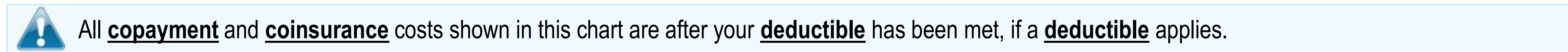
The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately. This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, call 1-800-621-5133. 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 1-800-621-5133 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	**$1,000** person/**$3,000** 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, outpatient lab tests, and prescription drugs are covered before you meet your deductible.	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost sharing and before you meet your deductible. See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/
Are there other deductibles for specific services?	Yes. **$550** non-PPO hospital deductible (except for an emergency medical condition); **$100** preauthorization non-compliance penalty. There are no other specific deductibles.	You must pay all of the costs for these services up to the specific deductible amount before this plan begins to pay for these services.
What is the out-of-pocket limit for this plan?	**$3,000** person/**$9,000** family Prescription drugs: **$4,350** person/**$5,700** 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.
What is not included in the out-of-pocket limit?	Out-of-network prescription drugs, preauthorization non-compliance penalty, non-PPO hospital deductible, premiums, balance-billing charges, and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out-of-pocket limit.
Will you pay less if you use a network provider?	Yes. See www.bcbs.com or call 1-800-810-2583 for a list of network providers; see https: wellview.welldyne.com or call 1-888-479-2000 for a list of pharmacy network providers; call 1-800-621-5133 to find a covered laboratory testing provider.	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.



Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		PPO Provider (You will pay the least)	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	20% coinsurance	20% coinsurance of a discounted fee + 100% of the remaining fee that was not discounted	None
	Specialist visit			
	Preventive care/screening/ immunization	No charge. Deductible does not apply.	20% coinsurance	You may have to pay for services that aren't preventive. Ask your provider if the services you need are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	20% coinsurance; deductible does not apply to outpatient lab tests	25% coinsurance of a discounted fee + 100% of the remaining fee that was not discounted; deductible does not apply to outpatient lab tests	None
	Imaging (CT/PET scans, MRIs)	20% coinsurance	25% coinsurance of a discounted fee + 100% of the remaining fee that was not discounted	Preauthorization required or $100 non-compliance penalty will be applied.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		PPO Provider (You will pay the least)	Non-PPO 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 https://wellview.welldyne.com/.	Tier Zero drugs and supplies (Tier 0)	No charge (retail & mail order); No charge for maintenance drugs. Deductible does not apply.	Full cost of retail drugs minus the amount the plan would have paid to a participating provider. Deductible does not apply.	Tier 0 are designated ACA medications and supplies + other selected medications (e.g., Simvastatin, Lovastatin and Omeprazole). 30-day supply retail and mail order; 90-day supply maintenance drugs K-mart, Meijer, and Wal-Mart pharmacies are not participating providers. Subject to prescription drug out-of-pocket limit: $4,350 person/$5,700 family No charge for ACA-required generic preventive drugs such as FDA-approved contraceptives (or brand name drugs if a generic is medically inappropriate). Designated maintenance drugs (90-day supply option) not available on Tier 3 drugs.
	Most Generic drugs (Tier 1)	$15 copay/script (retail & mail order); $18 copay/script for maintenance drugs. Deductible does not apply.		
	Preferred brand drugs (Tier 2)	$30 copay/script (retail & mail order); $45 copay/script for maintenance drugs. Deductible does not apply.		
	Non-preferred drugs (Tier 3)	$55 copay/script (retail & mail order). Deductible does not apply.		
	Specialty drugs	$55 copay/script (retail & mail order). Deductible does not apply.	Not covered	Must be obtained through US Specialty Care mail order program or another program that has been approved by the Trustees. Designated maintenance drugs (90-day supply option) not available.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance	20% coinsurance of a discounted fee + 100% of the remaining fee that was not discounted	Preauthorization required or $100 non-compliance penalty will be applied. Some surgeries require a 2nd opinion or expenses are paid at 50%.
	Physician/surgeon fees			

