Local 371 UFCW AW Trust Fund: ACA Part time Plan

Summary of Benefits and Coverage: What this Plan Covers & What it Costs

Coverage Period: 01/01/2016 - 12/31/2016

Coverage for: Individual | **Plan Type:** PPO + Dependent Children

This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at **www.ufcw371.org** or by calling **(203) 266-4217**.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	**$300/**person, **$700/**family. Doesn't apply to prescription drugs, dental, vision, and some in-network preventive care. Balance billing and excluded services do not count toward the **deductible**.	You must pay all the costs up to the **deductible** amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the **deductible** starts over (usually, but not always, January 1st). See the chart starting on page 2 for how much you pay for covered services after you meet the **deductible**.
Are there other deductibles for specific services?	No.	You don't have to meet **deductibles** for specific services, but see the chart starting on page 2 for other costs for services this plan covers.
Is there an out–of–pocket limit on my expenses?	Yes. In-Network: **$2,500/**person, **$5,000/**family; Out-of-Network: there is no limit.	The **out-of-pocket limit** is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.
What is not included in the out–of–pocket limit?	Premiums, balance billing, copayments, prescription drug charges, dental & vision charges, health care this plan does not cover, and penalties for failure to obtain pre-authorization for services.	Even though you pay these expenses, they don't count toward the **out-of-pocket limit**.
Is there an overall annual limit on what the plan pays?	No.	The chart starting on page 2 describes any limits on what the plan will pay for *specific* covered services, such as office visits.

Questions: Call **(203) 266-4217** or visit us at **www.ufcw371.org**.
If you aren't clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary at **www.dol.gov/ebsa/healthreform** or call **(203) 266-4217** to request a copy.

Important Questions	Answers	Why this Matters:
Does this plan use a network of providers?	Yes. For a list of in-network **providers**, see **www.cigna.com/SA-PPO2,** or call **(800) 468-4695**.	If you use an in-network doctor or other health care **provider**, this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network **provider** for some services. Plans use the term in-network, **preferred**, or participating for **providers** in their **network**. See the chart starting on page 2 for how this plan pays different kinds of **providers**.
Do I need a referral to see a specialist?	No.	You can see the **specialist** you choose without permission from this plan.
Are there services this plan doesn't cover?	Yes.	Some of the services this plan doesn't cover are listed on page 6. See your policy or plan document for additional information about **excluded services**.

- **Copayments** are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.
- **Coinsurance** is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is $1,000, your **coinsurance** payment of 20% would be $200. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount.** If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges $1,500 for an overnight stay and the **allowed amount** is $1,000, you may have to pay the $500 difference. (This is called **balance billing**.)
- This plan may encourage you to use in-network **providers** by charging you lower **deductibles**, **copayments** and **coinsurance** amounts.

Common Medical Event	Service You May Need	Your Cost if You Use an In-Network Provider	Your Cost if You Use an Out-of-Network Provider	Limitations & Exceptions
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	20% coinsurance	40% coinsurance on allowable charges + any excess balance	None
	Specialist visit	20% coinsurance		None
	Other practitioner office visit	20% coinsurance	40% coinsurance on allowable charges + any excess balance	Chiropractor visits limited to 20/year in or out-of network combined
	Preventive care/ screening/immunization	You pay nothing for most preventive care except well-child visits		In-network colonoscopy: $200 copay age 50+, once/10 years; in-network well child: $25 copay, visits/year limited based on child's age; physical exam: one/year for age 16 +

Common Medical Event	Service You May Need	Your Cost if You Use an In-Network Provider	Your Cost if You Use an Out-of-Network Provider	Limitations & Exceptions
If you have a test	Diagnostic test (x-ray, blood work)	20% coinsurance	40% coinsurance on allowable charges + any excess balance	None
	Imaging (CT/PET scans, MRIs)	20% coinsurance		None
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.optum.com	Generic drugs	Retail: $10 copay; mail order: $25 copay	No coverage	Maximum supply: 30-days retail, 90-days mail order; no coverage for a brand name drug when a generic is available
	Preferred brand drugs	30% coinsurance with $20 min/$100 max for retail, $40 min/$200 max for mail order	No coverage	
	Non-preferred brand drugs	30% coinsurance with $40 min/$200 max for retail, $80 min/$400 max for mail order	No coverage	
	Specialty drugs	$200 copay	No coverage	Contact Optum online if you need speciality pharmacy drugs
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	$200 copay and 20% coinsurance	$200 copay and 40% coinsurance on allowable charges + any excess balance	Pre-certification (pre-cert) required or $300 penalty and possible denial of claim; if a required second surgical opinion is not obtained, payment of covered charges reduced by 50%; no coverage for services performed outside a 100-mile radius of your residence when comparable services are available from a local provider (100-mile rule)
	Physician/surgeon fees	20% coinsurance	40% coinsurance on allowable charges + any excess balance	

Common Medical Event	Service You May Need	Your Cost if You Use an In-Network Provider	Your Cost if You Use an Out-of-Network Provider	Limitations & Exceptions
If you need immediate medical attention	Emergency room services	$200 copay	$200 copay and 40% coinsurance	Out-of-network ER visit: notification required w/in 1 business day or partial denial of claim possible; in-network: deductible & coinsurance waived when resulting diagnosis considered an emergency
	Emergency medical transportation	20% coinsurance	40% coinsurance on allowable charges + any excess balance	Must be medically necessary; generally limited to within 50 miles
	Urgent care	20% coinsurance		None
If you have a hospital stay	Facility fee (e.g., hospital room)	$200 copay and 20% coinsurance	$200 copay and 40% coinsurance on allowable charges + any excess balance	Pre-cert required or $300 penalty and possible denial of claim; if a required second surgical opinion is not obtained, payment of covered charges reduced by 50%; "100-mile rule" applies
	Physician/surgeon fee	20% coinsurance	40% coinsurance on allowable charges + any excess balance	
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	20% coinsurance	40% coinsurance on allowable charges + any excess balance	100-mile rule applies
	Mental/Behavioral health inpatient services	$200 copay and 20% coinsurance	$200 copay + 40% coinsurance on allowable charges + any excess balance	Pre-cert required or $300 penalty and possible denial of claim; "100-mile rule" applies
	Substance use disorder outpatient services	20% coinsurance	40% coinsurance on allowable charges + any excess balance	100-mile rule applies
	Substance use disorder inpatient services	$200 copay and 20% coinsurance	$200 copay + 40% coinsurance on allowable charges + any excess balance	Pre-cert required or $300 penalty and possible denial of claim; "100-mile rule" applies

