on company letterhead) to the Trust Fund Office (TFO) explaining that the employer does not offer insurance. If you do not submit this letter, a 60% reduction in benefits under the UCBT Plan will be applied to claims incurred by your Spouse/Domestic Partner. You can fax the letter to (925) 746-7549 or submit it online to **ufcwtrust.com**.

Question 6: What if I am a UCBT Active Plan member and my Spouse/Domestic Partner is retired and not a UCBT Retiree?

Answer: If your Spouse/Domestic Partner is retired and offered retiree health coverage through a past employer, they must enroll in that other insurance and select the option that is the most comparable to the UCBT Plan coverage, regardless of the cost; otherwise their benefits under the UCBT Plan will be reduced by 60%. If retiree health insurance is not offered by your Spouse/Domestic Partner's past employer, you must submit a letter from their past employer (on company letterhead) to the Trust Fund Office (TFO) explaining that the employer does not offer retiree insurance. If you are unable to obtain such a letter (for example because your Spouse's/Domestic Partner's former employer is no longer in business), please contact the TFO for acceptable alternative documentation.

Question 7: What if I am a UCBT Retiree and I, my Spouse/Domestic Partner, or covered Dependent Children work elsewhere?

Answer: A Spouse, Domestic Partner or Dependent Child enrolled in the UCBT Retiree Health Plan who has access to either retiree health benefits through a past employer or health benefits through a current employer must take the insurance offered by the employer (past or current) and select the option that is the most comparable to the UCBT Retiree Plan coverage, regardless of the cost; otherwise benefits under the UCBT Retiree Plan will be reduced by 60% for that individual.

A UCBT Retiree who has access to an active plan through a current employer must take the insurance offered by the current employer and select the option that is the most comparable to the UCBT Retiree Plan coverage, regardless of the cost; otherwise benefits under the UCBT Retiree Plan will be reduced by 60% for the Retiree.

Question 8: Both my Spouse/Domestic Partner and I are UCBT Retirees. Does my Spouse/Domestic Partner have to take their own UCBT Retiree coverage or may I cover my Spouse/Domestic Partner under my UCBT Retiree plan?

Answer: You may cover your Spouse/Domestic Partner under your UCBT Retiree Health Plan. Your Spouse/Domestic Partner does NOT need to enroll under his/her own UCBT Retiree Health Plan coverage. While UCBT Retirees are required to enroll in any other employer-based retiree group plan when offered, this rule does not apply if both of you are UCBT Retirees. However, if you want Dual Coverage, you must both enroll and select the same medical carrier, while covering each other and the same Dependent Children. (See Question/Answer 2.)

Notes

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Dental Providers Information

Delta Dental
For more information on Benefits from Delta Dental, please go to the following website:
https://www1.deltadentalins.com/ucbtfund

Cigna Dental
For more information on Cigna Dental benefits, please go to the following website:
https://view.ceros.com/cigna/ucfw/p/1

Cypress Dental
Please visit the link below and in the upper right corner, click in the blue box that says “Plan” and select “Union Employees” to find a provider near you.

https://directory.mycypressadmin.com/home

Liberty Dental
Visit the website to locate a provider at https://client.libertydentalplan.com/UFCW

Visit

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