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		PPO Provider (You will pay the least)	Non-PPO Provider (You will pay the most)	
If you need immediate medical attention	Emergency room care	10% coinsurance	10% coinsurance	None
	Emergency medical transportation	20% coinsurance	20% coinsurance of a discounted fee + 100% of the remaining fee that was not discounted; except 20% coinsurance for air ambulance services	Coverage for air ambulance is limited to $15,000 per incident in North America and $25,000 per incident elsewhere.
	Urgent care	20% coinsurance	20% coinsurance of a discounted fee + 100% of the remaining fee that was not discounted	None
If you have a hospital stay	Facility fee (e.g., hospital room)	10% coinsurance	25% coinsurance of a discounted fee + 100% of the remaining fee that was not discounted after $550 non-PPO hospital deductible	Preauthorization required or $100 non-compliance penalty will be applied. Some surgeries require a 2nd opinion or expenses are paid at 50%. Non-PPO hospital deductible does not apply for an emergency medical condition.
	Physician/surgeon fees	10% coinsurance	25% coinsurance of a discounted fee + 100% of the remaining fee that was not discounted	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	20% coinsurance	20% coinsurance of a discounted fee + 100% of the remaining fee that was not discounted	None
	Inpatient services	10% coinsurance	25% coinsurance of a discounted fee + 100% of the remaining fee that was not discounted after $550 non-PPO hospital deductible	Preauthorization required or $100 non-compliance penalty will be applied. Non-PPO hospital deductible does not apply for an emergency medical condition.
If you are pregnant	Office visits	20% coinsurance	20% coinsurance of a discounted fee + 100% of the remaining fee that was not discounted	Non-PPO hospital deductible does not apply for an emergency medical condition. Expenses of the baby are covered only if you have Dependent Coverage. Cost sharing does not apply for preventive services. Depending on the type of services, a copayment, coinsurance, or deductible may apply. Maternity care may include tests and services described somewhere else in the SBC (i.e., ultrasound).
	Childbirth/delivery professional services	10% coinsurance	25% coinsurance of a discounted fee + 100% of the remaining fee that was not discounted	
	Childbirth/delivery facility services	10% coinsurance	25% coinsurance of a discounted fee + 100% of the remaining fee that was not discounted after $550 non-PPO hospital deductible	

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		PPO Provider (You will pay the least)	Non-PPO Provider (You will pay the most)	
If you need help recovering or have other special health needs	Home health care	20% coinsurance	20% coinsurance of a discounted fee + 100% of the remaining fee that was not discounted	Preauthorization required or no coverage.
	Rehabilitation services	20% coinsurance	20% coinsurance of a discounted fee + 100% of the remaining fee that was not discounted	Chiropractic therapy limited to $2,200 per person per calendar year. Physical, occupational and speech therapy are each limited to 25 sessions per event. Cardiac/pulmonary rehab is limited to 30 sessions per event.
	Habilitation services	20% coinsurance	20% coinsurance of a discounted fee + 100% of the remaining fee that was not discounted	Coverage for physical, occupational and speech therapy are each limited to 25 sessions per event; beyond 15 sessions, preauthorization required or payment will be limited to 50%.
	Skilled nursing care	20% coinsurance	20% coinsurance of a discounted fee + 100% of the remaining fee that was not discounted	Preauthorization required or no coverage.
	Durable medical equipment	20% coinsurance	20% coinsurance of a discounted fee + 100% of the remaining fee that was not discounted	Preauthorization required or no coverage. Rental of equipment not to exceed purchase price of the equipment.
	Hospice services	20% coinsurance	20% coinsurance of a discounted fee + 100% of the remaining fee that was not discounted	Preauthorization required or no coverage.
If your child needs dental or eye care	Children's eye exam Children's glasses Children's dental check-up	No charge	No charge	None

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 (except for reconstructive surgery following mastectomy) • Infertility treatment	• Long-term care • Non-emergency care when traveling outside the U.S. • Private-duty nursing	• Routine foot care

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)		
• Acupuncture (covered under physical therapy) • Bariatric surgery (preauthorization required) • Chiropractic care (limited to $2,200 per person per calendar year)	• Dental care (Adult) (up to $150 per person per calendar year; no limit for individuals under age 19) • Hearing aids (up to $500 in a 5 consecutive year period)	• Routine eye care (Adult) (up to $100 per person per calendar year; no limit for individuals under age 19) • Weight loss programs

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/ebsa/healthreform. Other coverage options may be available to you, too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318-2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information 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: Joshua Todd, Fund Administrator, UFCW Calumet Region Insurance Fund, 2625 Butterfield Rd., Suite 208E, Oak Brook, IL 60523. You may also contact the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform.

Does this plan provide Minimum Essential Coverage? Yes

Minimum Essential Coverage generally includes plans, health insurance available through the Marketplace or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of Minimum Essential Coverage, you may not be eligible for the premium tax credit.

Does this plan meet 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:

Para obtener asistencia en Español, llame al 1-800-621-5133.

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 PPO provider pre-natal care and a hospital delivery)

- **The plan's overall deductible** **$1,000**
- **Specialist coinsurance** **20%**
- **Hospital (facility) coinsurance** **10%**
- **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	$1,000
Copayments	$10
Coinsurance	$1,330
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$2,400**

Managing Joe's Type 2 Diabetes

(a year of routine PPO provider care of a well-controlled condition)

- **The plan's overall deductible** **$1,000**
- **Specialist coinsurance** **20%**
- **Hospital (facility) coinsurance** **10%**
- **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	$1,000
Copayments	$830
Coinsurance	$30
What isn't covered	
Limits or exclusions	$0
The total Joe would pay is	**$1,860**

Mia's Simple Fracture

(PPO provider emergency room visit and follow up care)

- **The plan's overall deductible** **$1,000**
- **Specialist coinsurance** **20%**
- **Hospital (facility) coinsurance** **10%**
- **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	$1,000
Copayments	$0
Coinsurance	$270
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,280**