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, visit www.ufcwmidwest.org or 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 https://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?	PPO Providers: **$325**/person per calendar year, **$975**/family per calendar year; Non-PPO Providers: **$375**/person per calendar year; **$1,125**/family per calendar year	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 up to $50, mammogram up to $130, flu shot up to $30, well-child care for eligible dependents up to age 2, lab tests done outside a hospital, dental exams, 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.
Are there other deductibles for specific services?	Yes. **$450** non-PPO hospital deductible (except for an emergency medical condition); **$100** preauthorization non-compliance deductible; **$50** dental deductible (does not apply to diagnostic and palliative treatment or orthodontia).	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?	PPO Providers: **$2,650/**person per calendar year; Non-PPO Providers: **$2,900/**person per calendar year	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 limit until the overall family out-of-pocket limit has been met.
What is not included in the out-of-pocket limit?	Prescription drugs, expenses paid at 50% coinsurance, non-preauthorization deductible, non-PPO hospital deductible, premiums, balance-billed 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 wellview.welldyne.com or call 1-888-479-2000 for a list of pharmacy network providers; call 1-800-621-5133 for covered laboratory testing 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.

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 PPO Provider (You will pay the least)	 Non-PPO Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information
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	20% coinsurance	20% coinsurance of a discounted fee + 100% of the remaining fee that was not discounted	
	Preventive care/screening/ immunization	20% coinsurance	20% coinsurance of a discounted fee + 100% of the remaining fee that was not discounted	No charge and deductible does not apply for first $50 of routine annual physical, for first $30 of seasonal flu shot, for first $130 of mammograms, or for well-child care up to age 2. 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)	Lab work done outside of a hospital: No charge; deductible does not apply. Outpatient hospital lab work: 50% coinsurance	Lab work done outside a hospital: No charge; deductible does not apply. Outpatient hospital lab work: 50% coinsurance	Amounts paid for outpatient hospital lab work covered at 50% coinsurance are not included in the out-of-pocket limit. 50% coinsurance for lab work does not apply: if you are admitted to the hospital, if you are receiving emergency care, or prior to surgery. If you meet any of these exceptions, you pay 15% coinsurance instead.
	Imaging (CT/PET scans, MRIs)	20% coinsurance	35% coinsurance of a discounted fee + 100% of the remaining fee that was not discounted	Preauthorization required. $100 non-compliance deductible applies for failure to preauthorize.

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.	Preferred generic drugs (Tier 0)	$5 copay/prescription (retail & mail order); $5 copay/prescription (maintenance drugs). Deductible does not apply.	Copay + the amount above the participating provider rate. Deductible does not apply.	Covers up to a 30-day supply retail and mail order. Covers up to a 90-day supply for maintenance drugs. K-mart, Meijer, and Wal-Mart pharmacies are not participating providers. Your cost sharing does not count toward the out-of-pocket limit.
	Generic drugs (Tier 1)	$12 copay/prescription (retail & mail order); $19 copay/prescription (maintenance drugs). Deductible does not apply.		
	Preferred brand drugs (Tier 2)	$20 copay/prescription (retail & mail order); $40 copay/prescription (maintenance drugs). Deductible does not apply.		
	Non-preferred brand drugs (Tier 3)	$33 copay/prescription (retail & mail order); $67 copay/prescription (maintenance drugs). Deductible does not apply.		
	Specialty drugs	The applicable copay/prescription for Tier 0, Tier 1, Tier 2, and Tier 3 drugs. 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. Your cost sharing does not count toward the out-of-pocket limit.

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 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. $100 non-compliance deductible applies for failure to preauthorize. Some surgeries require a second opinion or expenses are paid at 50% and don't apply to the out-of-pocket limit.
	Physician/ surgeon fees			
If you need immediate medical attention	Emergency room care	15% coinsurance	15% coinsurance	None
	Emergency medical transportation	20% coinsurance	20% coinsurance	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)	15% coinsurance	35% coinsurance of a discounted fee + 100% of the remaining fee that was not discounted; Out-of-area hospital: 20% coinsurance of a discounted fee + 100% of the remaining fee that was not discounted	Preauthorization required. $100 non-compliance deductible applies for failure to preauthorize. $450 non-PPO hospital deductible applies for a stay in a non-PPO hospital. Non-PPO hospital deductible does not apply for an emergency medical condition. Some surgeries require a second opinion or expenses are paid at 50% and don't apply to the out-of-pocket limit.
	Physician/surgeon fees	20% coinsurance	20% 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	Outpatient services: 20% coinsurance Partial hospitalization/intensive outpatient: 15% coinsurance for facility + 20% coinsurance for physician	Outpatient services: 20% coinsurance of a discounted fee + 100% of the remaining fee that was not discounted Partial hospitalization/intensive outpatient: 35% coinsurance of a discounted facility fee (20% coinsurance for out-of-area hospital) + 20% coinsurance of a discounted physician fee + 100% of remaining fees that were not discounted	Partial hospitalization/intensive outpatient: Preauthorization required; $100 non-compliance deductible applies for failure to preauthorize; $450 non-PPO hospital deductible applies for admission to a non-PPO hospital. Non-PPO hospital deductible does not apply for an emergency medical condition.

