
 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.ufcw371.org](http://www.ufcw371.org) or call 203-226-4217. 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.dol.gov/ebsa/healthreform](http://www.dol.gov/ebsa/healthreform) or call 203-226-4217 to request a copy.

Important Questions	Answers	Why This Matters:
<b>What is the overall <u>deductible</u>?</b>	\$300/individual; \$700/family \$400/individual; \$800/family for Stop and Shop employees hired/promoted to full-time clerk after 05/01/2016	Generally, you must pay all of the costs from <u>providers</u> up to the <u>deductible</u> amount before this <u>plan</u> begins to pay. If you have other family members on the policy, the overall family <u>deductible</u> must be met before the <u>plan</u> begins to pay.
<b>Are there services covered before you meet your <u>deductible</u>?</b>	Yes. <u>Prescription drugs</u> , vision services, dental services and one routine physical exam/year are covered before you meet your <u>deductible</u> .	This <u>plan</u> covers some items and services even if you haven't yet met the <u>deductible</u> amount. But a <u>copayment</u> or <u>coinsurance</u> may apply.
<b>Are there other <u>deductibles</u> for specific services?</b>	No.	You don't have to meet <u>deductibles</u> for specific services.
<b>What is the <u>out-of-pocket limit</u> for this <u>plan</u>?</b>	<u>In-network</u> : \$2,500/person; \$5,000/family	The <u>out-of-pocket limit</u> is the most you could pay in a year for <u>in-network</u> covered services. If you have other family members in this <u>plan</u> , they have to meet their own <u>out-of-pocket limits</u> until the overall family <u>out-of-pocket limit</u> has been met.
<b>What is not included in the <u>out-of-pocket limit</u>?</b>	<u>Premiums</u> , <u>balance billing</u> , penalties for failure to obtain <u>preauthorization</u> , <u>copays</u> , vision services through Eyemed, dental services, health care this <u>plan</u> doesn't cover and <u>out-of-network</u> services.	Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u> .
<b>Will you pay less if you use a <u>network provider</u>?</b>	Yes. See <a href="http://www.cigna.com/SA-PPO2">www.cigna.com/SA-PPO2</a> or call 800-768-4695 for a list of <u>network providers</u> .	This <u>plan</u> uses a <u>provider network</u> . You will pay less if you use a <u>provider</u> in the <u>plan's network</u> . You will pay the most if you use an <u>out-of-network provider</u> , and you might receive a bill from a <u>provider</u> for the difference between the <u>provider's charge</u> and what your <u>plan</u> pays ( <u>balance billing</u> ). Be aware your <u>network provider</u> might use an <u>out-of-network provider</u> for some services (such as lab work). Check with your <u>provider</u> before you get services.

