
 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, contact United Agricultural Benefit Trust (UABT) Member Services Department at 1-800-223-4590. 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.UnitedAg.org](http://www.UnitedAg.org) or call 1-800-223-4590 to request a copy.

Important Questions	Answers	Why This Matters:
<b>What is the overall deductible?</b>	\$5,000 / Individual	Generally, you must pay all the costs from providers up to the <a href="#">deductible</a> amount before this <a href="#">plan</a> begins to pay.
<b>Are there services covered before you meet your deductible?</b>	Yes, <a href="#">Preventative Care</a> Visits	<a href="#">In-Network Preventative Care</a> is covered at 100%.
<b>Are there other deductibles for specific services?</b>	Yes. \$250 per patient per calendar year	Pharmacy Benefit Network Benefits. Applies to <a href="#">Formulary</a> and Non-Formulary Brand Medications.
<b>What is the <u>out-of-pocket limit</u> for this plan?</b>	For <a href="#">network providers</a> \$8,500/patient or \$17,000/family	The <a href="#">out-of-pocket limit</a> is the most you could pay in a year for covered services. If you have other family members in this plan, once the family <a href="#">out-of-pocket limit</a> is met, there is no further <a href="#">out-of-pocket expense</a> required. For <a href="#">out-of-network providers</a> , each patient must meet the individual patient <a href="#">out-of-pocket limit</a> .
<b>What is not included in the <u>out-of-pocket limit</u>?</b>	Any non-covered expenses which may include non-network providers' balance-billed charges.	You are always responsible for any non-covered expenses which may include non-network providers' balance-billed charges.
<b>Will you pay less if you use a <u>network provider</u>?</b>	Yes. See <a href="http://www.UnitedAg.org">www.UnitedAg.org</a> or call 1-800-223-4590 for a list of <a href="#">network providers</a>	This plan uses the Blue Shield of California <a href="#">provider network</a> . You will pay less if you use a <a href="#">provider</a> in the plan's <a href="#">network</a> . You will pay the most if you use an <a href="#">out-of-network provider</a> , and you might receive a bill from a <a href="#">provider</a> for the difference between the <a href="#">providers'</a> charge and what your <a href="#">plan</a> pays ( <a href="#">balance billing</a> ). Be aware, your <a href="#">network provider</a> might refer you to an <a href="#">out-of-network provider</a> for some services (such as lab work, emergency room services, anesthesiology). Check with your <a href="#">provider</a> before you get services.
<b>Do you need a <u>referral</u> to see a <u>specialist</u>?</b>	No.	You may see a specialist of your choice without obtaining permission from the plan. But do remember that there is a greater <a href="#">out-of-pocket</a> cost to you if your specialist is <a href="#">out-of-network</a> .

 All **copayment** and **coinsurance** costs shown in this chart are after your **deductible** has been met, if a deductible applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information*
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
<b>If you visit a health care provider's office or clinic</b>	Primary care visit to treat an injury or illness	\$20 <b>co-pay</b> (not subject to <b>deductible</b> )	Not Covered	No benefits are payable if you use an <b>Out-of-Network</b> Provider.
	<b>Specialist</b> visit	\$20 <b>co-pay</b> (not subject to <b>deductible</b> )	Not Covered	None
	<b>Preventive care/screening/immunization</b>	\$0	Not Covered	Preventative care paid in full through <b>in-network</b> providers only. You may have to pay for services that aren't <b>preventative</b> .
<b>If you have a test</b>	<b>Diagnostic test</b> (x-ray, blood work)	\$20 <b>co-pay</b> for lab work (not subject to <b>deductible</b> ) / x-rays payable at 25% after <b>deductible</b> is met	Not Covered	None
	Imaging (CT/PET scans, MRIs)	40% <b>co-insurance</b> after <b>deductible</b> is met	Not Covered	None
<b>If you need drugs to treat your illness or condition</b> More information about <b>prescription drug coverage</b> is available at <a href="http://www.unitedag.org">www.unitedag.org</a>	Generic drugs	\$20 <b>co-pay</b> for 34-day supply / \$40 <b>co-pay</b> for a 90-day supply thru mail order or retail	Not Covered	<b>Rx Deductible</b> does not apply
	<b>Preferred</b> brand drugs	\$40 <b>co-pay</b> for 34-day supply / \$80 <b>co-pay</b> for a 90-day supply thru mail order or retail supply after \$250 <b>deductible</b> is met	Not covered	<b>Formulary</b> Brand drugs are preferred, covered medications recommend to prescribing physicians. Formularies promote the use of medications chosen which are equally effective and less costly than alternative drugs. UABT Member Services can provide you with a list of <b>Formulary Medications</b> – call (800)223-4590.
	Non-preferred brand drugs	50% of the cost of the Medication after \$250 <b>deductible</b> is met	Not Covered	None
	<b>Specialty drugs</b>	Contact UABT Member Services 800-223-4590 or Costco Specialty Services (866) 443-0060.	Not Covered	Specialty medications must be purchased through our Specialty Pharmacy Program. When <b>co-pay</b> assistance program is available, member will be responsible for 20% <b>co-insurance</b> not to exceed applicable <b>co-pay</b> based tier.