Common Medical Event	Services You May Need	What You Will Pay: PPO Provider (You will pay the least)	What You Will Pay: Non-PPO Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information
	Inpatient services	15% coinsurance for facility + 20% coinsurance for physician	35% coinsurance of a discounted facility fee (20% coinsurance for out-of-area hospital) + 20% coinsurance of a discounted physician fee + 100% of remaining fees that were not discounted	Preauthorization required. $100 non-compliance deductible applies for failure to preauthorize. $450 non-PPO hospital deductible applies for admission to a non-PPO hospital. Non-PPO hospital deductible does not apply for an emergency medical condition.
If you are pregnant	Office visits Childbirth/delivery professional services	20% coinsurance	20% coinsurance of a discounted fee + 100% of the remaining fee that was not discounted	Expenses of the baby are covered only if you have Family Coverage. Maternity care may include tests and services described somewhere else in the SBC (i.e., ultrasound). $450 Non-PPO hospital deductible applies only if the hospital stay exceeds 48 hours for a vaginal delivery or 96 hours for a cesarean section. Non-PPO hospital deductible does not apply for an emergency medical condition.
	Childbirth/delivery facility services	15% coinsurance	35% coinsurance of a discounted fee (20% coinsurance for out-of-area hospital) + 100% of the remaining fee that was not discounted	
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	Outpatient: 20% coinsurance; Inpatient: 15% coinsurance for facility + 20% coinsurance for physician	Outpatient: 20% coinsurance of a discounted fee + 100% of the remaining fee that was not discounted; Inpatient: 35% coinsurance of a discounted facility fee (20% coinsurance for out-of-area hospital) + 20% coinsurance of a discounted physician fee + 100% of remaining fees that were not discounted	Chiropractic therapy limited to $1,500 per calendar year. Physical, occupational, and speech therapy are generally limited to 25 sessions per event. Cardiac/pulmonary rehab is limited to 30 sessions per event. For inpatient rehabilitation services: Preauthorization required. $100 non-compliance deductible applies for failure to preauthorize. $450 non-PPO hospital deductible applies for a stay in a non-PPO hospital. Non-PPO hospital deductible does not apply for an emergency medical condition.
	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.

Common Medical Event	Services You May Need	What You Will Pay PPO Provider (You will pay the least)	What You Will Pay Non-PPO Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information
	Skilled nursing care	Outpatient: 20% coinsurance; Inpatient: 15% coinsurance for facility + 20% coinsurance for physician	Outpatient: 20% coinsurance of a discounted fee + 100% of the remaining fee that was not discounted; Inpatient: Not covered unless a PPO facility is unavailable; 35% coinsurance of a discounted facility fee (20% coinsurance for out-of-area hospital) + 20% coinsurance of a discounted physician fee + 100% of remaining fees that were 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. Coverage of rental of equipment limited to purchase price of equipment.
	Hospice services	Outpatient: 20% coinsurance; Inpatient: 15% coinsurance for facility + 20% coinsurance for physician	Outpatient: 20% coinsurance of a discounted fee + 100% of the remaining fee that was not discounted; Inpatient: 35% coinsurance of a discounted facility fee (20% coinsurance for out-of-area hospital) + 20% coinsurance of a discounted physician fee + 100% of remaining fees that were not discounted	Preauthorization required or no coverage. No coverage for services at a hospice inpatient facility that exceed 80% of average hospital semi-private room daily rate.
If your child needs dental or eye care	Children's eye exam	No charge	No charge	Coverage for eye exam and glasses is limited to $135 per person per calendar year. Only covered if you have Family Coverage.
	Children's glasses			
	Children's dental check-up	No charge. Medical and dental deductibles do not apply.	No charge. Medical and dental deductibles do not apply.	Coverage is limited to $43 annual maximum for exam and $65 annual maximum for cleaning. Only covered if you have Family Coverage.

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 (up to $1,500 per calendar year)	• Dental care (Adult) (up to $1,000 per lifetime for orthodontia and non-surgical TMJ treatment) • Hearing aids (up to $500 per 5 consecutive year period)	• Routine eye care (Adult) (up to $135 per person per calendar year) • Weight loss programs (preauthorization required)

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 Midwest Health Benefits Fund, 2625 Butterfield Road, 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. Additionally, a consumer assistance program can help you file your appeal. Contact the Illinois Consumer Assistance Program at 877-527-9431.

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** **$325**
- **Specialist coinsurance** **20%**
- **Hospital (facility) coinsurance** **15%**
- **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	$325
Copayments	$10
Coinsurance	$1,870
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$2,265**

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

- **The plan's overall deductible** **$325**
- **Specialist coinsurance** **20%**
- **Hospital (facility) coinsurance** **15%**
- **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	$325
Copayments	$680
Coinsurance	$170
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$1,195**

Mia's Simple Fracture
(PPO provider emergency room visit and follow up care)

- **The plan's overall deductible** **$325**
- **Specialist coinsurance** **20%**
- **Hospital (facility) coinsurance** **15%**
- **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	$325
Copayments	$10
Coinsurance	$440
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$775**

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