Do you need a <u>referral</u> to see a <u>specialist</u> ?	No.	You can see the <u>specialist</u> you choose without a <u>referral</u> .
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 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
		<u>In-Network Provider</u> (You will pay the least)	<u>Out-of-Network Provider</u> (You will pay the most)	
If you visit a health care <u>provider's</u> office or clinic	Primary care visit to treat an injury or illness	20% <u>coinsurance</u> .	40% <u>coinsurance</u> plus charges above <u>allowed amount</u> .	None.
	<u>Specialist</u> visit	20% <u>coinsurance</u> .	40% <u>coinsurance</u> plus charges above <u>allowed amount</u> .	None.
	<u>Preventive care/screening/immunization</u>	Routine physical exam: no charge and <u>deductible</u> does not apply. Well-child visit: \$25 <u>copay</u> /visit. Other services: 20% <u>coinsurance</u> .	40% <u>coinsurance</u> plus charges above <u>allowed amount</u> .	One routine physical exam/calendar year. Colonoscopy covered once/10 years for age 50+. Other age and frequency limits apply. Well-child visit: <u>copay</u> does not count toward the <u>out-of-pocket limit</u> .
If you have a test	<u>Diagnostic test</u> (x-ray, blood work)	20% <u>coinsurance</u> .	40% <u>coinsurance</u> plus charges above <u>allowed amount</u> .	None.
	Imaging (CT/PET scans, MRIs)	20% <u>coinsurance</u> .	40% <u>coinsurance</u> plus charges above <u>allowed amount</u> .	None.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		<u>In-Network Provider</u> (You will pay the least)	<u>Out-of-Network Provider</u> (You will pay the most)	
<b>If you need drugs to treat your illness or condition</b> More information about <b><u>prescription drug coverage</u></b> is available at <a href="http://www.optumrx.com">www.optumrx.com</a>	Generic drugs	Retail: \$10 <u>copay</u> /prescription Mail order: \$25 <u>copay</u> /prescription. <u>Copay</u> does not count toward <u>out-of-pocket limit</u> . <u>Deductible</u> does not apply.	Not covered.	Retail: up to 30-day supply; Mail order: up to 90-day supply.  Generic is mandatory when available.
	Preferred brand drugs	30% <u>coinsurance</u> ; Retail: \$20 minimum; \$100 maximum. Mail order: \$40 minimum; \$200 maximum <u>Deductible</u> does not apply.	Not covered.	
	Non-preferred brand drugs	30% <u>coinsurance</u> . Retail: \$40 minimum; \$200 maximum. Mail order: \$80 minimum; \$400 maximum <u>Deductible</u> does not apply.	Not covered.	
	<u>Specialty drugs</u>	\$200 <u>copay</u> /prescription. <u>Copay</u> does not count toward <u>out-of-pocket limit</u> . <u>Deductible</u> does not apply.	Not covered.	Retail: up to 30-day supply. No mail order.
<b>If you have outpatient surgery</b>	Facility fee (e.g., ambulatory surgery center)	20% <u>coinsurance</u> .	40% <u>coinsurance</u> plus charges above <u>allowed amount</u> .	<u>Preauthorization</u> is required to avoid \$300 penalty.
	Physician/surgeon fees	20% <u>coinsurance</u> .	40% <u>coinsurance</u> plus charges above <u>allowed amount</u> .	<u>Preauthorization</u> is required to avoid \$300 penalty.
<b>If you need immediate medical attention</b>	<u>Emergency room care</u>	\$200 <u>copay</u> /visit and 20% <u>coinsurance</u> . <u>Copay</u> does not count toward <u>out-of-pocket limit</u> .	\$200 <u>copay</u> /visit and 40% <u>coinsurance</u> plus charges above <u>allowed amount</u> .	Professional and physician charges may be billed separately.
	<u>Emergency medical transportation</u>	20% <u>coinsurance</u> .	40% <u>coinsurance</u> plus charges above <u>allowed amount</u> .	Limited to nearest facility within 50 miles from place of pickup.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		<u>In-Network Provider</u> (You will pay the least)	<u>Out-of-Network Provider</u> (You will pay the most)	
	<u>Urgent care</u>	20% <u>coinsurance</u> .	40% <u>coinsurance</u> plus charges above <u>allowed amount</u> .	None.
If you have a hospital stay	Facility fee (e.g., hospital room)	\$200 <u>copay</u> /admission and 20% <u>coinsurance</u> . <u>Copay</u> does not count toward <u>out-of-pocket limit</u> .	\$200 <u>copay</u> /admission and 40% <u>coinsurance</u> .	Coverage limited to rate for a semi-private room. <u>Preauthorization</u> is required to avoid \$300 penalty.
	Physician/surgeon fees	20% <u>coinsurance</u> .	40% <u>coinsurance</u> plus charges above <u>allowed amount</u> .	<u>Preauthorization</u> is required to avoid \$300 penalty.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	20% <u>coinsurance</u> .	40% <u>coinsurance</u> plus charges above <u>allowed amount</u> .	None.
	Inpatient services	\$200 <u>copay</u> /admission and 20% <u>coinsurance</u> . <u>Copay</u> does not count toward <u>out-of-pocket limit</u> .	\$200 <u>copay</u> /admission and 40% <u>coinsurance</u> plus charges above <u>allowed amount</u> .	<u>Preauthorization</u> is required to avoid \$300 penalty.
If you are pregnant	Office visits	20% <u>coinsurance</u> .	40% <u>coinsurance</u> plus charges above <u>allowed amount</u> .	Maternity care may include tests and services described somewhere else in the SBC (i.e., ultrasound).
	Childbirth/delivery professional services	No charge.	20% <u>coinsurance</u> plus charges above <u>allowed amount</u> .	None.
	Childbirth/delivery facility services			
If you need help recovering or have other special health needs	<u>Home health care</u>	20% <u>coinsurance</u> .	40% <u>coinsurance</u> plus charges above <u>allowed amount</u> .	<u>Preauthorization</u> is required to avoid \$300 penalty.
	<u>Rehabilitation services</u>	20% <u>coinsurance</u> .	40% <u>coinsurance</u> plus charges above <u>allowed amount</u> .	Inpatient speech therapy, occupational therapy, physical therapy: limit is 60 visits/injury/illness within 90 consecutive days. <u>Preauthorization</u> is required to avoid \$300 penalty.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		<u>In-Network Provider</u> (You will pay the least)	<u>Out-of-Network Provider</u> (You will pay the most)	
	<u>Habilitation services</u>	Not covered.	Not covered.	You must pay 100% of this service, even <u>in-network</u> .
	<u>Skilled nursing care</u>	20% <u>coinsurance</u> .	40% <u>coinsurance</u> plus charges above <u>allowed amount</u> .	<u>Preauthorization</u> is required to avoid \$300 penalty. Covered within 15 days of <u>hospitalization</u> or instead of <u>hospitalization</u> of at least 3 days.
	<u>Durable medical equipment</u>	20% <u>coinsurance</u> .	40% <u>coinsurance</u> plus charges above <u>allowed amount</u> .	<u>Preauthorization</u> is required to avoid \$300 penalty. Foot <u>orthotics</u> covered once/3 years up to \$350.
	<u>Hospice services</u>	20% <u>coinsurance</u> .	40% <u>coinsurance</u> plus charges above <u>allowed amount</u> .	<u>Preauthorization</u> is required to avoid \$300 penalty. Limited to terminal condition with 6-month life expectancy.
If your child needs dental or eye care	Children's eye exam	No charge.	No charge up to \$40 <u>allowed amount</u> .	1 exam/year. <u>Deductible</u> does not apply. Separately administered by Eyemed.
	Children's glasses	Frames: no charge up to \$75 <u>allowed amount</u> . Standard lenses: no charge.	Frames: no charge up to \$42 <u>allowed amount</u> . Standard lenses: no charge up to \$35 <u>allowed amount</u> .	<u>Deductible</u> does not apply. Lenses: once/12 months. Frames (16 and under): once/12 months. Frames (over 16): once/24 months. Separately administered by Eyemed.
	Children's dental check-up	You pay 100% and apply for reimbursement of <u>allowed amounts</u> .		<u>Deductible</u> does not apply. 1 exam/6 months. Limit: \$2,500/person/year. Predetermination required where charge is expected to be \$500 or more.