\* For more information about limitations and exceptions, see the plan or policy document at [www.unitedag.org](http://www.unitedag.org) or call 1-800-223-4590.

<b>If you have outpatient surgery</b>	Facility fee (e.g., ambulatory surgery center)	40% <a href="#">co-insurance</a> after <a href="#">deductible</a> is met	Not Covered	None
	Physician/surgeon fees	40% <a href="#">co-insurance</a> after <a href="#">deductible</a> is met	Not Covered	
<b>If you need immediate medical attention</b>	Emergency room care	40% <a href="#">co-insurance</a> after <a href="#">deductible</a> is met	40% <a href="#">co-insurance</a> after <a href="#">deductible</a> is met	<a href="#">Non-network</a> emergency room for emergency care is paid at the same rate as <a href="#">in-network</a> emergency room care. Non-Network Providers' balance-billing may be charged.
	<a href="#">Emergency medical transportation</a>	40% <a href="#">co-insurance</a> after <a href="#">deductible</a> is met	Not Covered	None
	<a href="#">Urgent care</a>	\$20 <a href="#">co-pay</a> (not subject to <a href="#">deductible</a> )	Not Covered	None
<b>If you have a hospital stay</b>	Facility fee (e.g., hospital room)	40% <a href="#">co-insurance</a> after <a href="#">deductible</a> is met	Not Covered	<a href="#">Preauthorization</a> is required. If you do not get <a href="#">preauthorization</a> , benefits could be reduced. Room & Board charges limited to Hospital's average semi-private room rate.
	Physician/surgeon fees	\$20 <a href="#">co-pay</a> (not subject to <a href="#">deductible</a> )	Not Covered	<a href="#">Preauthorization</a> is required. If you do not get <a href="#">preauthorization</a> , benefits could be reduced.
<b>If you need mental health, behavioral health, or substance abuse services</b>	Outpatient services	\$20 <a href="#">co-pay</a> (not subject to <a href="#">deductible</a> )	Not Covered	None
	Inpatient services	40% <a href="#">co-insurance</a> after <a href="#">deductible</a> is met	Not Covered	<a href="#">Preauthorization</a> is required. If you do not get <a href="#">preauthorization</a> , benefits could be reduced.
<b>If you are pregnant</b>	Office visits	\$20 <a href="#">co-pay</a> (not subject to <a href="#">deductible</a> )	Not Covered	Your eligible dependents are covered for pregnancy
	Childbirth/delivery professional services	40% <a href="#">co-insurance</a> after <a href="#">deductible</a> is met	Not Covered	
	Childbirth/delivery facility services	40% <a href="#">co-insurance</a> after <a href="#">deductible</a> is met	Not Covered	

