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 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 or call 203-226-4217 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	$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 providers up to the deductible amount before this plan begins to pay. If you have other family members on the policy, the overall family deductible must be met before the plan begins to pay.
Are there services covered before you meet your deductible?	Yes. Prescription drugs, vision services, dental services and one routine physical exam/year 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?	No.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	In-network: $2,500/person; $5,000/family	The out-of-pocket limit is the most you could pay in a year for in-network 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?	Premiums, balance billing, penalties for failure to obtain preauthorization, copays, vision services through Eyemed, dental services, health care this plan doesn't cover and out-of-network services.	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.cigna.com/SA-PPO2 or call 800-768-4695 for a list of network 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		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network 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.	40% coinsurance plus charges above allowed amount.	None.
	Specialist visit	20% coinsurance.	40% coinsurance plus charges above allowed amount.	None.
	Preventive care/screening/ immunization	Routine physical exam: no charge and deductible does not apply. Well-child visit: $25 copay/visit. Other services: 20% coinsurance.	40% coinsurance plus charges above allowed amount.	One routine physical exam/calendar year. Colonoscopy covered once/10 years for age 50+. Other age and frequency limits apply. Well-child visit: copay does not count toward the out-of-pocket limit.
If you have a test	Diagnostic test (x-ray, blood work)	20% coinsurance.	40% coinsurance plus charges above allowed amount.	None.
	Imaging (CT/PET scans, MRIs)	20% coinsurance.	40% coinsurance plus charges above allowed amount.	None.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network 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 www.optumrx.com	Generic drugs	Retail: $10 copay/prescription Mail order: $25 copay/ prescription. Copay does not count toward out-of-pocket limit. Deductible 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% coinsurance; Retail: $20 minimum; $100 maximum. Mail order: $40 minimum; $200 maximum Deductible does not apply.	Not covered.	
	Non-preferred brand drugs	30% coinsurance. Retail: $40 minimum; $200 maximum. Mail order: $80 minimum; $400 maximum Deductible does not apply.	Not covered.	
	Specialty drugs	$200 copay/prescription. Copay does not count toward out-of-pocket limit. Deductible does not apply.	Not covered.	Retail: up to 30-day supply. No mail order.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance.	40% coinsurance plus charges above allowed amount.	Preauthorization is required to avoid $300 penalty.
	Physician/surgeon fees	20% coinsurance.	40% coinsurance plus charges above allowed amount.	Preauthorization is required to avoid $300 penalty.
If you need immediate medical attention	Emergency room care	$200 copay/visit and 20% coinsurance. Copay does not count toward out-of-pocket limit.	$200 copay/visit and 40% coinsurance plus charges above allowed amount.	Professional and physician charges may be billed separately.
	Emergency medical transportation	20% coinsurance.	40% coinsurance plus charges above allowed amount.	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
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
	Urgent care	20% coinsurance.	40% coinsurance plus charges above allowed amount.	None.
If you have a hospital stay	Facility fee (e.g., hospital room)	$200 copay/admission and 20% coinsurance. Copay does not count toward out-of-pocket limit.	$200 copay/admission and 40% coinsurance.	Coverage limited to rate for a semi-private room. Preauthorization is required to avoid $300 penalty.
	Physician/surgeon fees	20% coinsurance.	40% coinsurance plus charges above allowed amount.	Preauthorization is required to avoid $300 penalty.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	20% coinsurance.	40% coinsurance plus charges above allowed amount.	None.
	Inpatient services	$200 copay/admission and 20% coinsurance. Copay does not count toward out-of-pocket limit.	$200 copay/admission and 40% coinsurance plus charges above allowed amount.	Preauthorization is required to avoid $300 penalty.
If you are pregnant	Office visits	20% coinsurance.	40% coinsurance plus charges above allowed amount.	Maternity care may include tests and services described somewhere else in the SBC (i.e., ultrasound).
	Childbirth/delivery professional services	No charge.	20% coinsurance plus charges above allowed amount.	None.
	Childbirth/delivery facility services			
If you need help recovering or have other special health needs	Home health care	20% coinsurance.	40% coinsurance plus charges above allowed amount.	Preauthorization is required to avoid $300 penalty.
	Rehabilitation services	20% coinsurance.	40% coinsurance plus charges above allowed amount.	Inpatient speech therapy, occupational therapy, physical therapy: limit is 60 visits/injury/illness within 90 consecutive days. Preauthorization is required to avoid $300 penalty.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
	Habilitation services	Not covered.	Not covered.	You must pay 100% of this service, even in-network.
	Skilled nursing care	20% coinsurance.	40% coinsurance plus charges above allowed amount.	Preauthorization is required to avoid $300 penalty. Covered within 15 days of hospitalization or instead of hospitalization of at least 3 days.
	Durable medical equipment	20% coinsurance.	40% coinsurance plus charges above allowed amount.	Preauthorization is required to avoid $300 penalty. Foot orthotics covered once/3 years up to $350.
	Hospice services	20% coinsurance.	40% coinsurance plus charges above allowed amount.	Preauthorization 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 allowed amount.	1 exam/year. Deductible does not apply. Separately administered by Eyemed.
	Children's glasses	Frames: no charge up to $75 allowed amount. Standard lenses: no charge.	Frames: no charge up to $42 allowed amount. Standard lenses: no charge up to $35 allowed amount.	Deductible 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 allowed amounts.		Deductible 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.)		
• Bariatric surgery • Cosmetic surgery (except to correct abnormal congenital conditions and following mastectomy)	• Habilitation services • Infertility treatment • Long term care	• Non-emergency care when traveling outside the U.S. • Routine foot care • Weight loss programs

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)		
• Acupuncture (by licensed M.D. only up to $500/year) • Chiropractic care (limit of 20 visits/year)	• Dental care (Adult) (annual maximum: $2,500/person) • Hearing aids	• Private-duty nursing • Routine eye care (Adult) (dollar limits on progressive lenses; lenses once/12 months; frames once/24 months)

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 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.

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)*

Total Example Cost	$12,800

In this example, Peg would pay:

Cost Sharing	
Deductibles	$300
Copayments	$470
Coinsurance	$370
What isn't covered	
Limits or exclusions	$10
The total Peg would pay is	$1,150

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)*

Total Example Cost	$7,400

In this example, Joe would pay:

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

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)*

Total Example Cost	$1,900

In this example, Mia would pay:

Cost Sharing	
Deductibles	$300
Copayments	$200
Coinsurance	$290
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	$790

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.