Common Medical Event	Service You May Need	Your Cost if You Use an In-Network Provider	Your Cost if You Use an Out-of-Network Provider	Limitations & Exceptions
If you are pregnant	Prenatal and postnatal care	20% coinsurance	40% coinsurance on allowable charges + any excess balance	None
	Delivery and all inpatient services	$200 copay, no coinsurance for facility fee + 20% coinsurance on all other charges	$200 copay + 20% coinsurance on allowable charges + any excess balance	Notification required within 72 hours of admission or partial denial of coverage possible
If you need help recovering or have other special health needs	Home health care	20% coinsurance	40% coinsurance on allowable charges + any excess balance	Pre-cert required or $300 penalty and possible denial of claim; "100-mile rule" applies
	Rehabilitation services	20% coinsurance	40% coinsurance on allowable charges + any excess balance	Pre-cert or $300 penalty and possible denial of claim; "100-mile rule" applies; inpatient PT, OT, & ST limited to 60 days & only when therapy can't be provided on an outpatient basis
	Habilitation services	Not covered	Not covered	You must pay 100% of these expenses, even in-network.
	Skilled nursing care	20% coinsurance	40% coinsurance on allowable charges + any excess balance	Pre-cert required or $300 penalty and possible denial of claim; "100-mile rule" applies
	Durable medical equipment			
	Hospice service			
If your child needs dental or eye care	Eye exam	Not covered	Not covered	You must pay 100% of these expenses, even in-network.
	Glasses	Not covered	Not covered	You must pay 100% of these expenses, even in-network.
	Dental check-up	Not covered	Not covered	You must pay 100% of these expenses, even in-network.

Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy or plan document for other excluded services.)		
● Bariatric surgery	● Hearing aids	● Non-emergency care when traveling outside the U.S.
● Cosmetic surgery (Exceptions apply)	● Infertility treatment	● Routine foot care (Exceptions apply)
● Habilitation services	● Long-term care	● Weight loss programs

Other Covered Services (This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)		
● Acupuncture (By physician only, to Plan limits)	● Dental care (Adult) (To Plan limits)	● Routine eye care (Adult) (To Plan limits)
● Chiropractic care (To Plan limits)	● Private-duty nursing (in limited circumstances)	

Your Rights to Continue Coverage:

If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a **premium**, which may be significantly higher than the premium you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply.

For more information on your rights to continue coverage, contact the plan at (203) 266-4217. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cciio.cms.gov.

Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to **appeal** or file a **grievance**. For questions about your rights, this notice, or assistance, you can contact the plan at (203) 266-4217. 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 Coverage Provide Minimum Essential Coverage?

The Affordable Care Act requires most people to have health care coverage that qualifies as "minimum essential coverage." **This plan does provide minimum essential coverage.**

Does this Coverage Meet the Minimum Value Standard?

The Affordable Care Act establishes a minimum value standard of benefits of a health plan. The minimum value standard is 60% (actuarial value). **This health coverage does meet the minimum value standard for the benefits it provides.**

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

About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.

This is not a cost estimator.

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

Having a baby
(normal delivery)

- **Amount owed to providers:** $7,540
- **Plan pays** $6,370
- **Patient pays** $1,170

Sample care costs:

Hospital charges (mother)	$2,700
Routine obstetric care	$2,100
Hospital charges (baby)	$900
Anesthesia	$900
Laboratory tests	$500
Prescriptions	$200
Radiology	$200
Vaccines, other preventive	$40
Total	**$7,540**

Patient pays:

Deductibles	$300
Copays	$220
Coinsurance	$500
Limits or exclusions	$150
Total	**$1,170**

Managing type 2 diabetes
(routine maintenance of a well-controlled condition)

- **Amount owed to providers:** $5,400
- **Plan pays** $4,090
- **Patient pays** $1,310

Sample care costs:

Prescriptions	$2,900
Medical Equipment and Supplies	$1,300
Office Visits and Procedures	$700
Education	$300
Laboratory tests	$100
Vaccines, other preventive	$100
Total	**$5,400**

Patient pays:

Deductibles	$300
Copays	$400
Coinsurance	$400
Limits or exclusions	$210
Total	**$1,310**

Questions and answers about the Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

- Costs don't include **premiums**.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network **providers**. If the patient had received care from out-of-network **providers**, costs would have been higher.

What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how **deductibles**, **copayments**, and **coinsurance** can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

Does the Coverage Example predict my own care needs?

✘ **No.** Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

Does the Coverage Example predict my future expenses?

✘ **No.** Coverage Examples are **not** cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your **providers** charge, and the reimbursement your health plan allows.

Can I use Coverage Examples to compare plans?

✓ **Yes.** When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

Are there other costs I should consider when comparing plans?

✓ **Yes.** An important cost is the **premium** you pay. Generally, the lower your **premium**, the more you'll pay in out-of-pocket costs, such as **copayments**, **deductibles**, and **coinsurance**. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.

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