<b>If you need help recovering or have other special health needs</b>	<u>Home health care</u>	30% <u>co-insurance</u> after <u>deductible</u> is met	Not Covered	Must be medically necessary, doctor's orders required.
	<u>Rehabilitation services</u>	40% <u>co-insurance</u> after <u>deductible</u> is met	Not Covered	None
	<u>Habilitation services</u>	40% <u>co-insurance</u> after <u>deductible</u> is met	Not Covered	None
	<u>Skilled nursing care</u>	40% <u>co-insurance</u> after <u>deductible</u> is met	Not Covered	\$75 per day to a maximum of 90 days after at least 3 days of hospital confinement
	<u>Durable medical equipment</u>	40% <u>co-insurance</u> after <u>deductible</u> is met	Not Covered	None
	<u>Hospice services</u>	40% <u>co-insurance</u> after <u>deductible</u> is met	Not Covered	A maximum of \$150 per day to a maximum of 150 days
<b>If your child needs dental or eye care (Small Group ONLY-check with UABT)</b>	Children's eye exam	0%	Not covered	Dependent Children up to age 19 only
	Children's glasses	\$0	Not Covered	Dependent Children up to age 19 only
	Children's dental check-up	0%	Not Covered	Dependent Children up to age 19 only
<b>Telemedicine</b>	Consultation and/or Treatment by Contracting Telemedicine Provider	\$0 per consultation	Not Covered	Covers Physician Consultation, Dermatological Exam, Behavioral Health Counseling and Smoking Cessation (expenses beyond the telephone consultation will be subject to your deductible)
<b>If you use the Mexican Panel</b>	Doctor Visits	\$5 <u>co-pay</u> per visit	Limited to UABT Mexican Panel schedules	All covered expenses are paid in full. Pre-approved travel costs for patient and/or companion for specific inpatient medical procedures. Pre-admission authorization is required for all hospitalizations in Mexico.
	Inpatient & Outpatient Hospital/Pharmacy	Hospital: \$0 <u>co-pay</u> Rx: \$5 <u>co-pay</u> per drug		

## 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.)		
<ul style="list-style-type: none"> <li>Charges which would not have been billed to you if tis benefit plan was not in effect.</li> </ul>	<ul style="list-style-type: none"> <li>Eye glasses; treatment or surgical correction of refractive error including, but not limited to keratomy, keratoplasty and/or laser surgery; visual motor training and or other eye exercise unless performed in lieu of surgery to correct an eye muscle disorder.</li> </ul>	<ul style="list-style-type: none"> <li>Fees in excess of Usual and Customary charges in the geographic area</li> </ul>
<ul style="list-style-type: none"> <li>Dental Care (Adults)</li> </ul>	<ul style="list-style-type: none"> <li>Hearing Aides</li> </ul>	<ul style="list-style-type: none"> <li>Infertility Treatment</li> </ul>
<ul style="list-style-type: none"> <li>Long Term Care</li> </ul>	<ul style="list-style-type: none"> <li>Medical or surgical treatment related to sexual dysfunction</li> </ul>	<ul style="list-style-type: none"> <li>Medical or surgical treatment related to sex change</li> </ul>
<ul style="list-style-type: none"> <li>Non-Surgical Treatment of feet, including but not limited to treatment of weak or fallen arches, flat or pronated feet, metatarasalgia, bunions, hammer toes, paring or excision of corns or calluses or trimming of toenails.</li> </ul>	<ul style="list-style-type: none"> <li>Over-the-Counter medications, vitamins, minerals and dietary supplement, unless prescribed by a doctor for prenatal care;</li> </ul>	<ul style="list-style-type: none"> <li>Prescription medications not purchased through a contracted pharmacy (the Pharmacy Plan)</li> </ul>
<ul style="list-style-type: none"> <li>Private Duty Nursing</li> </ul>	<ul style="list-style-type: none"> <li>Routine Adult Eye Care</li> </ul>	<ul style="list-style-type: none"> <li>Services not considered medically necessary</li> </ul>
<ul style="list-style-type: none"> <li>Services provided by <a href="#">non-contracting panel providers</a> unless the treatment qualifies under the special Provisions for <a href="#">Non-Contracting Panel/Out of Area Provider</a> Benefits included in this <a href="#">Plan</a></li> </ul>	<ul style="list-style-type: none"> <li>Surrogate parenting, procedures designed to reverse a previous elective sterilization, invitro fertilization, artificial insemination, zygote transfer, hormone therapy or any other service intended as treatment of infertility</li> </ul>	<ul style="list-style-type: none"> <li>Treatment for injuries sustained during participation in criminal activities, unlawful activities and/or any illegal activities</li> </ul>
<ul style="list-style-type: none"> <li>Use of growth hormone therapy unless demonstrated growth hormone deficiency had been medically substantiated.</li> </ul>	<ul style="list-style-type: none"> <li>Weight Loss Programs</li> </ul>	
Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your <a href="#">plan document</a> .)		
<ul style="list-style-type: none"> <li>Acupuncture (when prescribed for pain)</li> </ul>	<ul style="list-style-type: none"> <li>Bariatric Surgery (when medically necessary)</li> </ul>	<ul style="list-style-type: none"> <li>Chiropractic Care (limited to 24 visits per calendar)</li> </ul>
<ul style="list-style-type: none"> <li>Cosmetic Surgery only for necessary repair to injury sustained within 1 year of an accident which occurred while under the <a href="#">Plan</a>; for correction of congenital deformity in a child who was eligible under the <a href="#">Plan</a> at birth; and/or to post mastectomy reconstructive surgery.</li> </ul>	<ul style="list-style-type: none"> <li>Telemedicine</li> </ul>	

