UFCW & Employers Food Trades and Industries Health & Welfare Plan

Coverage Period: 01/01/2020 – 12/31/2020

Core Coverage Plan

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

For: Individual and Family | **Plan Type:** PPO

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, contact NEBA at (888) 815-8329. 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 (888) 815-8329 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	$3,118/Individual or $9,354/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. Network provider office visits 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. $50/visit for emergency room care. 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?	For network providers: $9,000 individual / $27,000 family. For specialty drugs: $1,500 individual	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?	Premiums, deductibles, copayments on certain services, Out-of-network provider charges, balance billing, penalties for failure to obtain preauthorization for services, health care this plan doesn't cover and prescription drugs (other than specialty drugs which only apply toward their own limit).	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.cignasharedadministration.com or call (888) 815-8329 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 don't need a referral to see a specialist.	You can see the specialist you choose without permission from this plan.

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
		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	$25 copay/visit; deductible does not apply	40% coinsurance	None
	Specialist visit	$25 copay/visit; deductible does not apply	40% coinsurance	None
	Preventive care/screening/ immunization	20% coinsurance	40% 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	40% coinsurance	Preauthorization is required for certain testing. If you don't get preauthorization, all charges may be denied.
	Imaging (CT/PET scans, MRIs)	20% coinsurance	40% coinsurance	
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.medtrakrx.com	Generic drugs	Retail-30: Greater of $10 copay/script or 10% coinsurance MedTrak-90 or Mail Order: $20 copay/script	Not covered	Deductible does not apply. Prescriptions obtained under Retail-30 are limited to a 30-day supply. Prescriptions obtained through the MedTrak-90 network or Mail Order are limited to a 90-day supply. Drugs that are excluded from the Pharmacy Benefit Manager's formulary are not covered. Coverage for certain medications may be subject to step therapy, preauthorization or other utilization management programs. Failure to obtain preauthorization will result in the drug not being covered.
	Preferred brand drugs	Retail-30: Greater of $20 copay/script or 20% coinsurance MedTrak-90 or Mail Order: $40 copay/script	Not covered	
	Non Preferred brand drugs	Retail-30: Greater of $40 copay/script or 40% coinsurance MedTrak-90 or Mail Order: $80 copay/script	Not covered	
	Specialty drugs	20% coinsurance	Not covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance	40% coinsurance	Preauthorization is required for certain services. If you don't get preauthorization, all charges may be denied. Out-of-network ambulatory surgery centers are not covered.
	Physician/surgeon fees	20% coinsurance	40% coinsurance	

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need immediate medical attention	Emergency room care	$50 Emergency Room deductible, then 20% coinsurance	$50 Emergency Room deductible, then 40% coinsurance	The network provider benefits will be applied to charges from out-of-network provider when the chances of suffering permanent harm to health or death would be significantly increased because of the delay necessary to utilize a network provider.
	Emergency medical transportation	20% coinsurance	40% coinsurance	
	Urgent care	20% coinsurance	40% coinsurance	
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance	40% coinsurance	Preauthorization is required. If you don't get preauthorization, your coinsurance percentage will be increased by 10 percentage points, up to a maximum penalty of $500 per hospital admission.
	Physician/surgeon fees	20% coinsurance	40% coinsurance	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	20% coinsurance	40% coinsurance, deductible does apply	Preauthorization is required for certain services other than office visits. If you don't get preauthorization, all charges may be denied.
	Inpatient services	20% coinsurance	40% coinsurance	Preauthorization is required. If you don't get preauthorization, your coinsurance percentage will be increased by 10 percentage points, up to a maximum penalty of $500 per hospital admission.
If you are pregnant	Office visits	20% coinsurance	40% coinsurance	Maternity care may include tests and services described elsewhere in the SBC (i.e., ultrasound). No coverage for dependent child pregnancy,
	Childbirth/delivery professional services	20% coinsurance	40% coinsurance	
	Childbirth/delivery facility services	20% coinsurance	40% coinsurance	
If you need help recovering or have other special health needs	Home health care	20% coinsurance	40% coinsurance	Home health care is limited to 90 visits per calendar year. Speech therapy is covered only if the condition being treated is due to an illness or injury which has symptoms other than that condition.
	Rehabilitation services	20% coinsurance	40% coinsurance	
	Habilitation services	20% coinsurance	40% coinsurance	

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
	Skilled nursing care	20% coinsurance	40% coinsurance	Extended care facility charges limited to 60 days per calendar year. Hospice services are limited to 365 days per lifetime. Preauthorization is required. If you don't get preauthorization, all charges may be denied.
	Durable medical equipment	20% coinsurance	40% coinsurance	
	Hospice services	20% coinsurance	40% coinsurance	
If your child needs dental or eye care	Children's eye exam	Not covered	Not covered	None
	Children's glasses	Not covered	Not covered	None
	Children's dental check-up	Not covered	Not covered	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.)

- Acupuncture
- Bariatric Surgery
- Chiropractic Care
- Cosmetic Surgery
- Dental Care (Adult)
- Dental Care (Child)
- Hearing Aids
- Infertility Treatment
- Long Term Care
- Private Duty Nursing
- Routine Eye Care (Adult)
- Routine Eye Care (Child)
- 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.)

- Non-emergency Care When Traveling Outside the U.S.

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 the US Department of Labor, Employee Benefits Security Administration is 1-866-444-3272 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, contact: Department of Labor 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 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:
Spanish (Español): Para obtener asistencia en Español, llame al (888) 815-8329.
Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa (888) 815-8329.
Chinese (中文): 如果需要中文的帮助， 请拨打这个号码 (888) 815-8329.
Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' (888) 815-8329.

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** **$3,118**
- **Specialist copayment** **$25**
- **Hospital (facility) coinsurance** **20%**
- **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	$3,118
Copayments	$30
Coinsurance	$1,900
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$5,108**

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

- **The plan's overall deductible** **$3,118**
- **Specialist copayment** **$25**
- **Hospital (facility) coinsurance** **20%**
- **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*	$1,920
Copayments	$810
Coinsurance	$940
What isn't covered	
Limits or exclusions	$30
The total Joe would pay is	**$2,700**

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

- **The plan's overall deductible** **$3,118**
- **Specialist copayment** **$25**
- **Hospital (facility) coinsurance** **20%**
- **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*	$1,740
Copayments	$50
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,790**

*Note: This plan has other deductibles for specific services included in this coverage example. See "Are there other deductibles for specific services?" row above.

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