**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.)

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|---|---|---|
| <ul style="list-style-type: none"> <li>• Bariatric surgery</li> <li>• Cosmetic surgery (except to correct abnormal congenital conditions and following mastectomy)</li> </ul> | <ul style="list-style-type: none"> <li>• <u>Habilitation services</u></li> <li>• Infertility treatment</li> <li>• Long term care</li> </ul> | <ul style="list-style-type: none"> <li>• Non-emergency care when traveling outside the U.S.</li> <li>• Routine foot care</li> <li>• Weight loss programs</li> </ul> |
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Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

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| <ul style="list-style-type: none"> <li>• Acupuncture (by licensed M.D. only up to</li> </ul> | <ul style="list-style-type: none"> <li>• Dental care (Adult) (annual maximum:</li> </ul> | <ul style="list-style-type: none"> <li>• Private-duty nursing</li> </ul> |
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<ul style="list-style-type: none"> <li>\$500/year)</li> <li>• Chiropractic care (limit of 20 visits/year)</li> </ul>	<ul style="list-style-type: none"> <li>\$2,500/person)</li> <li>• Hearing aids</li> </ul>	<ul style="list-style-type: none"> <li>• Routine eye care (Adult) (dollar limits on progressive lenses; lenses once/12 months; frames once/24 months)</li> </ul>
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**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](http://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](http://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 to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, call 203-226-4217. 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](http://www.dol.gov/ebsa/healthreform).

**Does this plan provide Minimum Essential Coverage? Yes**

If you don't have Minimum Essential Coverage for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

**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.

-----*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 \$300
- Specialist coinsurance 20%
- Hospital (facility) copay \$200
- 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*)

<b>Total Example Cost</b>	<b>\$12,800</b>
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In this example, Peg would pay:

<u>Cost Sharing</u>	
<u>Deductibles</u>	\$300
<u>Copayments</u>	\$470
<u>Coinsurance</u>	\$370
<i>What isn't covered</i>	
Limits or exclusions	\$10
<b>The total Peg would pay is</b>	<b>\$1,150</b>

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

- The plan's overall deductible \$300
- Specialist coinsurance 20%
- Hospital (facility) copay \$200
- 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*)

<b>Total Example Cost</b>	<b>\$7,400</b>
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In this example, Joe would pay:

<u>Cost Sharing</u>	
<u>Deductibles</u>	\$300
<u>Copayments</u>	\$660
<u>Coinsurance</u>	\$1,220
<i>What isn't covered</i>	
Limits or exclusions	\$180
<b>The total Joe would pay is</b>	<b>\$2,360</b>

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

- The plan's overall deductible \$300
- Specialist coinsurance 20%
- Hospital (facility) copay \$200
- 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*)

<b>Total Example Cost</b>	<b>\$1,900</b>
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In this example, Mia would pay:

<u>Cost Sharing</u>	
<u>Deductibles</u>	\$300
<u>Copayments</u>	\$200
<u>Coinsurance</u>	\$290
<i>What isn't covered</i>	
Limits or exclusions	\$0
<b>The total Mia would pay is</b>	<b>\$790</b>

The plan would be responsible for the other costs of these EXAMPLE covered services. These examples do not illustrate coverage for Stop and Shop clerks; those individuals have a \$400/individual or \$800/family deductible.