**Your Rights to Continue Coverage:** If you lose coverage through your employer, you may be entitled to keep your benefits for a limited duration at your own cost through COBRA. Please contact the UABT Administration Department at (800)223-4590 for more information on this opportunity. In addition, there are agencies that can help if you want to continue your coverage after it ends. The contact information is the Department of Labor's Employee Benefits Security Administration at 1(866)444-EBSA (3272) or [www.dol.gov/ebsa/healthreform](http://www.dol.gov/ebsa/healthreform). Other options to continue coverage are available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the [Marketplace](#), visit [www.HealthCare.gov](http://www.HealthCare.gov) or call 1-800-318-2596.

**Your Grievance and Appeals Rights:** UABT has procedures in place for the review and appeal of denied medical, prescription medical, dental or visions claims. There are also agencies that can help if you have a complaint against your [plan](#) for a denial of a [claim](#). This complaint is called a [grievance](#) or [appeal](#). For more information about your rights, look at the [explanation of benefits](#) you will receive for that medical [claim](#). Your [plan documents](#) also provide complete information to submit a [claim appeal](#) or a grievance for any reason to your [plan](#). For more information about your rights, this notice, or assistance, contact the Department of Labor's Employee Benefits Security Administration at (866)444-EBSA (3272) or [www.dol.gov/esba/healthreform](http://www.dol.gov/esba/healthreform). Or contact the California Department of Insurance at (800)927.4357.

**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 (800)223-4590.

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

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About these Coverage Examples:



**This is not a cost estimator.** Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

**Peg is Having a Baby**  
(9 months of in-network pre-natal care and a hospital delivery)

- The plan's overall deductible \$5,000
- Specialist copayment \$20
- Hospital (facility) coinsurance 30%
- Other coinsurance 30%

**This EXAMPLE event includes services like:**  
Specialist office visits (*prenatal care*)  
Childbirth/Delivery Professional Services  
Childbirth/Delivery Facility Services  
Diagnostic tests (*ultrasounds and blood work*)  
Specialist visit (*anesthesia*)

<b>Total Example Cost</b>	<b>\$39,400</b>
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In this example, Peg would pay:

<i>Cost Sharing</i>	
Deductibles	\$5,000
Copayments	\$180
Coinsurance	\$6,100
<i>What isn't covered</i>	
Limits or exclusions	\$0
<b>The total Peg would pay is</b>	<b>\$8,500</b>

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

- The plan's overall deductible \$5,000
- Specialist copayment \$20
- Hospital (facility) coinsurance 30%
- Other coinsurance 30%

**This EXAMPLE event includes services like:**  
Primary care physician office visits (*including disease education*)  
Diagnostic tests (*blood work*)  
Prescription drugs  
Durable medical equipment (*glucose meter*)

<b>Total Example Cost</b>	<b>\$4,140</b>
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In this example, Joe would pay:

<i>Cost Sharing</i>	
Deductibles	\$5,000
Copayments	\$200
Coinsurance	\$1,035
<i>What isn't covered</i>	
Limits or exclusions	\$0
<b>The total Joe would pay is</b>	<b>\$6,235</b>

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

- The plan's overall deductible \$5,000
- Specialist copayment \$20
- Hospital (facility) coinsurance 30%
- Other coinsurance 30%

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

<b>Total Example Cost</b>	<b>\$14,437</b>
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In this example, Mia would pay:

<i>Cost Sharing</i>	
Deductibles	\$5,000
Copayments	\$0
Coinsurance	\$3,609
<i>What isn't covered</i>	
Limits or exclusions	\$0
<b>The total Mia would pay is</b>	<b>\$8,500</b>